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State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. **1233**

03/04/2013 Authored by Huntley; Moran; Ward, J.E.; Isaacson and Loeffler
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

04/18/2013 Adoption of Report: Pass as Amended and Read Second Time

04/22/2013 Calendar for the Day, Amended
Read Third Time as Amended
Passed by the House as Amended and transmitted to the Senate to include Floor Amendments

05/17/2013 Conference Committee Report Adopted
Read Third Time as Amended by Conference and repassed by the House

A bill for an act

1.1 relating to state government; establishing the health and human services budget;
1.2 modifying provisions related to health care, continuing care, human services
1.3 licensing, children and family services, program integrity, health-related
1.4 licensing boards, chemical and mental health services, managed care
1.5 organizations, waiver provider standards, home care, and the Department of
1.6 Health; redesigning home and community-based services; establishing payment
1.7 methodologies for home and community-based services; adjusting provider
1.8 rates; setting and modifying fees; modifying autism coverage; modifying
1.9 assistance programs; establishing Northstar care for children; making technical
1.10 changes; requiring studies; requiring reports; appropriating money; amending
1.11 Minnesota Statutes 2012, sections 13.381, subdivisions 2, 10; 13.461, by adding
1.12 subdivisions; 16A.724, subdivisions 2, 3; 16C.10, subdivision 5; 16C.155,
1.13 subdivision 1; 43A.23, by adding a subdivision; 62J.692, subdivisions 1, 3, 4,
1.14 5, 9, by adding a subdivision; 62Q.19, subdivision 1; 103I.005, by adding a
1.15 subdivision; 103I.521; 119B.011, by adding a subdivision; 119B.02, by adding
1.16 a subdivision; 119B.025, subdivision 1; 119B.03, subdivision 4; 119B.05,
1.17 subdivision 1; 119B.13, subdivisions 1, 1a, 3a, 6, 7, by adding subdivisions;
1.18 144.051, by adding subdivisions; 144.0724, subdivisions 4, 6; 144.123,
1.19 subdivision 1; 144.125, subdivision 1; 144.212; 144.213; 144.215, subdivisions
1.20 3, 4; 144.216, subdivision 1; 144.217, subdivision 2; 144.218, subdivision 5;
1.21 144.225, subdivisions 1, 4, 7, 8; 144.226; 144.966, subdivisions 2, 3a; 144.98,
1.22 subdivisions 3, 5, by adding subdivisions; 144.99, subdivision 4; 144A.071,
1.23 subdivision 4b; 144A.351; 144A.43; 144A.44; 144A.45; 144D.01, subdivision 4;
1.24 145.906; 145.986; 145A.17, subdivision 1; 145C.01, subdivision 7; 148B.17,
1.25 subdivision 2; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5,
1.26 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding
1.27 subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;
1.28 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions 1,
1.29 2, 4; 149A.74; 149A.91, subdivision 9; 149A.93, subdivisions 3, 6; 149A.94;
1.30 149A.96, subdivision 9; 151.19, subdivisions 1, 3; 151.37, subdivision 4; 151.47,
1.31 subdivision 1, by adding a subdivision; 151.49; 174.30, subdivision 1; 214.12, by
1.32 adding a subdivision; 214.40, subdivision 1; 243.166, subdivisions 4b, 7; 245.03,
1.33 subdivision 1; 245.462, subdivision 20; 245.4661, subdivisions 5, 6; 245.4682,
1.34 subdivision 2; 245.4871, subdivision 26; 245.4875, subdivision 8; 245.4881,
1.35 subdivision 1; 245.91, by adding a subdivision; 245.94, subdivisions 2, 2a;
1.36 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04,
1.37 subdivision 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08,
1.38 subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435;
1.39

2.1 245A.144; 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5;
 2.2 245A.50; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245D.02;
 2.3 245D.03; 245D.04; 245D.05; 245D.06; 245D.07; 245D.09; 245D.10; 246.18,
 2.4 subdivision 8, by adding a subdivision; 246.54; 252.27, subdivision 2a;
 2.5 252.291, by adding a subdivision; 252.41, subdivision 3; 252.42; 252.43;
 2.6 252.44; 252.45; 252.46, subdivision 1a; 253B.10, subdivision 1; 254B.04,
 2.7 subdivision 1; 254B.13; 256.01, subdivisions 2, 24, 34, by adding subdivisions;
 2.8 256.0112, by adding a subdivision; 256.015, subdivision 1; 256.82, subdivisions
 2.9 2, 3; 256.9657, subdivisions 3, 3a, 4; 256.969, subdivision 29; 256.975,
 2.10 subdivision 7, by adding subdivisions; 256.9754, subdivision 5, by adding
 2.11 subdivisions; 256.98, subdivision 8; 256B.02, subdivision 17, as added, by
 2.12 adding subdivisions; 256B.021, by adding subdivisions; 256B.04, subdivisions
 2.13 18, 21, by adding a subdivision; 256B.055, subdivisions 3a, 6, 10, 14, 15, by
 2.14 adding a subdivision; 256B.056, subdivisions 1, 1c, 3, 4, as amended, 5c, 10, by
 2.15 adding a subdivision; 256B.057, subdivisions 1, 8, 10, by adding a subdivision;
 2.16 256B.06, subdivision 4; 256B.0623, subdivision 2; 256B.0625, subdivisions 9,
 2.17 13, 13e, 19c, 31, 39, 48, 56, 58, by adding subdivisions; 256B.0631, subdivision
 2.18 1; 256B.064, subdivisions 1a, 1b, 2; 256B.0659, subdivision 21; 256B.0755,
 2.19 subdivision 3; 256B.0756; 256B.0911, subdivisions 1, 1a, 3a, 4d, 6, 7, by
 2.20 adding a subdivision; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a,
 2.21 5, by adding a subdivision; 256B.0916, by adding a subdivision; 256B.0917,
 2.22 subdivisions 6, 13, by adding subdivisions; 256B.092, subdivisions 1a, 7,
 2.23 11, 12, by adding subdivisions; 256B.0943, subdivisions 1, 2, 7, by adding a
 2.24 subdivision; 256B.0946; 256B.095; 256B.0951, subdivisions 1, 4; 256B.0952,
 2.25 subdivisions 1, 5; 256B.0955; 256B.097, subdivisions 1, 3; 256B.196,
 2.26 subdivision 2; 256B.431, subdivision 44; 256B.434, subdivision 4, by adding
 2.27 subdivisions; 256B.437, subdivision 6; 256B.439, subdivisions 1, 2, 3, 4, by
 2.28 adding subdivisions; 256B.441, subdivisions 13, 44, 53, by adding subdivisions;
 2.29 256B.49, subdivisions 11a, 12, 13, 14, 15, by adding subdivisions; 256B.4912,
 2.30 subdivisions 1, 2, 3, 7, by adding subdivisions; 256B.4913, subdivisions 5, 6, by
 2.31 adding a subdivision; 256B.492; 256B.493, subdivision 2; 256B.501, by adding
 2.32 a subdivision; 256B.5011, subdivision 2; 256B.5012, by adding subdivisions;
 2.33 256B.69, subdivisions 5c, 5i, 8, 9c, 31, by adding subdivisions; 256B.694;
 2.34 256B.76, subdivisions 1, 2, 4, by adding a subdivision; 256B.761; 256B.764;
 2.35 256B.766; 256B.767; 256D.44, subdivision 5; 256I.05, by adding a subdivision;
 2.36 256J.08, subdivision 24; 256J.21, subdivisions 2, 3; 256J.24, subdivisions 5, 7;
 2.37 256J.35; 256J.621; 256J.626, subdivision 7; 256K.45; 256L.01, subdivisions
 2.38 3a, 5, by adding subdivisions; 256L.02, subdivision 2, by adding subdivisions;
 2.39 256L.03, subdivisions 1, 1a, 3, 5, 6, by adding a subdivision; 256L.04,
 2.40 subdivisions 1, 7, 8, 10, 12, by adding subdivisions; 256L.05, subdivisions
 2.41 1, 2, 3, 3c; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3; 256L.09,
 2.42 subdivision 2; 256L.11, subdivisions 1, 3; 256L.12, subdivision 1; 256L.15,
 2.43 subdivisions 1, 2; 256M.40, subdivision 1; 257.0755, subdivision 1; 257.75,
 2.44 subdivision 7; 257.85, subdivisions 2, 5, 6; 259A.20, subdivision 4; 260B.007,
 2.45 subdivisions 6, 16; 260C.007, subdivisions 6, 31; 260C.446; 260C.635,
 2.46 subdivision 1; 299C.093; 402A.10; 402A.18; 471.59, subdivision 1; 517.001;
 2.47 518A.60; 626.556, subdivisions 2, 3, 10d; 626.557, subdivisions 4, 9, 9a, 9e;
 2.48 626.5572, subdivision 13; Laws 1998, chapter 407, article 6, section 116; Laws
 2.49 2011, First Special Session chapter 9, article 1, section 3; article 2, section 27;
 2.50 article 10, section 3, subdivision 3, as amended; Laws 2012, chapter 247, article
 2.51 6, section 4; Laws 2013, chapter 1, section 6; proposing coding for new law in
 2.52 Minnesota Statutes, chapters 62A; 144; 144A; 145; 149A; 151; 214; 245; 245A;
 2.53 245D; 254B; 256; 256B; 256J; 256L; 259A; 260C; 402A; proposing coding
 2.54 for new law as Minnesota Statutes, chapters 245E; 256N; repealing Minnesota
 2.55 Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 144.123, subdivision
 2.56 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision
 2.57 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6;
 2.58 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9;

3.1 151.19, subdivision 2; 151.25; 151.45; 151.47, subdivision 2; 151.48; 245A.655;
 3.2 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2,
 3.3 3, 5, 6, 7; 245B.055; 245B.06; 245B.07; 245B.08; 245D.08; 252.40; 252.46,
 3.4 subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, 21; 256.82,
 3.5 subdivision 4; 256B.055, subdivisions 3, 5, 10b; 256B.056, subdivision 5b;
 3.6 256B.057, subdivisions 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917,
 3.7 subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.096, subdivisions 1, 2, 3,
 3.8 4; 256B.14, subdivision 3a; 256B.49, subdivision 16a; 256B.4913, subdivisions
 3.9 1, 2, 3, 4; 256B.501, subdivision 8; 256B.5012, subdivision 13; 256J.24;
 3.10 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, 10a; 256L.05,
 3.11 subdivision 3b; 256L.07, subdivisions 1, 5, 8, 9; 256L.11, subdivisions 5, 6;
 3.12 256L.17, subdivisions 1, 2, 3, 4, 5; 260C.441; 485.14; 609.093; Laws 2011, First
 3.13 Special Session chapter 9, article 7, section 54, as amended; Minnesota Rules,
 3.14 parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016;
 3.15 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040; 4668.0050;
 3.16 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
 3.17 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160;
 3.18 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220;
 3.19 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810; 4668.0815;
 3.20 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840; 4668.0845;
 3.21 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010;
 3.22 4669.0020; 4669.0030; 4669.0040; 4669.0050; 9525.1860, subparts 3, items B,
 3.23 C, 4, item D; 9560.0650, subparts 1, 3, 6; 9560.0651; 9560.0655.

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

3.25 ARTICLE 1

3.26 AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH 3.27 CARE FOR MORE MINNESOTANS

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

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

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

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

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

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

4.15 (b) A person not entitled to services under paragraph (a), but with family income
4.16 that is less than 215 percent of the federal poverty guidelines for the applicable family
4.17 size, shall be eligible to receive chemical dependency fund services within the limit
4.18 of funds appropriated for this group for the fiscal year. If notified by the state agency
4.19 of limited funds, a county must give preferential treatment to persons with dependent
4.20 children who are in need of chemical dependency treatment pursuant to an assessment
4.21 under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision
4.22 6, or 260C.212. A county may spend money from its own sources to serve persons under
4.23 this paragraph. State money appropriated for this paragraph must be placed in a separate
4.24 account established for this purpose.

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

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

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

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

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

5.11 (2) Medicaid funding; and

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

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

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

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

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

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

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

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

5.32 (e) The commissioner shall report to the chairs and ranking minority members of
5.33 the legislative committees with jurisdiction over health and human services policy and
5.34 financing by January 15, 2015, on the progress of receiving a federal waiver and shall
5.35 make recommendations on any legislative changes necessary to accomplish the project
5.36 in this subdivision. Any implementation of the waiver that requires a state financial

6.1 contribution to operate a health coverage program for Minnesotans with incomes between
6.2 200 and 275 percent of the federal poverty guidelines, shall be contingent on legislative
6.3 action approving the contribution.

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

6.6 Sec. 4. Minnesota Statutes 2012, section 256.015, subdivision 1, is amended to read:

6.7 Subdivision 1. **State agency has lien.** When the state agency provides, pays for, or
6.8 becomes liable for medical care or furnishes subsistence or other payments to a person,
6.9 the agency shall have a lien for the cost of the care and payments on any and all causes of
6.10 action or recovery rights under any policy, plan, or contract providing benefits for health
6.11 care or injury which accrue to the person to whom the care or payments were furnished,
6.12 or to the person's legal representatives, as a result of the occurrence that necessitated the
6.13 medical care, subsistence, or other payments. For purposes of this section, "state agency"
6.14 includes prepaid health plans under contract with the commissioner according to sections
6.15 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12, 256L.01, subdivision 7,
6.16 and 256L.03, subdivision 6; children's mental health collaboratives under section 245.493;
6.17 demonstration projects for persons with disabilities under section 256B.77; nursing
6.18 homes under the alternative payment demonstration project under section 256B.434; and
6.19 county-based purchasing entities under section 256B.692.

6.20 Sec. 5. Minnesota Statutes 2012, section 256B.02, subdivision 17, as added by Laws
6.21 2013, chapter 1, section 1, is amended to read:

6.22 Subd. 17. **Affordable Care Act or ACA.** "Affordable Care Act" ~~or "ACA"~~ means
6.23 ~~Public Law 111-148, as amended by the federal Health Care and Education Reconciliation~~
6.24 ~~Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance~~
6.25 ~~issued under, those acts~~ means the federal Patient Protection and Affordable Care Act,
6.26 Public Law 111-148, as amended, including the federal Health Care and Education
6.27 Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal
6.28 guidance or regulations issued under, these acts.

6.29 **EFFECTIVE DATE.** This section is effective July 1, 2013.

6.30 Sec. 6. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
6.31 to read:

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

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

7.5 Sec. 7. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
7.6 to read:

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

7.9 (1) medical assistance under this chapter;

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

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

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

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

7.16 Sec. 8. Minnesota Statutes 2012, section 256B.04, subdivision 18, is amended to read:

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

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

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

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

7.29 Sec. 9. Minnesota Statutes 2012, section 256B.055, subdivision 3a, is amended to read:

7.30 Subd. 3a. **Families with children.** ~~Beginning July 1, 2002,~~ Medical assistance may
7.31 be paid for a person who is a child under the age of 18, ~~or age 18 if a full-time student~~
7.32 ~~in a secondary school, or in the equivalent level of vocational or technical training, and~~

8.1 ~~reasonably expected to complete the program before reaching age 19; the parent or~~
8.2 ~~stepparent of a dependent child under the age of 19, including a pregnant woman; or a~~
8.3 ~~caretaker relative of a dependent child under the age of 19.~~

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

8.7 Sec. 10. Minnesota Statutes 2012, section 256B.055, subdivision 6, is amended to read:

8.8 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid
8.9 for a pregnant woman who ~~has written verification of a positive pregnancy test from a~~
8.10 ~~physician or licensed registered nurse, who~~ meets the other eligibility criteria of this
8.11 section and whose unborn child would be eligible as a needy child under subdivision 10 if
8.12 born and living with the woman. In accordance with Code of Federal Regulations, title
8.13 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless
8.14 the agency has information that is not reasonably compatible with such attestation. For
8.15 purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

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

8.17 Sec. 11. Minnesota Statutes 2012, section 256B.055, subdivision 10, is amended to read:

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

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

8.25 Sec. 12. Minnesota Statutes 2012, section 256B.055, subdivision 15, is amended to read:

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

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

8.29 (2) not pregnant;

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

9.1 (4) ~~not an adult in a family with children as defined in section 256L.01, subdivision~~
 9.2 ~~3a; and~~ not otherwise eligible under subdivision 7 as a person who meets the categorical
 9.3 eligibility requirements of the supplemental security income program;

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

9.7 ~~(5)~~ (6) not described in another subdivision of this section.

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

9.9 Sec. 13. Minnesota Statutes 2012, section 256B.055, is amended by adding a
 9.10 subdivision to read:

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

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

9.17 Sec. 14. Minnesota Statutes 2012, section 256B.056, subdivision 1, is amended to read:

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

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

9.23 Sec. 15. Minnesota Statutes 2012, section 256B.056, subdivision 1c, is amended to read:

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

9.26 (2) ~~For applications processed within one calendar month prior to July 1, 2003,~~
 9.27 ~~eligibility shall be determined by applying the income standards and methodologies in~~
 9.28 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July~~
 9.29 ~~1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any~~
 9.30 ~~months in the six-month budget period on or after that date. The income standards for~~
 9.31 ~~each month shall be added together and compared to the applicant's total countable income~~
 9.32 ~~for the six-month budget period to determine eligibility.~~

10.1 ~~(3) For children ages one through 18 whose eligibility is determined under section~~
10.2 ~~256B.057, subdivision 2, the following deductions shall be applied to income counted~~
10.3 ~~toward the child's eligibility as allowed under the state's AFDC plan in effect as of July~~
10.4 ~~16, 1996: \$90 work expense, dependent care, and child support paid under court order.~~
10.5 ~~This clause is effective October 1, 2003.~~

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

10.12 ~~(c) If the four-month disregard in paragraph (b) has been applied to the wage~~
10.13 ~~earner's income for four months, the disregard shall not be applied again until the wage~~
10.14 ~~earner's income has not been considered in determining medical assistance eligibility for~~
10.15 ~~12 consecutive months.~~

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

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

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

10.24 Sec. 16. Minnesota Statutes 2012, section 256B.056, subdivision 3, is amended to read:

10.25 Subd. 3. **Asset limitations for certain individuals and families.** (a) To be
10.26 eligible for medical assistance, a person must not individually own more than \$3,000 in
10.27 assets, or if a member of a household with two family members, husband and wife, or
10.28 parent and child, the household must not own more than \$6,000 in assets, plus \$200 for
10.29 each additional legal dependent. In addition to these maximum amounts, an eligible
10.30 individual or family may accrue interest on these amounts, but they must be reduced to the
10.31 maximum at the time of an eligibility redetermination. The accumulation of the clothing
10.32 and personal needs allowance according to section 256B.35 must also be reduced to the
10.33 maximum at the time of the eligibility redetermination. The value of assets that are not
10.34 considered in determining eligibility for medical assistance is the value of those assets

11.1 excluded under the supplemental security income program for aged, blind, and disabled
11.2 persons, with the following exceptions:

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

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

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

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

11.12 (5) for a person who no longer qualifies as an employed person with a disability due
11.13 to loss of earnings, assets allowed while eligible for medical assistance under section
11.14 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
11.15 of ineligibility as an employed person with a disability, to the extent that the person's total
11.16 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

11.17 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
11.18 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
11.19 before the person's 65th birthday, the assets owned by the person and the person's spouse
11.20 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
11.21 when determining eligibility for medical assistance under section 256B.055, subdivision
11.22 7. The income of a spouse of a person enrolled in medical assistance under section
11.23 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
11.24 65th birthday must be disregarded when determining eligibility for medical assistance
11.25 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
11.26 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
11.27 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
11.28 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65; and

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

11.33 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
11.34 15.

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

12.1 Sec. 17. Minnesota Statutes 2012, section 256B.056, subdivision 4, as amended by
12.2 Laws 2013, chapter 1, section 5, is amended to read:

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

12.8 ~~(b) To be eligible for medical assistance, families and children may have an income~~
12.9 ~~up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,~~
12.10 ~~AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,~~
12.11 ~~1996, shall be increased by three percent.~~

12.12 ~~(e)~~ (b) Effective January 1, 2014, to be eligible for medical assistance, under section
12.13 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
12.14 percent of the federal poverty guidelines for the household size.

12.15 ~~(d)~~ (c) To be eligible for medical assistance under section 256B.055, subdivision
12.16 15, a person may have an income up to 133 percent of federal poverty guidelines for
12.17 the household size.

12.18 ~~(e)~~ (d) To be eligible for medical assistance under section 256B.055, subdivision
12.19 16, a child age 19 to 20 may have an income up to 133 percent of the federal poverty
12.20 guidelines for the household size.

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

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

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

13.1 Sec. 18. Minnesota Statutes 2012, section 256B.056, subdivision 5c, is amended to read:

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

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

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

13.10 Sec. 19. Minnesota Statutes 2012, section 256B.056, is amended by adding a
13.11 subdivision to read:

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

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

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

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

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

13.29 Sec. 20. Minnesota Statutes 2012, section 256B.056, subdivision 10, is amended to read:

13.30 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who
13.31 are applying for the continuation of medical assistance coverage following the end of the
13.32 60-day postpartum period to update their income and asset information and to submit
13.33 any required income or asset verification.

14.1 (b) The commissioner shall determine the eligibility of private-sector health care
14.2 coverage for infants less than one year of age eligible under section 256B.055, subdivision
14.3 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage
14.4 if this is determined to be cost-effective.

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

14.7 (d) The commissioner shall utilize information obtained through the electronic
14.8 service established by the secretary of the United States Department of Health and Human
14.9 Services and other available electronic data sources in Code of Federal Regulations, title
14.10 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner
14.11 shall establish standards to define when information obtained electronically is reasonably
14.12 compatible with information provided by applicants and enrollees, including use of
14.13 self-attestation, to accomplish real-time eligibility determinations and maintain program
14.14 integrity.

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

14.16 Sec. 21. Minnesota Statutes 2012, section 256B.057, subdivision 1, is amended to read:

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

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

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

15.1 ~~(2) For applications processed within one calendar month prior to July 1, 2003,~~
15.2 ~~eligibility shall be determined by applying the income standards and methodologies in~~
15.3 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July 1,~~
15.4 ~~2003, and the income standards and methodologies in effect on the expiration date for any~~
15.5 ~~months in the six-month budget period on or after July 1, 2003. The income standards~~
15.6 ~~for each month shall be added together and compared to the applicant's total countable~~
15.7 ~~income for the six-month budget period to determine eligibility.~~

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

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

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

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

15.21 Sec. 22. Minnesota Statutes 2012, section 256B.057, subdivision 8, is amended to read:

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

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

15.28 Sec. 23. Minnesota Statutes 2012, section 256B.057, subdivision 10, is amended to read:

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

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

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

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

16.6 (4) is under age 65;

16.7 (5) is not otherwise eligible for medical assistance under United States Code, title
16.8 42, section 1396a(a)(10)(A)(i); and

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

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

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

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

16.18 Sec. 24. Minnesota Statutes 2012, section 256B.057, is amended by adding a
16.19 subdivision to read:

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

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

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

16.27 Sec. 25. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

17.22 (c) All qualified noncitizens who were residing in the United States before August
17.23 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
17.24 medical assistance with federal financial participation.

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

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

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

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

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

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

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

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

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

18.17 (g) For purposes of this subdivision, the term "emergency medical condition" means
18.18 a medical condition that meets the requirements of United States Code, title 42, section
18.19 1396b(v).

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

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

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

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

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

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

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

18.34 (iii) services for routine prenatal care;

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

- 19.1 (v) elective surgery;
- 19.2 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
19.3 part of an emergency room visit;
- 19.4 (vii) preventative health care and family planning services;
- 19.5 (viii) dialysis;
- 19.6 (ix) chemotherapy or therapeutic radiation services;
- 19.7 (x) rehabilitation services;
- 19.8 (xi) physical, occupational, or speech therapy;
- 19.9 (xii) transportation services;
- 19.10 (xiii) case management;
- 19.11 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
- 19.12 (xv) dental services;
- 19.13 (xvi) hospice care;
- 19.14 (xvii) audiology services and hearing aids;
- 19.15 (xviii) podiatry services;
- 19.16 (xix) chiropractic services;
- 19.17 (xx) immunizations;
- 19.18 (xxi) vision services and eyeglasses;
- 19.19 (xxii) waiver services;
- 19.20 (xxiii) individualized education programs; or
- 19.21 (xxiv) chemical dependency treatment.
- 19.22 (i) ~~Beginning July 1, 2009, Pregnant noncitizens who are undocumented,~~
19.23 ~~nonimmigrants, or lawfully present in the United States as defined in Code of Federal~~
19.24 ~~Regulations, title 8, section 103.12, ineligible for federally funded medical assistance~~
19.25 ~~because of immigration status, are not covered by a group health plan or health insurance~~
19.26 ~~coverage according to Code of Federal Regulations, title 42, section 457.310, and who~~
19.27 ~~otherwise meet the eligibility requirements of this chapter, are eligible for medical~~
19.28 ~~assistance through the period of pregnancy, including labor and delivery, and 60 days~~
19.29 ~~postpartum, to the extent federal funds are available under title XXI of the Social Security~~
19.30 ~~Act, and the state children's health insurance program.~~
- 19.31 (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation
19.32 services from a nonprofit center established to serve victims of torture and are otherwise
19.33 ineligible for medical assistance under this chapter are eligible for medical assistance
19.34 without federal financial participation. These individuals are eligible only for the period
19.35 during which they are receiving services from the center. Individuals eligible under this
19.36 paragraph shall not be required to participate in prepaid medical assistance.

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

20.2 Sec. 26. Minnesota Statutes 2012, section 256B.0755, subdivision 3, is amended to read:

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

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

20.11 (c) A health care delivery system must indicate how it will coordinate with other
20.12 services affecting its patients' health, quality of care, and cost of care that are provided by
20.13 other providers, county agencies, and other organizations in the local service area. The
20.14 health care delivery system must indicate how it will engage other providers, counties, and
20.15 organizations, including county-based purchasing plans, that provide services to patients
20.16 of the health care delivery system on issues related to local population health, including
20.17 applicable local needs, priorities, and public health goals. The health care delivery system
20.18 must describe how local providers, counties, organizations, including county-based
20.19 purchasing plans, and other relevant purchasers were consulted in developing the
20.20 application to participate in the demonstration project.

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

20.23 Sec. 27. Minnesota Statutes 2012, section 256B.694, is amended to read:

20.24 **256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE**
20.25 **CONTRACT.**

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

20.27 (b) The commissioner shall consider, and may approve, contracting on a
20.28 single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified
20.29 health plans that have coordination arrangements with counties, to serve persons ~~with a~~
20.30 ~~disability who voluntarily enroll~~ enrolled in state public health care programs, in order
20.31 to promote better coordination or integration of health care services, social services and
20.32 other community-based services, provided that all requirements applicable to health plan
20.33 purchasing, including those in ~~section 256B.69, subdivision 23~~ sections 256B.69 and

21.1 256B.692, are satisfied. ~~Nothing in this paragraph supersedes or modifies the requirements~~
21.2 ~~in paragraph (a).~~

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

21.5 Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means the federal Patient
21.6 Protection and Affordable Care Act, Public Law 111-148, as amended, including the
21.7 federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and
21.8 any amendments to, and any federal guidance or regulations issued under, these acts.

21.9 Sec. 29. Minnesota Statutes 2012, section 256L.01, subdivision 3a, is amended to read:

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

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

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

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

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

21.21 Sec. 30. Minnesota Statutes 2012, section 256L.01, subdivision 5, is amended to read:

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

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

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

22.4 Sec. 31. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
22.5 to read:

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

22.8 Sec. 32. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
22.9 to read:

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

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

22.18 Sec. 33. Minnesota Statutes 2012, section 256L.02, subdivision 2, is amended to read:

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

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

22.29 **EFFECTIVE DATE.** Paragraph (a) is effective January 1, 2015. Paragraph (b) is
22.30 effective January 1, 2014, or upon federal approval, whichever is later. The commissioner
22.31 of human services shall notify the revisor of statutes when federal approval is obtained.

23.1 Sec. 34. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
23.2 to read:

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

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

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

23.22 Sec. 35. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
23.23 to read:

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

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

23.27 Sec. 36. Minnesota Statutes 2012, section 256L.03, subdivision 1, is amended to read:

23.28 Subdivision 1. **Covered health services.** (a) "Covered health services" means the
23.29 health services reimbursed under chapter 256B, with the exception of ~~inpatient hospital~~
23.30 ~~services~~, special education services, private duty nursing services, adult dental care
23.31 services other than services covered under section 256B.0625, subdivision 9, orthodontic
23.32 services, nonemergency medical transportation services, personal care assistance and case

24.1 management services, and nursing home or intermediate care facilities services, ~~inpatient~~
 24.2 ~~mental health services, and chemical dependency services.~~

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

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

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

24.11 Sec. 37. Minnesota Statutes 2012, section 256L.03, subdivision 1a, is amended to read:

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

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

24.25 Sec. 38. Minnesota Statutes 2012, section 256L.03, subdivision 3, is amended to read:

24.26 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
 24.27 inpatient hospital services, including inpatient hospital mental health services and inpatient
 24.28 hospital and residential chemical dependency treatment, subject to those limitations
 24.29 necessary to coordinate the provision of these services with eligibility under the medical
 24.30 assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under~~
 24.31 ~~section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and~~
 24.32 ~~2, with family gross income that exceeds 200 percent of the federal poverty guidelines or~~

25.1 ~~215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not~~
 25.2 ~~pregnant, is subject to an annual limit of \$10,000.~~

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

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

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

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

25.15 Sec. 39. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision
 25.16 to read:

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

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

25.21 Sec. 40. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

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

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

25.27 ~~(2) (1) \$3 per prescription for adult enrollees;~~

25.28 ~~(3) (2) \$25 for eyeglasses for adult enrollees;~~

25.29 ~~(4) (3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means~~
 25.30 ~~an episode of service which is required because of a recipient's symptoms, diagnosis, or~~
 25.31 ~~established illness, and which is delivered in an ambulatory setting by a physician or~~
 25.32 ~~physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,~~
 25.33 ~~audiologist, optician, or optometrist;~~

26.1 ~~(5)~~ (4) \$6 for nonemergency visits to a hospital-based emergency room for services
26.2 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

26.3 ~~(6)~~ (5) a family deductible equal to the maximum amount allowed under Code of
26.4 Federal Regulations, title 42, part 447.54.

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

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

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

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

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

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

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

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

26.31 Sec. 41. Minnesota Statutes 2012, section 256L.03, subdivision 6, is amended to read:

26.32 Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for
26.33 covered health services, the agency shall have a lien for the cost of the covered health
26.34 services upon any and all causes of action accruing to the enrollee, or to the enrollee's
26.35 legal representatives, as a result of the occurrence that necessitated the payment for the

27.1 covered health services. All liens under this section shall be subject to the provisions
27.2 of section 256.015. For purposes of this subdivision, "state agency" includes ~~prepaid~~
27.3 ~~health plans participating entities,~~ under contract with the commissioner according to
27.4 sections ~~256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12;~~ and county-based
27.5 ~~purchasing entities under section 256B.692~~ section 256L.121.

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

27.7 Sec. 42. Minnesota Statutes 2012, section 256L.04, subdivision 1, is amended to read:

27.8 Subdivision 1. **Families with children.** ~~(a)~~ Families with children with family
27.9 income above 133 percent of the federal poverty guidelines and equal to or less than 275
27.10 200 percent of the federal poverty guidelines for the applicable family size shall be eligible
27.11 for MinnesotaCare according to this section. All other provisions of sections 256L.01 to
27.12 256L.18, including the insurance-related barriers to enrollment under section 256L.07,
27.13 shall apply unless otherwise specified. Children under age 19 with family income at or
27.14 below 200 percent of the federal poverty guidelines and who are ineligible for medical
27.15 assistance by sole reason of the application of federal household composition rules for
27.16 medical assistance are eligible for MinnesotaCare.

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

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

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

27.28 ~~(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision~~
27.29 ~~8, are exempt from the eligibility requirements of this subdivision.~~

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

28.1 Sec. 43. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
28.2 to read:

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

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

28.9 Sec. 44. Minnesota Statutes 2012, section 256L.04, subdivision 7, is amended to read:

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

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

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

28.20 Sec. 45. Minnesota Statutes 2012, section 256L.04, subdivision 8, is amended to read:

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

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

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

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

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

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

29.16 Sec. 46. Minnesota Statutes 2012, section 256L.04, subdivision 10, is amended to read:

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

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

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

30.4 Sec. 47. Minnesota Statutes 2012, section 256L.04, subdivision 12, is amended to read:

30.5 Subd. 12. **Persons in detention.** ~~Beginning January 1, 1999,~~ An applicant or
30.6 enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare,²
30.7 unless the applicant or enrollee is awaiting disposition of charges. ~~An enrollee residing in~~
30.8 ~~a correctional or detention facility is not eligible at renewal of eligibility under section~~
30.9 ~~256L.05, subdivision 3a.~~

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

30.11 Sec. 48. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
30.12 to read:

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

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

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

30.22 Sec. 49. Minnesota Statutes 2012, section 256L.05, subdivision 1, is amended to read:

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

31.1 program sites, legal aid offices, and libraries, and at any other locations at which medical
31.2 assistance applications must be made available. These sites may accept applications and
31.3 forward the forms to the commissioner or local county human services agencies that
31.4 choose to participate as an enrollment site. Otherwise, applicants may apply directly to the
31.5 commissioner or to participating local county human services agencies.

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

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

31.9 Sec. 50. Minnesota Statutes 2012, section 256L.05, subdivision 2, is amended to read:

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

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

31.20 Sec. 51. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

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

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

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

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

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

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

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

32.19 Sec. 52. Minnesota Statutes 2012, section 256L.05, subdivision 3c, is amended to read:

32.20 Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective
 32.21 date of coverage shall be the first day of the month following termination from medical
 32.22 assistance for families and individuals who are eligible for MinnesotaCare and who
 32.23 submitted a written request for retroactive MinnesotaCare coverage with a completed
 32.24 application within 30 days of the mailing of notification of termination from medical
 32.25 assistance. The applicant must provide all required verifications within 30 days of the
 32.26 written request for verification. For retroactive coverage, premiums must be paid in full
 32.27 for any retroactive month, current month, and next month within 30 days of the premium
 32.28 billing. ~~General assistance medical care recipients may qualify for retroactive coverage~~
 32.29 ~~under this subdivision at six-month renewal.~~ This subdivision does not apply, and shall not
 32.30 be implemented by the commissioner, once eligibility determination for MinnesotaCare is
 32.31 conducted by the Minnesota Insurance Marketplace eligibility determination system.

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

32.33 Sec. 53. Minnesota Statutes 2012, section 256L.06, subdivision 3, is amended to read:

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

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

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

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

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

33.32 Sec. 54. Minnesota Statutes 2012, section 256L.07, subdivision 1, is amended to read:

33.33 Subdivision 1. **General requirements.** ~~(a) Children enrolled in the original~~
33.34 ~~children's health plan as of September 30, 1992, children who enrolled in the~~
33.35 ~~MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,~~

34.1 ~~article 4, section 17, and children who have family gross incomes that are equal to or~~
 34.2 ~~less than 200 percent of the federal poverty guidelines are eligible without meeting the~~
 34.3 ~~requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as~~
 34.4 ~~they maintain continuous coverage in the MinnesotaCare program or medical assistance.~~

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

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

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

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

34.25 Sec. 55. Minnesota Statutes 2012, section 256L.07, subdivision 2, is amended to read:

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

34.34 (b) This subdivision does not apply to a family or individual who was enrolled
 34.35 in MinnesotaCare within six months or less of reapplication and who no longer has

35.1 employer-subsidized coverage due to the employer terminating health care coverage as an
 35.2 employee benefit. ~~This subdivision does not apply to children with family gross incomes~~
 35.3 ~~that are equal to or less than 200 percent of federal poverty guidelines.~~

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

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

35.15 Sec. 56. Minnesota Statutes 2012, section 256L.07, subdivision 3, is amended to read:

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

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

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

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

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

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

35.30 (v) ~~vision coverage;~~

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

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

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

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

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

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

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

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

36.24 Sec. 57. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

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

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

36.33 Sec. 58. Minnesota Statutes 2012, section 256L.11, subdivision 1, is amended to read:

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

37.4 (b) ~~Effective for services provided on or after July 1, 2009, total payments for basic~~
 37.5 ~~care services shall be reduced by three percent, in accordance with section 256B.766.~~
 37.6 ~~Payments made to managed care and county-based purchasing plans shall be reduced for~~
 37.7 ~~services provided on or after October 1, 2009, to reflect this reduction.~~

37.8 (c) ~~Effective for services provided on or after July 1, 2009, payment rates for~~
 37.9 ~~physician and professional services shall be reduced as described under section 256B.76,~~
 37.10 ~~subdivision 1, paragraph (c). Payments made to managed care and county-based~~
 37.11 ~~purchasing plans shall be reduced for services provided on or after October 1, 2009,~~
 37.12 ~~to reflect this reduction.~~

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

37.14 Sec. 59. Minnesota Statutes 2012, section 256L.11, subdivision 3, is amended to read:

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

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

37.19 Sec. 60. Minnesota Statutes 2012, section 256L.12, subdivision 1, is amended to read:

37.20 Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of
 37.21 human services shall select vendors of medical care who can provide the most economical
 37.22 care consistent with high medical standards and shall, where possible, contract with
 37.23 organizations on a prepaid capitation basis to provide these services. The commissioner
 37.24 shall consider proposals by counties and vendors for managed care plans and managed
 37.25 care-like entities as defined by the final regulation implementing section 1331 of the
 37.26 Affordable Care Act regarding basic health plans, which may include: prepaid capitation
 37.27 programs, competitive bidding programs, or other vendor payment mechanisms designed
 37.28 to provide services in an economical manner or to control utilization, with safeguards to
 37.29 ensure that necessary services are provided.

37.30 Sec. 61. **[256L.121] SERVICE DELIVERY.**

37.31 Subdivision 1. **Competitive process.** The commissioner of human services shall
 37.32 establish a competitive process for entering into contracts with participating entities for

38.1 the offering of standard health plans through MinnesotaCare. Coverage through standard
38.2 health plans must be available to enrollees beginning January 1, 2015. Each standard
38.3 health plan must cover the health services listed in and meet the requirements of section
38.4 256L.03. The competitive process must meet the requirements of section 1331 of the
38.5 Affordable Care Act and be designed to ensure enrollee access to high-quality health care
38.6 coverage options. The commissioner, to the extent feasible, shall seek to ensure that
38.7 enrollees have a choice of coverage from more than one participating entity within a
38.8 geographic area. In counties that were part of a county-based purchasing plan on January
38.9 1, 2013, the commissioner shall use the medical assistance competitive procurement
38.10 process under section 256B.69, subdivisions 1 to 32, under which selection of entities is
38.11 based on criteria related to provider network access, coordination of health care with other
38.12 local services, alignment with local public health goals, and other factors.

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

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

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

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

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

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

38.28 (3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and
38.29 256B.694, when contracting with MinnesotaCare participating entities;

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

38.35 (5) establishing requirements and criteria for selection that ensure that covered
38.36 health care services will be coordinated with local public health services, social services,

39.1 long-term care services, mental health services, and other local services affecting
39.2 enrollees' health, access, and quality of care.

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

39.4 Sec. 62. Minnesota Statutes 2012, section 256L.15, subdivision 1, is amended to read:

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

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

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

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

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

39.28 Sec. 63. Minnesota Statutes 2012, section 256L.15, subdivision 2, is amended to read:

39.29 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
39.30 commissioner shall establish a sliding fee scale to determine the percentage of monthly
39.31 ~~gross~~ individual or family income that households at different income levels must pay to
39.32 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
39.33 on the enrollee's monthly ~~gross~~ individual or family income. ~~The sliding fee scale must~~

40.1 contain separate tables based on enrollment of one, two, or three or more persons. Until
 40.2 June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross
 40.3 individual or family income for individuals or families with incomes below the limits for
 40.4 the medical assistance program for families and children in effect on January 1, 1999, and
 40.5 proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and
 40.6 8.8 percent. These percentages are matched to evenly spaced income steps ranging from
 40.7 the medical assistance income limit for families and children in effect on January 1, 1999,
 40.8 to 275 percent of the federal poverty guidelines for the applicable family size, up to a
 40.9 family size of five. The sliding fee scale for a family of five must be used for families of
 40.10 more than five. The sliding fee scale and percentages are not subject to the provisions of
 40.11 chapter 14. If a family or individual reports increased income after enrollment, premiums
 40.12 shall be adjusted at the time the change in income is reported.

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

40.23 (e) Beginning July 1, 2009 January 1, 2014, MinnesotaCare enrollees shall pay
 40.24 premiums according to the premium scale specified in paragraph (d) (c) with the exception
 40.25 that children 20 years of age and younger in families with income at or below 200 percent
 40.26 of the federal poverty guidelines shall pay no premiums. For purposes of paragraph (d),
 40.27 "minimum" means a monthly premium of \$4.

40.28 (d) (c) The following premium scale is established for individuals and families
 40.29 with gross family incomes of 275 percent of the federal poverty guidelines or less each
 40.30 individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

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%

41.1	137-164%	3.6%
41.2	165-191%	4.6%
41.3	192-219%	5.6%
41.4	220-248%	6.5%
41.5	249-275%	7.2%

41.6	<u>Federal Poverty Guideline</u>		<u>Individual Premium</u>
41.7	<u>Greater than or Equal to</u>	<u>Less than</u>	<u>Amount</u>
41.8	<u>0%</u>	<u>55%</u>	<u>\$4</u>
41.9	<u>55%</u>	<u>80%</u>	<u>\$6</u>
41.10	<u>80%</u>	<u>90%</u>	<u>\$8</u>
41.11	<u>90%</u>	<u>100%</u>	<u>\$10</u>
41.12	<u>100%</u>	<u>110%</u>	<u>\$12</u>
41.13	<u>110%</u>	<u>120%</u>	<u>\$15</u>
41.14	<u>120%</u>	<u>130%</u>	<u>\$18</u>
41.15	<u>130%</u>	<u>140%</u>	<u>\$21</u>
41.16	<u>140%</u>	<u>150%</u>	<u>\$25</u>
41.17	<u>150%</u>	<u>160%</u>	<u>\$29</u>
41.18	<u>160%</u>	<u>170%</u>	<u>\$33</u>
41.19	<u>170%</u>	<u>180%</u>	<u>\$38</u>
41.20	<u>180%</u>	<u>190%</u>	<u>\$43</u>
41.21	<u>190%</u>		<u>\$50</u>

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

41.25 Sec. 64. DETERMINATION OF FUNDING ADEQUACY FOR
 41.26 MINNESOTACARE.

41.27 The commissioners of revenue and management and budget, in consultation with
 41.28 the commissioner of human services, shall conduct an assessment of health care taxes,
 41.29 including the gross premiums tax, the provider tax, and Medicaid surcharges, and their
 41.30 relationship to the long-term solvency of the health care access fund, as part of the state
 41.31 revenue and expenditure forecast in November 2013. The commissioners shall determine
 41.32 the amount of state funding that will be required after December 31, 2019, in addition
 41.33 to the federal payments made available under section 1331 of the Affordable Care Act,
 41.34 for the MinnesotaCare program. The commissioners shall evaluate the stability and
 41.35 likelihood of long-term federal funding for the MinnesotaCare program under section
 41.36 1331. The commissioners shall report the results of this assessment to the chairs and
 41.37 ranking minority members of the legislative committees with jurisdiction over human
 41.38 services, finances, and taxes by January 15, 2014, along with recommendations for

42.1 changes to state revenue for the health care access fund, if state funding continues to
42.2 be required beyond December 31, 2019.

42.3 **Sec. 65. STATE-BASED RISK ADJUSTMENT SYSTEM ASSESSMENT.**

42.4 (a) Notwithstanding Minnesota Rules, chapter 4653, the commissioner of health,
42.5 as part of the commissioner's responsibilities under Minnesota Statutes, section 62U.04,
42.6 subdivision 4, paragraph (b), shall collect from health carriers in the individual and
42.7 small group health insurance market, beginning on January 1, 2014, for service dates
42.8 beginning October 1, 2013, through December 31, 2014, all data required for conducting
42.9 risk adjustment with standard risk adjusters such as the Adjusted Clinical Groups or the
42.10 Hierarchical Condition Category System, including, but not limited to:

42.11 (1) an indicator identifying the health plan product under which an enrollee is covered;

42.12 (2) an indicator identifying whether an enrollee's policy is an individual or small
42.13 group market policy;

42.14 (3) an indicator identifying, if applicable, the metal level of an enrollee's health plan
42.15 product, and whether the policy is a catastrophic policy; and

42.16 (4) additional identified demographic data necessary to link individuals' data across
42.17 health carriers and insurance affordability programs with 95 percent accuracy. The
42.18 commissioner shall not collect more than the last four digits of an individual's Social
42.19 Security number.

42.20 (b) The commissioner of health shall assess the extent to which data collected under
42.21 paragraph (a) and under Minnesota Statutes, section 62U.04, subdivision 4, paragraph (a),
42.22 are sufficient for developing and operating a state alternative risk adjustment methodology
42.23 consistent with applicable federal rules by evaluating:

42.24 (1) if the data submitted are adequately complete, accurate, and timely;

42.25 (2) if the data should be further enriched by nontraditional risk adjusters that help
42.26 in better explaining variation in health care costs of a given population and account for
42.27 risk selection across metal levels;

42.28 (3) whether additional data or identifiers have the potential to strengthen a
42.29 Minnesota-based risk adjustment approach; and

42.30 (4) what, if any, changes to the technical infrastructure will be necessary to
42.31 effectively perform state-based risk adjustment.

42.32 (c) For purposes of paragraph (b), the commissioner of health shall have the
42.33 authority to use identified data to validate and audit a statistically valid sample of data for
42.34 each health carrier in the individual and small group health insurance market.

43.1 (d) If the assessment conducted in paragraph (b) finds that the data collected
43.2 under Minnesota Statutes, section 62U.04, subdivision 4, are sufficient for developing
43.3 and operating a state alternative risk adjustment methodology consistent with applicable
43.4 federal rules, the commissioners of health and human services, in consultation with the
43.5 commissioner of commerce and the Board of MNsure, shall study whether Minnesota-based
43.6 risk adjustment of the individual and small group health insurance market, using either the
43.7 federal risk adjustment model or a state-based alternative, can be more cost-effective and
43.8 perform better than risk adjustment conducted by federal agencies. The study shall assess
43.9 the policies, infrastructure, and resources necessary to satisfy the requirements of Code of
43.10 Federal Regulations, title 45, section 153, subpart D. The study shall also evaluate the
43.11 extent to which Minnesota-based risk adjustment could meet requirements established in
43.12 Code of Federal Regulations, title 45, section 153.330, including:

43.13 (1) explaining the variation in health care costs of a given population;

43.14 (2) linking risk factors to daily clinical practices and that which is clinically
43.15 meaningful to providers;

43.16 (3) encouraging favorable behavior among health care market participants and
43.17 discouraging unfavorable behavior;

43.18 (4) whether risk adjustment factors are relatively easy for stakeholders to understand
43.19 and participate in;

43.20 (5) providing stable risk scores over time and across health plan products;

43.21 (6) minimizing administrative costs;

43.22 (7) accounting for risk selection across metal levels;

43.23 (8) aligning each of the elements of the methodology; and

43.24 (9) can be conducted at per-member cost equal to or lower than the projected cost of
43.25 the federal risk adjustment model.

43.26 (e) In conducting the study described in paragraph (d), the commissioner of health
43.27 shall contract with entities that do not have an economic interest in the outcome of
43.28 Minnesota-based risk adjustment, but have demonstrated expertise in actuarial science
43.29 or health economics and demonstrated experience with designing and implementing risk
43.30 adjustment models. The commissioner of human services shall evaluate opportunities
43.31 to maximize federal funding under section 1331 of the Affordable Care Act. The
43.32 commissioner of human services shall make recommendations on risk adjustment
43.33 strategies to maximize federal funding to the state of Minnesota.

43.34 (f) The commissioner of health shall submit an interim report to the legislature by
43.35 March 15, 2014, with preliminary findings from the assessment conducted in paragraph
43.36 (b). The interim report shall include legislative recommendations for any necessary

44.1 changes to Minnesota Statutes, section 62Q.03. The commissioners of health and human
44.2 services shall submit a final report to the legislature by October 1, 2015. The final report
44.3 must include findings from the overall assessment conducted under paragraph (e), and a
44.4 recommendation on whether to conduct state-based risk adjustment.

44.5 (g) The Board of MNsure shall apply for federal funding under section 1311 or
44.6 1321 of the Affordable Care Act, to fund the work under paragraphs (a), (b), (d), and (e).
44.7 Federal funding awarded to MNsure for this purpose is approved and appropriated for
44.8 this purpose. The commissioners of health and human services may only proceed with
44.9 activities under paragraphs (a) to (e) if funding has been made available for this purpose.

44.10 (h) For purposes of this section, the Board of MNsure means the board established
44.11 under Minnesota Statutes, section 62V.03, and the Affordable Care Act has the meaning
44.12 given in Minnesota Statutes, section 256B.02, subdivision 17.

44.13 **Sec. 66. REQUEST FOR FEDERAL AUTHORITY.**

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

44.22 **Sec. 67. REVISOR'S INSTRUCTION.**

44.23 The revisor of statutes shall: (1) remove cross-references to the sections repealed
44.24 in this article wherever they appear in Minnesota Statutes and Minnesota Rules; (2)
44.25 change the term "Minnesota Insurance Marketplace" to "MNsure" wherever it appears
44.26 in this article and in Minnesota Statutes; and (3) make changes necessary to correct the
44.27 punctuation, grammar, or structure of the remaining text and preserve its meaning.

44.28 **Sec. 68. REPEALER.**

44.29 Minnesota Statutes 2012, sections 256L.01, subdivision 4a; 256L.031; 256L.04,
44.30 subdivisions 1b, 9, and 10a; 256L.05, subdivision 3b; 256L.07, subdivisions 1, 5, 8, and 9;
44.31 256L.11, subdivisions 5 and 6; and 256L.17, subdivisions 1, 2, 3, 4, and 5, are repealed
44.32 effective January 1, 2014.

45.1 (b) Minnesota Statutes 2012, sections 256B.055, subdivisions 3, 5, and 10b;
45.2 256B.056, subdivision 5b; and 256B.057, subdivisions 1c and 2, are repealed effective
45.3 January 1, 2014.

45.4 ARTICLE 2

45.5 CONTINGENT REFORM 2020; REDESIGNING HOME AND 45.6 COMMUNITY-BASED SERVICES

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

45.8 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
45.9 electronically submit to the commissioner of health case mix assessments that conform
45.10 with the assessment schedule defined by Code of Federal Regulations, title 42, section
45.11 483.20, and published by the United States Department of Health and Human Services,
45.12 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
45.13 Instrument User's Manual, version 3.0, and subsequent updates when issued by the
45.14 Centers for Medicare and Medicaid Services. The commissioner of health may substitute
45.15 successor manuals or question and answer documents published by the United States
45.16 Department of Health and Human Services, Centers for Medicare and Medicaid Services,
45.17 to replace or supplement the current version of the manual or document.

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

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

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

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

45.25 (4) all quarterly assessments must have an assessment reference date (ARD) within
45.26 92 days of the ARD of the previous assessment.

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

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

45.33 (2) a nursing facility level of care determination as provided for under section
45.34 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment

46.1 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
46.2 managed care organization under contract with the Department of Human Services.

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

46.4 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
46.5 **REPORT AND STUDY REQUIRED.**

46.6 Subdivision 1. Report requirements. The commissioners of health and human
46.7 services, with the cooperation of counties and in consultation with stakeholders, including
46.8 persons who need or are using long-term care services and supports, lead agencies,
46.9 regional entities, senior, disability, and mental health organization representatives, service
46.10 providers, and community members shall prepare a report to the legislature by August 15,
46.11 2013, and biennially thereafter, regarding the status of the full range of long-term care
46.12 services and supports for the elderly and children and adults with disabilities and mental
46.13 illnesses in Minnesota. The report shall address:

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

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

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

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

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

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

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

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

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

46.33 Subd. 4a. **City, county, and state social workers.** (a) Beginning July 1, 2016, the
46.34 licensure of city, county, and state agency social workers is voluntary, except an individual

47.1 who is newly employed by a city or state agency after July 1, 2016, must be licensed
47.2 if the individual who provides social work services, as those services are defined in
47.3 section 148E.010, subdivision 11, paragraph (b), is presented to the public by any title
47.4 incorporating the words "social work" or "social worker."

47.5 (b) City, county, and state agencies employing social workers and staff who are
47.6 designated to perform mandated duties under sections 256.975, subdivisions 7 to 7c and
47.7 256.01, subdivision 24, are not required to employ licensed social workers.

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

47.9 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision
47.10 2, the commissioner of human services shall carry out the specific duties in paragraphs (a)
47.11 through ~~(ee)~~ (dd):

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

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

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

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

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

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

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

47.34 (7) enter into contractual agreements with federally recognized Indian tribes with
47.35 a reservation in Minnesota to the extent necessary for the tribe to operate a federally

48.1 approved family assistance program or any other program under the supervision of the
48.2 commissioner. The commissioner shall consult with the affected county or counties in
48.3 the contractual agreement negotiations, if the county or counties wish to be included,
48.4 in order to avoid the duplication of county and tribal assistance program services. The
48.5 commissioner may establish necessary accounts for the purposes of receiving and
48.6 disbursing funds as necessary for the operation of the programs.

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

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

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

48.21 (e) Assist and actively cooperate with other departments, agencies and institutions,
48.22 local, state, and federal, by performing services in conformity with the purposes of Laws
48.23 1939, chapter 431.

48.24 (f) Act as the agent of and cooperate with the federal government in matters of
48.25 mutual concern relative to and in conformity with the provisions of Laws 1939, chapter
48.26 431, including the administration of any federal funds granted to the state to aid in the
48.27 performance of any functions of the commissioner as specified in Laws 1939, chapter 431,
48.28 and including the promulgation of rules making uniformly available medical care benefits
48.29 to all recipients of public assistance, at such times as the federal government increases its
48.30 participation in assistance expenditures for medical care to recipients of public assistance,
48.31 the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

48.34 (h) Act as designated guardian of both the estate and the person of all the wards of
48.35 the state of Minnesota, whether by operation of law or by an order of court, without any
48.36 further act or proceeding whatever, except as to persons committed as developmentally

49.1 disabled. For children under the guardianship of the commissioner or a tribe in Minnesota
49.2 recognized by the Secretary of the Interior whose interests would be best served by
49.3 adoptive placement, the commissioner may contract with a licensed child-placing agency
49.4 or a Minnesota tribal social services agency to provide adoption services. A contract
49.5 with a licensed child-placing agency must be designed to supplement existing county
49.6 efforts and may not replace existing county programs or tribal social services, unless the
49.7 replacement is agreed to by the county board and the appropriate exclusive bargaining
49.8 representative, tribal governing body, or the commissioner has evidence that child
49.9 placements of the county continue to be substantially below that of other counties. Funds
49.10 encumbered and obligated under an agreement for a specific child shall remain available
49.11 until the terms of the agreement are fulfilled or the agreement is terminated.

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

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

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

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

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

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

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

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

50.8 (1) one-half of the total amount of the disallowance shall be borne by the county
50.9 boards responsible for administering the programs. For the medical assistance and the
50.10 AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be
50.11 shared by each county board in the same proportion as that county's expenditures for the
50.12 sanctioned program are to the total of all counties' expenditures for the AFDC program
50.13 formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the
50.14 food stamp program, sanctions shall be shared by each county board, with 50 percent of
50.15 the sanction being distributed to each county in the same proportion as that county's
50.16 administrative costs for food stamps are to the total of all food stamp administrative costs
50.17 for all counties, and 50 percent of the sanctions being distributed to each county in the
50.18 same proportion as that county's value of food stamp benefits issued are to the total of
50.19 all benefits issued for all counties. Each county shall pay its share of the disallowance
50.20 to the state of Minnesota. When a county fails to pay the amount due hereunder, the
50.21 commissioner may deduct the amount from reimbursement otherwise due the county, or
50.22 the attorney general, upon the request of the commissioner, may institute civil action
50.23 to recover the amount due; and

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

50.30 (o) Develop and implement special projects that maximize reimbursements and
50.31 result in the recovery of money to the state. For the purpose of recovering state money,
50.32 the commissioner may enter into contracts with third parties. Any recoveries that result
50.33 from projects or contracts entered into under this paragraph shall be deposited in the
50.34 state treasury and credited to a special account until the balance in the account reaches
50.35 \$1,000,000. When the balance in the account exceeds \$1,000,000, the excess shall be

51.1 transferred and credited to the general fund. All money in the account is appropriated to
51.2 the commissioner for the purposes of this paragraph.

51.3 (p) Have the authority to make direct payments to facilities providing shelter
51.4 to women and their children according to section 256D.05, subdivision 3. Upon
51.5 the written request of a shelter facility that has been denied payments under section
51.6 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make
51.7 a determination within 30 days of the request for review regarding issuance of direct
51.8 payments to the shelter facility. Failure to act within 30 days shall be considered a
51.9 determination not to issue direct payments.

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

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

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

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

51.30 (4) a county board that submits reports that are late, illegible, incomplete, or not
51.31 in the required format for two out of three consecutive reporting periods is considered
51.32 noncompliant. When a county board is found to be noncompliant, the commissioner
51.33 shall notify the county board of the reason the county board is considered noncompliant
51.34 and request that the county board develop a corrective action plan stating how the
51.35 county board plans to correct the problem. The corrective action plan must be submitted

52.1 to the commissioner within 45 days after the date the county board received notice
52.2 of noncompliance;

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

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

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

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

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

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

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

53.1 used for the federal rebate program established pursuant to section 1927 of title XIX of
53.2 the Social Security Act. The manufacturers must provide the commissioner with any
53.3 information necessary to verify the rebate determined per drug. The rebate program shall
53.4 utilize the terms and conditions used for the federal rebate program established pursuant to
53.5 section 1927 of title XIX of the Social Security Act.

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

53.12 (w) Have the authority to administer a supplemental drug rebate program for drugs
53.13 purchased under the medical assistance program. The commissioner may enter into
53.14 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
53.15 authorization for drugs that are from manufacturers that have not signed a supplemental
53.16 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
53.17 256B.0625, subdivision 13.

53.18 (x) Operate the department's communication systems account established in Laws
53.19 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
53.20 communication costs necessary for the operation of the programs the commissioner
53.21 supervises. A communications account may also be established for each regional
53.22 treatment center which operates communications systems. Each account must be used
53.23 to manage shared communication costs necessary for the operations of the programs the
53.24 commissioner supervises. The commissioner may distribute the costs of operating and
53.25 maintaining communication systems to participants in a manner that reflects actual usage.
53.26 Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and
53.27 other costs as determined by the commissioner. Nonprofit organizations and state, county,
53.28 and local government agencies involved in the operation of programs the commissioner
53.29 supervises may participate in the use of the department's communications technology and
53.30 share in the cost of operation. The commissioner may accept on behalf of the state any
53.31 gift, bequest, devise or personal property of any kind, or money tendered to the state for
53.32 any lawful purpose pertaining to the communication activities of the department. Any
53.33 money received for this purpose must be deposited in the department's communication
53.34 systems accounts. Money collected by the commissioner for the use of communication
53.35 systems must be deposited in the state communication systems account and is appropriated
53.36 to the commissioner for purposes of this section.

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

54.6 (z) Designate community information and referral call centers and incorporate
54.7 cost reimbursement claims from the designated community information and referral
54.8 call centers into the federal cost reimbursement claiming processes of the department
54.9 according to federal law, rule, and regulations. Existing information and referral centers
54.10 provided by Greater Twin Cities United Way or existing call centers for which Greater
54.11 Twin Cities United Way has legal authority to represent, shall be included in these
54.12 designations upon review by the commissioner and assurance that these services are
54.13 accredited and in compliance with national standards. Any reimbursement is appropriated
54.14 to the commissioner and all designated information and referral centers shall receive
54.15 payments according to normal department schedules established by the commissioner
54.16 upon final approval of allocation methodologies from the United States Department of
54.17 Health and Human Services Division of Cost Allocation or other appropriate authorities.

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

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

54.25 (cc) Have the authority to administer a drug rebate program for drugs purchased for
54.26 persons eligible for general assistance medical care under section 256D.03, subdivision 3.
54.27 For manufacturers that agree to participate in the general assistance medical care rebate
54.28 program, the commissioner shall enter into a rebate agreement for covered drugs as
54.29 defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the
54.30 rebate shall be equal to the rebate as defined for purposes of the federal rebate program in
54.31 United States Code, title 42, section 1396r-8. The manufacturers must provide payment
54.32 within the terms and conditions used for the federal rebate program established under
54.33 section 1927 of title XIX of the Social Security Act. The rebate program shall utilize
54.34 the terms and conditions used for the federal rebate program established under section
54.35 1927 of title XIX of the Social Security Act.

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

55.3 (1) are covered under the medical assistance program as described in section
55.4 256B.0625, subdivisions 13 and 13d; and

55.5 (2) are provided by manufacturers that have fully executed general assistance
55.6 medical care rebate agreements with the commissioner and comply with such agreements.

55.7 Prescription drug coverage under general assistance medical care shall conform to
55.8 coverage under the medical assistance program according to section 256B.0625,
55.9 subdivisions 13 to 13g.

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

55.12 (dd) Designate the agencies that operate the Senior LinkAge Line under section
55.13 256.975, subdivision 7, and the Disability Linkage Line under subdivision 24 as the state
55.14 of Minnesota Aging and the Disability Resource Centers under United States Code, title
55.15 42, section 3001, the Older Americans Act Amendments of 2006, and incorporate cost
55.16 reimbursement claims from the designated centers into the federal cost reimbursement
55.17 claiming processes of the department according to federal law, rule, and regulations. Any
55.18 reimbursement must be appropriated to the commissioner and treated consistent with
55.19 section 256.011. All Aging and Disability Resource Center designated agencies shall
55.20 receive payments of grant funding that supports the activity and generates the federal
55.21 financial participation according to Board on Aging administrative granting mechanisms.

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

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

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

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

55.33 (3) provide benefits and options counseling;

55.34 (4) make referrals to appropriate support entities;

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

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

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

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

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

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

56.10 Subd. 7. **Consumer information and assistance and long-term care options**

56.11 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
 56.12 statewide service to aid older Minnesotans and their families in making informed choices
 56.13 about long-term care options and health care benefits. Language services to persons
 56.14 with limited English language skills may be made available. The service, known as
 56.15 Senior LinkAge Line, shall serve older adults as the designated Aging and Disability
 56.16 Resource Center under United States Code, title 42, section 3001, the Older Americans
 56.17 Act Amendments of 2006 in partnership with the Disability LinkAge Line under section
 56.18 256.01, subdivision 24, and must be available during business hours through a statewide
 56.19 toll-free number and ~~must also be available through~~ the Internet. The Minnesota Board
 56.20 on Aging shall consult with, and when appropriate work through, the area agencies on
 56.21 aging counties, and other entities that serve aging and disabled populations of all ages,
 56.22 to provide and maintain the telephone infrastructure and related support for the Aging
 56.23 and Disability Resource Center partners which agree by memorandum to access the
 56.24 infrastructure, including the designated providers of the Senior LinkAge Line and the
 56.25 Disability Linkage Line.

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

56.30 (1) develop and provide for regular updating of a comprehensive database that
 56.31 includes detailed listings in both consumer- and provider-oriented formats that can provide
 56.32 search results down to the neighborhood level;

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

- 57.1 (3) link callers to interactive long-term care screening tools and make these tools
57.2 available through the Internet by integrating the tools with the database;
- 57.3 (4) develop community education materials with a focus on planning for long-term
57.4 care and evaluating independent living, housing, and service options;
- 57.5 (5) conduct an outreach campaign to assist older adults and their caregivers in
57.6 finding information on the Internet and through other means of communication;
- 57.7 (6) implement a messaging system for overflow callers and respond to these callers
57.8 by the next business day;
- 57.9 (7) link callers with county human services and other providers to receive more
57.10 in-depth assistance and consultation related to long-term care options;
- 57.11 (8) link callers with quality profiles for nursing facilities and other home and
57.12 community-based services providers developed by the ~~commissioner~~ commissioners of
57.13 health and human services;
- 57.14 (9) develop an outreach plan to seniors and their caregivers with a particular focus
57.15 on establishing a clear presence in places that seniors recognize and:
- 57.16 (i) place a significant emphasis on improved outreach and service to seniors and
57.17 their caregivers by establishing annual plans by neighborhood, city, and county, as
57.18 necessary, to address the unique needs of geographic areas in the state where there are
57.19 dense populations of seniors;
- 57.20 (ii) establish an efficient workforce management approach and assign community
57.21 living specialist staff and volunteers to geographic areas as well as aging and disability
57.22 resource center sites so that seniors and their caregivers and professionals recognize the
57.23 Senior LinkAge Line as the place to call for aging services and information;
- 57.24 (iii) recognize the size and complexity of the metropolitan area service system by
57.25 working with metropolitan counties to establish a clear partnership with them, including
57.26 seeking county advice on the establishment of local aging and disabilities resource center
57.27 sites; and
- 57.28 (iv) maintain dashboards with metrics that demonstrate how the service is expanding
57.29 and extending or enhancing its outreach efforts in dispersed or hard to reach locations in
57.30 varied population centers;
- 57.31 (9) (10) incorporate information about the availability of housing options, as well
57.32 as registered housing with services and consumer rights within the MinnesotaHelp.info
57.33 network long-term care database to facilitate consumer comparison of services and costs
57.34 among housing with services establishments and with other in-home services and to
57.35 support financial self-sufficiency as long as possible. Housing with services establishments
57.36 and their arranged home care providers shall provide information that will facilitate price

58.1 comparisons, including delineation of charges for rent and for services available. The
58.2 commissioners of health and human services shall align the data elements required by
58.3 section 144G.06, the Uniform Consumer Information Guide, and this section to provide
58.4 consumers standardized information and ease of comparison of long-term care options.
58.5 The commissioner of human services shall provide the data to the Minnesota Board on
58.6 Aging for inclusion in the MinnesotaHelp.info network long-term care database;

58.7 ~~(10)~~ (11) provide long-term care options counseling. Long-term care options
58.8 counselors shall:

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

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

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

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

58.24 ~~(11)~~ (12) using risk management and support planning protocols, provide long-term
58.25 care options counseling to current residents of nursing homes deemed appropriate for
58.26 discharge by the commissioner and older adults who request service after consultation
58.27 with the Senior LinkAge Line under clause (12). ~~In order to meet this requirement, The~~
58.28 Senior LinkAge Line shall also receive referrals from the residents or staff of nursing
58.29 homes. The Senior LinkAge Line shall identify and contact residents deemed appropriate
58.30 for discharge by developing targeting criteria in consultation with the commissioner who
58.31 shall provide designated Senior LinkAge Line contact centers with a list of nursing
58.32 home residents that meet the criteria as being appropriate for discharge planning via a
58.33 secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a
58.34 preference to receive long-term care options counseling, with initial assessment, review of
58.35 risk factors, independent living support consultation, or and, if appropriate, a referral to:

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

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

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

59.6 ~~(12)~~ (13) develop referral protocols and processes that will assist certified health
 59.7 care homes and hospitals to identify at-risk older adults and determine when to refer these
 59.8 individuals to the Senior LinkAge Line for long-term care options counseling under this
 59.9 section. The commissioner is directed to work with the commissioner of health to develop
 59.10 protocols that would comply with the health care home designation criteria and protocols
 59.11 available at the time of hospital discharge. The commissioner shall keep a record of the
 59.12 number of people who choose long-term care options counseling as a result of this section.

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

59.15 Subd. 7a. Preadmission screening activities related to nursing facility
 59.16 admissions. (a) All individuals seeking admission to Medicaid certified nursing facilities,
 59.17 including certified boarding care facilities, must be screened prior to admission regardless
 59.18 of income, assets, or funding sources for nursing facility care, except as described in
 59.19 subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the
 59.20 need for nursing facility level of care as described in section 256B.0911, subdivision
 59.21 4e, and to complete activities required under federal law related to mental illness and
 59.22 developmental disability as outlined in paragraph (b).

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

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

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

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

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

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

60.5 (ii) a qualified developmental disability professional, for persons with a primary or
60.6 secondary diagnosis of developmental disability. For purposes of this requirement, a
60.7 qualified developmental disability professional must meet the standards for a qualified
60.8 developmental disability professional under Code of Federal Regulations, title 42, section
60.9 483.430.

60.10 (d) The local county mental health authority or the state developmental disability
60.11 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
60.12 nursing facility if the individual does not meet the nursing facility level of care criteria or
60.13 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
60.14 purposes of this section, "specialized services" for a person with developmental disability
60.15 means active treatment as that term is defined under Code of Federal Regulations, title
60.16 42, section 483.440(a)(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

61.13 (1) a person is admitted from the community to a certified nursing or certified
61.14 boarding care facility during Senior LinkAge Line nonworking hours;

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

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

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

61.22 (5) the Senior LinkAge Line is contacted on the first working day following the
61.23 emergency admission.

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

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

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

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

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

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

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

62.14 (3) the person may be exempt from screening requirements as outlined in subdivision
62.15 7b, but will need transitional assistance after admission or in-person follow-along after
62.16 a return home.

62.17 (b) Individuals under 65 years of age who are admitted to nursing facilities with
62.18 only a telephone screening must receive a face-to-face assessment from the long-term
62.19 care consultation team member of the county in which the facility is located or from the
62.20 recipient's county case manager within 40 calendar days of admission as described in
62.21 section 256B.0911, subdivision 4d, paragraph (c).

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

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

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

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

62.30 Subd. 7d. **Payment for preadmission screening.** Funding for preadmission
62.31 screening shall be provided to the Minnesota Board on Aging by the Department of
62.32 Human Services to cover screener salaries and expenses to provide the services described
62.33 in subdivisions 7a to 7c. The Minnesota Board on Aging shall employ, or contract with
62.34 other agencies to employ, within the limits of available funding, sufficient personnel to
62.35 provide preadmission screening and level of care determination services and shall seek to

63.1 maximize federal funding for the service as provided under section 256.01, subdivision
63.2 2, paragraph (dd).

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

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

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

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

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

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

63.20 **Subd. 5. Grant preference.** The commissioner of human services shall give
63.21 preference when awarding grants under this section to areas where nursing facility
63.22 closures have occurred or are occurring or areas with service needs identified by section
63.23 144A.351. The commissioner may award grants to the extent grant funds are available
63.24 and to the extent applications are approved by the commissioner. Denial of approval of an
63.25 application in one year does not preclude submission of an application in a subsequent
63.26 year. The maximum grant amount is limited to \$750,000.

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

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

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

64.1 (2) study samples drawn from the population of interest for each project; and
64.2 (3) a time series analysis to examine aggregate trends in average monthly
64.3 utilization, expenditures, and other outcomes in the targeted populations before and after
64.4 implementation of the initiatives.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

65.23 ~~(7)~~ (6) determination of home and community-based waiver and other service
 65.24 eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level
 65.25 of care determination for individuals who need an institutional level of care as determined
 65.26 under section 256B.0911, subdivision ~~4a~~, ~~paragraph (d)~~ 4e, based on assessment and
 65.27 community support plan development, appropriate referrals to obtain necessary diagnostic
 65.28 information, and including an eligibility determination for consumer-directed community
 65.29 supports;

65.30 ~~(8)~~ (7) providing recommendations for institutional placement when there are no
 65.31 cost-effective community services available;

65.32 ~~(9)~~ (8) providing access to assistance to transition people back to community settings
 65.33 after institutional admission; and

65.34 ~~(10)~~ (9) providing information about competitive employment, with or without
 65.35 supports, for school-age youth and working-age adults and referrals to the Disability

66.1 Linkage Line and Disability Benefits 101 to ensure that an informed choice about
66.2 competitive employment can be made. For the purposes of this subdivision, "competitive
66.3 employment" means work in the competitive labor market that is performed on a full-time
66.4 or part-time basis in an integrated setting, and for which an individual is compensated at or
66.5 above the minimum wage, but not less than the customary wage and level of benefits paid
66.6 by the employer for the same or similar work performed by individuals without disabilities.

66.7 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
66.8 2c, and 3a, "long-term care consultation services" also means:

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

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

66.11 (ii) section 256B.0657; or

66.12 (iii) consumer support grants under section 256.476;

66.13 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
66.14 determination of eligibility for case management services available under sections
66.15 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
66.16 9525.0016;

66.17 (3) determination of institutional level of care, home and community-based service
66.18 waiver, and other service eligibility as required under section 256B.092, determination
66.19 of eligibility for family support grants under section 252.32, semi-independent living
66.20 services under section 252.275, and day training and habilitation services under section
66.21 256B.092; and

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

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

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

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

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

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

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

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

67.21 (d) The assessment must be conducted in a face-to-face interview with the person
67.22 being assessed and the person's legal representative, and other individuals as requested by
67.23 the person, who can provide information on the needs, strengths, and preferences of the
67.24 person necessary to develop a community support plan that ensures the person's health and
67.25 safety, but who is not a provider of service or has any financial interest in the provision
67.26 of services. For persons who are to be assessed for elderly waiver customized living
67.27 services under section 256B.0915, with the permission of the person being assessed or
67.28 the person's designated or legal representative, the client's current or proposed provider
67.29 of services may submit a copy of the provider's nursing assessment or written report
67.30 outlining its recommendations regarding the client's care needs. The person conducting
67.31 the assessment will notify the provider of the date by which this information is to be
67.32 submitted. This information shall be provided to the person conducting the assessment
67.33 prior to the assessment.

67.34 (e) If the person chooses to use community-based services, the person or the person's
67.35 legal representative must be provided with a written community support plan within 40

68.1 calendar days of the assessment visit, regardless of whether the individual is eligible for
68.2 Minnesota health care programs. The written community support plan must include:

- 68.3 (1) a summary of assessed needs as defined in paragraphs (c) and (d);
68.4 (2) the individual's options and choices to meet identified needs, including all
68.5 available options for case management services and providers;
68.6 (3) identification of health and safety risks and how those risks will be addressed,
68.7 including personal risk management strategies;
68.8 (4) referral information; and
68.9 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

68.32 (3) the need for and purpose of preadmission screening conducted by long-term care
68.33 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
68.34 nursing facility placement. If the individual selects nursing facility placement, the lead
68.35 agency shall forward information needed to complete the level of care determinations and

69.1 screening for developmental disability and mental illness collected during the assessment
69.2 to the long-term care options counselor using forms provided by the commissioner;

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

69.7 (5) information about Minnesota health care programs;

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

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

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

69.15 (9) the person's right to appeal the certified assessor's decision regarding eligibility
69.16 for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and
69.17 (b), and incorporating the decision regarding the need for institutional level of care or the
69.18 lead agency's final decisions regarding public programs eligibility according to section
69.19 256.045, subdivision 3.

69.20 (i) Face-to-face assessment completed as part of eligibility determination for
69.21 the alternative care, elderly waiver, community alternatives for disabled individuals,
69.22 community alternative care, and brain injury waiver programs under sections 256B.0913,
69.23 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60
69.24 calendar days after the date of assessment.

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

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

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

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

70.6 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified
70.7 nursing facility ~~from a hospital~~ must be screened prior to admission ~~as outlined in~~
70.8 ~~subdivisions 4a through 4e~~ according to the requirements outlined in section 256.975,
70.9 subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required
70.10 under section 256.975, subdivision 7.

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

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

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

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

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

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

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

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

71.9 (j) Funding for preadmission screening follow-up shall be provided to the Disability
 71.10 Linkage Line for the under 60 population by the Department of Human Services to
 71.11 cover options counseling salaries and expenses to provide the services described in
 71.12 subdivisions 7a to 7c. The Disability Linkage Line shall employ, or contract with other
 71.13 agencies to employ, within the limits of available funding, sufficient personnel to provide
 71.14 preadmission screening follow-up services and shall seek to maximize federal funding for
 71.15 the service as provided under section 256.01, subdivision 2, paragraph (dd).

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

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

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

71.28 Sec. 22. Minnesota Statutes 2012, section 256B.0911, subdivision 6, is amended to read:

71.29 Subd. 6. **Payment for long-term care consultation services.** (a) Until September
 71.30 30, 2013, payment for long-term care consultation face-to-face assessment shall be made
 71.31 as described in this subdivision.

71.32 (b) The total payment for each county must be paid monthly by certified nursing
 71.33 facilities in the county. The monthly amount to be paid by each nursing facility for each
 71.34 fiscal year must be determined by dividing the county's annual allocation for long-term

72.1 care consultation services by 12 to determine the monthly payment and allocating the
72.2 monthly payment to each nursing facility based on the number of licensed beds in the
72.3 nursing facility. Payments to counties in which there is no certified nursing facility must be
72.4 made by increasing the payment rate of the two facilities located nearest to the county seat.

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

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

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

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

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

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

72.32 ~~(h)~~ (i) The commissioner shall develop an alternative payment methodology,
72.33 effective on October 1, 2013, for long-term care consultation services that includes
72.34 the funding available under this subdivision, and for assessments authorized under
72.35 sections 256B.092 and 256B.0659. In developing the new payment methodology, the
72.36 commissioner shall consider the maximization of other funding sources, including federal

73.1 administrative reimbursement through federal financial participation funding, for all
 73.2 long-term care consultation and preadmission screening activity. The alternative payment
 73.3 methodology shall include the use of the appropriate time studies and the state financing
 73.4 of nonfederal share as part of the state's medical assistance program.

73.5 Sec. 23. Minnesota Statutes 2012, section 256B.0911, subdivision 7, is amended to read:

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

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

73.22 Sec. 24. Minnesota Statutes 2012, section 256B.0913, subdivision 4, is amended to read:

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

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

73.26 (1) the person has been determined by a community assessment under section
 73.27 256B.0911 to be a person who would require the level of care provided in a nursing
 73.28 facility, as determined under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, but for
 73.29 the provision of services under the alternative care program;

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

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

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

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

74.7 (6) except for individuals described in clause (7), the monthly cost of the alternative
74.8 care services funded by the program for this person does not exceed 75 percent of the
74.9 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
74.10 does not prohibit the alternative care client from payment for additional services, but in no
74.11 case may the cost of additional services purchased under this section exceed the difference
74.12 between the client's monthly service limit defined under section 256B.0915, subdivision
74.13 3, and the alternative care program monthly service limit defined in this paragraph. If
74.14 care-related supplies and equipment or environmental modifications and adaptations are or
74.15 will be purchased for an alternative care services recipient, the costs may be prorated on a
74.16 monthly basis for up to 12 consecutive months beginning with the month of purchase.
74.17 If the monthly cost of a recipient's other alternative care services exceeds the monthly
74.18 limit established in this paragraph, the annual cost of the alternative care services shall be
74.19 determined. In this event, the annual cost of alternative care services shall not exceed 12
74.20 times the monthly limit described in this paragraph;

74.21 (7) for individuals assigned a case mix classification A as described under section
74.22 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
74.23 living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating
74.24 when the dependency score in eating is three or greater as determined by an assessment
74.25 performed under section 256B.0911, the monthly cost of alternative care services funded
74.26 by the program cannot exceed \$593 per month for all new participants enrolled in
74.27 the program on or after July 1, 2011. This monthly limit shall be applied to all other
74.28 participants who meet this criteria at reassessment. This monthly limit shall be increased
74.29 annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly
74.30 limit does not prohibit the alternative care client from payment for additional services, but
74.31 in no case may the cost of additional services purchased exceed the difference between the
74.32 client's monthly service limit defined in this clause and the limit described in clause (6)
74.33 for case mix classification A; and

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

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

- 75.1 (i) the appointment of a representative payee;
75.2 (ii) automatic payment from a financial account;
75.3 (iii) the establishment of greater family involvement in the financial management of
75.4 payments; or
75.5 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

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

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

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

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

75.32 Sec. 25. Minnesota Statutes 2012, section 256B.0915, subdivision 5, is amended to read:

75.33 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
75.34 shall receive an initial assessment of strengths, informal supports, and need for services
75.35 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a

76.1 client served under the elderly waiver must be conducted at least every 12 months and at
76.2 other times when the case manager determines that there has been significant change in
76.3 the client's functioning. This may include instances where the client is discharged from
76.4 the hospital. There must be a determination that the client requires nursing facility level
76.5 of care as defined in section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, at initial and
76.6 subsequent assessments to initiate and maintain participation in the waiver program.

76.7 (b) Regardless of other assessments identified in section 144.0724, subdivision
76.8 4, as appropriate to determine nursing facility level of care for purposes of medical
76.9 assistance payment for nursing facility services, only face-to-face assessments conducted
76.10 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
76.11 level of care determination will be accepted for purposes of initial and ongoing access to
76.12 waiver service payment.

76.13 Sec. 26. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
76.14 subdivision to read:

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

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

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

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

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

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

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

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

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

77.5 (9) strengthen programs that use volunteers.

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

77.11 Sec. 27. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
77.12 subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.19 Sec. 29. Minnesota Statutes 2012, section 256B.0917, subdivision 6, is amended to read:

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

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

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

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

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

78.33 (c) The commissioner shall publish a notice in the State Register to solicit proposals
 78.34 from public or private nonprofit agencies for the projects not included in the four to six
 78.35 local long-term care strategy projects defined in subdivision 2. A county agency may,

79.1 ~~alone or in combination with other county agencies, apply for caregiver support and~~
 79.2 ~~respite care project funds. A public or nonprofit agency within a designated SAIL project~~
 79.3 ~~area may apply for project funds if the agency has a letter of agreement with the county~~
 79.4 ~~or counties in which services will be developed, stating the intention of the county or~~
 79.5 ~~counties to coordinate their activities with the agency requesting a grant.~~

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

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

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

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

79.11 (4) identify at-risk caregivers;

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

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

79.18 (b) Projects must clearly describe:

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

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

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

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

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

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

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

79.31 (2) recruit and train volunteer providers;

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

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

79.34 (5) (4) advertise the availability of the caregiver support and respite care project; and

79.35 (6) (5) purchase equipment to maintain a system of assigning workers to clients.

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

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

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

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

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

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

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

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

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

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

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

80.23 Sec. 31. Minnesota Statutes 2012, section 256B.0917, subdivision 13, is amended to
80.24 read:

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

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

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

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

81.1 Sec. 32. Minnesota Statutes 2012, section 256B.439, subdivision 3, is amended to read:

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

81.9 Sec. 33. Minnesota Statutes 2012, section 256B.439, is amended by adding a
 81.10 subdivision to read:

81.11 Subd. 3a. **Home and community-based services report card in cooperation with**
 81.12 **the commissioner of health.** The commissioner shall work with existing Department
 81.13 of Human Services advisory groups to develop recommendations for a home and
 81.14 community-based services report card. Health and human services staff that regulate
 81.15 home and community-based services as provided in chapter 245D and licensed home care
 81.16 as provided in chapter 144A shall be consulted. The advisory groups shall consider the
 81.17 requirements from the Minnesota consumer information guide under section 144G.06 as a
 81.18 base for development of the home and community-based services report card to compare
 81.19 the housing options available to consumers. Other items to be considered by the advisory
 81.20 groups in developing recommendations include:

81.21 (1) defining the goals of the report card, including measuring outcomes, providing
 81.22 consumer information, and defining vehicle-for-pay performance;

81.23 (2) developing separate measures for programs for the elderly population and for
 81.24 persons with disabilities;

81.25 (3) the sources of information needed that are standardized and contain sufficient data;

81.26 (4) the financial support needed for creating and publicizing the housing information
 81.27 guide, and ongoing funding for data collection and staffing to monitor, report, and analyze;

81.28 (5) a recognition that home and community-based services settings exist with
 81.29 significant variations in size, settings, and services available;

81.30 (6) ensuring that consumer choice and consumer information is retained and valued;

81.31 (7) the applicability of these measures to providers based on payor source, size,
 81.32 and population served; and

81.33 (8) dissemination of quality profiles.

81.34 The advisory groups shall discuss whether there are additional funding, resources,
 81.35 and research needed. The commissioner shall report recommendations to the chairs and

82.1 ranking minority members of the legislative committees and divisions with jurisdiction
82.2 over health and human services issues by August 1, 2014. The report card shall be
82.3 available on July 1, 2015.

82.4 Sec. 34. Minnesota Statutes 2012, section 256B.439, subdivision 4, is amended to read:

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

82.12 Sec. 35. Minnesota Statutes 2012, section 256B.441, subdivision 13, is amended to read:

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

82.20 Sec. 36. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:

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

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

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

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

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

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

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

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

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

83.15 (i) The single bed room incentives shall be as determined under section 256B.431,
83.16 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
83.17 no longer be included in the payment rate for external fixed costs beginning October 1,
83.18 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
83.19 longer be included in the payment rate for external fixed costs beginning on October 1 of
83.20 the first year not less than two years after their effective date.

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

83.23 Sec. 37. Minnesota Statutes 2012, section 256B.49, subdivision 12, is amended to read:

83.24 Subd. 12. **Informed choice.** Persons who are determined likely to require the level
83.25 of care provided in a nursing facility as determined under section 256B.0911, subdivision
83.26 4e, or a hospital shall be informed of the home and community-based support alternatives
83.27 to the provision of inpatient hospital services or nursing facility services. Each person
83.28 must be given the choice of either institutional or home and community-based services
83.29 using the provisions described in section 256B.77, subdivision 2, paragraph (p).

83.30 Sec. 38. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

83.31 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments
83.32 shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.
83.33 With the permission of the recipient or the recipient's designated legal representative,
83.34 the recipient's current provider of services may submit a written report outlining their

84.1 recommendations regarding the recipient's care needs prepared by a direct service
84.2 employee with at least 20 hours of service to that client. The person conducting the
84.3 assessment or reassessment must notify the provider of the date by which this information
84.4 is to be submitted. This information shall be provided to the person conducting the
84.5 assessment and the person or the person's legal representative and must be considered
84.6 prior to the finalization of the assessment or reassessment.

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

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

84.17 (d) Recipients who are found eligible for home and community-based services under
84.18 this section before their 65th birthday may remain eligible for these services after their
84.19 65th birthday if they continue to meet all other eligibility factors.

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

84.31 Sec. 39. Minnesota Statutes 2012, section 256B.69, subdivision 8, is amended to read:

84.32 Subd. 8. **Preadmission screening waiver.** Except as applicable to the project's
84.33 operation, the provisions of ~~section~~ sections 256.975 and 256B.0911 are waived for the
84.34 purposes of this section for recipients enrolled with demonstration providers or in the
84.35 prepaid medical assistance program for seniors.

85.1 Sec. 40. Minnesota Statutes 2012, section 256I.05, is amended by adding a subdivision
85.2 to read:

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

85.10 Sec. 41. Minnesota Statutes 2012, section 626.557, subdivision 4, is amended to read:

85.11 Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter
85.12 shall immediately make an oral report to the common entry point. The common entry
85.13 point may accept electronic reports submitted through a Web-based reporting system
85.14 established by the commissioner. Use of a telecommunications device for the deaf or other
85.15 similar device shall be considered an oral report. The common entry point may not require
85.16 written reports. To the extent possible, the report must be of sufficient content to identify
85.17 the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment,
85.18 any evidence of previous maltreatment, the name and address of the reporter, the time,
85.19 date, and location of the incident, and any other information that the reporter believes
85.20 might be helpful in investigating the suspected maltreatment. A mandated reporter may
85.21 disclose not public data, as defined in section 13.02, and medical records under sections
85.22 144.291 to 144.298, to the extent necessary to comply with this subdivision.

85.23 (b) A boarding care home that is licensed under sections 144.50 to 144.58 and
85.24 certified under Title 19 of the Social Security Act, a nursing home that is licensed under
85.25 section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a
85.26 hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under
85.27 Code of Federal Regulations, title 42, section 482.66, may submit a report electronically
85.28 to the common entry point instead of submitting an oral report. The report may be a
85.29 duplicate of the initial report the facility submits electronically to the commissioner of
85.30 health to comply with the reporting requirements under Code of Federal Regulations, title
85.31 42, section 483.13. The commissioner of health may modify these reporting requirements
85.32 to include items required under paragraph (a) that are not currently included in the
85.33 electronic reporting form.

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

86.1 Sec. 42. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:

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

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

86.10 (1) the time and date of the report;

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

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

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

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

86.16 (6) a description of the suspected maltreatment;

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

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

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

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

86.21 (11) whether law enforcement has been notified;

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

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

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

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

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

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

86.35 (g) The commissioner of human services shall maintain a centralized database
86.36 for the collection of common entry point data, lead investigative agency data including

87.1 maltreatment report disposition, and appeals data. The common entry point shall
87.2 have access to the centralized database and must log the reports into the database and
87.3 immediately identify and locate prior reports of abuse, neglect, or exploitation.

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

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

87.9 (1) track critical steps in the reporting, evaluation, referral, response, disposition,
87.10 and investigative process to ensure compliance with all requirements for all reports;

87.11 (2) maintain data to facilitate the production of aggregate statistical reports for
87.12 monitoring patterns of abuse, neglect, or exploitation;

87.13 (3) serve as a resource for the evaluation, management, and planning of preventative
87.14 and remedial services for vulnerable adults who have been subject to abuse, neglect,
87.15 or exploitation;

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

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

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

87.24 Sec. 43. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:

87.25 Subd. 9e. **Education requirements.** (a) The commissioners of health, human
87.26 services, and public safety shall cooperate in the development of a joint program for
87.27 education of lead investigative agency investigators in the appropriate techniques for
87.28 investigation of complaints of maltreatment. This program must be developed by July
87.29 1, 1996. The program must include but need not be limited to the following areas: (1)
87.30 information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4)
87.31 conclusions based on evidence; (5) interviewing skills, including specialized training to
87.32 interview people with unique needs; (6) report writing; (7) coordination and referral
87.33 to other necessary agencies such as law enforcement and judicial agencies; (8) human
87.34 relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family
87.35 systems and the appropriate methods for interviewing relatives in the course of the

88.1 assessment or investigation; (10) the protective social services that are available to protect
88.2 alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by
88.3 which lead investigative agency investigators and law enforcement workers cooperate in
88.4 conducting assessments and investigations in order to avoid duplication of efforts; and
88.5 (12) data practices laws and procedures, including provisions for sharing data.

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

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

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

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

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

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

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

88.32 Sec. 44. **FEDERAL APPROVAL.**

88.33 This article is contingent on federal approval.

88.34 Sec. 45. **REPEALER.**

89.1 (a) Minnesota Statutes 2012, sections 245A.655; and 256B.0917, subdivisions 1, 2,
89.2 3, 4, 5, 7, 8, 9, 10, 11, and 12, are repealed.

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

89.5 ARTICLE 3

89.6 SAFE AND HEALTHY DEVELOPMENT OF CHILDREN, 89.7 YOUTH, AND FAMILIES

89.8 Section 1. Minnesota Statutes 2012, section 119B.011, is amended by adding a
89.9 subdivision to read:

89.10 Subd. 19b. **Student parent.** "Student parent" means a person who is:

89.11 (1) under 21 years of age and has a child;

89.12 (2) pursuing a high school or general equivalency diploma;

89.13 (3) residing within a county that has a basic sliding fee waiting list under section
89.14 119B.03, subdivision 4; and

89.15 (4) not an MFIP participant.

89.16 **EFFECTIVE DATE.** This section is effective November 11, 2013.

89.17 Sec. 2. Minnesota Statutes 2012, section 119B.02, is amended by adding a subdivision
89.18 to read:

89.19 Subd. 7. **Child care market rate survey.** Biennially, the commissioner shall survey
89.20 prices charged by child care providers in Minnesota to determine the 75th percentile for
89.21 like-care arrangements in county price clusters.

89.22 **EFFECTIVE DATE.** This section is effective February 3, 2014.

89.23 Sec. 3. Minnesota Statutes 2012, section 119B.025, subdivision 1, is amended to read:

89.24 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the
89.25 following at all initial child care applications using the universal application:

89.26 (1) identity of adults;

89.27 (2) presence of the minor child in the home, if questionable;

89.28 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible
89.29 relative caretaker, or the spouses of any of the foregoing;

89.30 (4) age;

89.31 (5) immigration status, if related to eligibility;

89.32 (6) Social Security number, if given;

90.1 (7) income;

90.2 (8) spousal support and child support payments made to persons outside the
90.3 household;

90.4 (9) residence; and

90.5 (10) inconsistent information, if related to eligibility.

90.6 (b) If a family did not use the universal application or child care addendum to apply
90.7 for child care assistance, the family must complete the universal application or child care
90.8 addendum at its next eligibility redetermination and the county must verify the factors
90.9 listed in paragraph (a) as part of that redetermination. Once a family has completed a
90.10 universal application or child care addendum, the county shall use the redetermination
90.11 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility
90.12 must be redetermined at least every six months. A family is considered to have met the
90.13 eligibility redetermination requirement if a complete redetermination form and all required
90.14 verifications are received within 30 days after the date the form was due. Assistance shall
90.15 be payable retroactively from the redetermination due date. For a family where at least
90.16 one parent is under the age of 21, does not have a high school or general equivalency
90.17 diploma, and is a student in a school district or another similar program that provides or
90.18 arranges for child care, as well as parenting, social services, career and employment
90.19 supports, and academic support to achieve high school graduation, the redetermination of
90.20 eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of
90.21 the student's school year. If a family reports a change in an eligibility factor before the
90.22 family's next regularly scheduled redetermination, the county must recalculate eligibility
90.23 without requiring verification of any eligibility factor that did not change.

90.24 (c) The commissioner shall develop a redetermination form to redetermine eligibility
90.25 and a change report form to report changes that minimize paperwork for the county and
90.26 the participant.

90.27 **EFFECTIVE DATE.** This section is effective August 4, 2014.

90.28 Sec. 4. Minnesota Statutes 2012, section 119B.03, subdivision 4, is amended to read:

90.29 Subd. 4. **Funding priority.** (a) First priority for child care assistance under the
90.30 basic sliding fee program must be given to eligible non-MFIP families who do not have a
90.31 high school or general equivalency diploma or who need remedial and basic skill courses
90.32 in order to pursue employment or to pursue education leading to employment and who
90.33 need child care assistance to participate in the education program. This includes student
90.34 parents as defined under section 119B.011, subdivision 19b. Within this priority, the
90.35 following subpriorities must be used:

91.1 (1) child care needs of minor parents;
91.2 (2) child care needs of parents under 21 years of age; and
91.3 (3) child care needs of other parents within the priority group described in this
91.4 paragraph.

91.5 (b) Second priority must be given to parents who have completed their MFIP or
91.6 DWP transition year, or parents who are no longer receiving or eligible for diversionary
91.7 work program supports.

91.8 (c) Third priority must be given to families who are eligible for portable basic sliding
91.9 fee assistance through the portability pool under subdivision 9.

91.10 (d) Fourth priority must be given to families in which at least one parent is a veteran
91.11 as defined under section 197.447.

91.12 (e) Families under paragraph (b) must be added to the basic sliding fee waiting list
91.13 on the date they begin the transition year under section 119B.011, subdivision 20, and
91.14 must be moved into the basic sliding fee program as soon as possible after they complete
91.15 their transition year.

91.16 **EFFECTIVE DATE.** This section is effective November 11, 2013.

91.17 Sec. 5. Minnesota Statutes 2012, section 119B.05, subdivision 1, is amended to read:

91.18 Subdivision 1. **Eligible participants.** Families eligible for child care assistance
91.19 under the MFIP child care program are:

91.20 (1) MFIP participants who are employed or in job search and meet the requirements
91.21 of section 119B.10;

91.22 (2) persons who are members of transition year families under section 119B.011,
91.23 subdivision 20, and meet the requirements of section 119B.10;

91.24 (3) families who are participating in employment orientation or job search, or
91.25 other employment or training activities that are included in an approved employability
91.26 development plan under section 256J.95;

91.27 (4) MFIP families who are participating in work job search, job support,
91.28 employment, or training activities as required in their employment plan, or in appeals,
91.29 hearings, assessments, or orientations according to chapter 256J;

91.30 (5) MFIP families who are participating in social services activities under chapter
91.31 256J as required in their employment plan approved according to chapter 256J;

91.32 (6) families who are participating in services or activities that are included in an
91.33 approved family stabilization plan under section 256J.575;

91.34 (7) families who are participating in programs as required in tribal contracts under
91.35 section 119B.02, subdivision 2, or 256.01, subdivision 2; and

- 92.1 (8) families who are participating in the transition year extension under section
 92.2 119B.011, subdivision 20a; and
 92.3 (9) student parents as defined under section 119B.011, subdivision 19b.

92.4 **EFFECTIVE DATE.** This section is effective November 11, 2013.

92.5 Sec. 6. Minnesota Statutes 2012, section 119B.13, subdivision 1, is amended to read:

92.6 Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~October 31, 2011~~ February 3,
 92.7 2014, the maximum rate paid for child care assistance in any county or ~~multicounty region~~
 92.8 county price cluster under the child care fund shall be the ~~rate for like-care arrangements in~~
 92.9 ~~the county effective July 1, 2006, decreased by 2.5 percent~~ greater of the 25th percentile of
 92.10 the 2011 child care provider rate survey or the maximum rate effective November 28, 2011.
 92.11 The commissioner may: (1) assign a county with no reported provider prices to a similar
 92.12 price cluster; and (2) consider county level access when determining final price clusters.

92.13 ~~(b) Biennially, beginning in 2012, the commissioner shall survey rates charged~~
 92.14 ~~by child care providers in Minnesota to determine the 75th percentile for like-care~~
 92.15 ~~arrangements in counties. When the commissioner determines that, using the~~
 92.16 ~~commissioner's established protocol, the number of providers responding to the survey is~~
 92.17 ~~too small to determine the 75th percentile rate for like-care arrangements in a county or~~
 92.18 ~~multicounty region, the commissioner may establish the 75th percentile maximum rate~~
 92.19 ~~based on like-care arrangements in a county, region, or category that the commissioner~~
 92.20 ~~deems to be similar.~~

92.21 ~~(e)~~ (b) A rate which includes a special needs rate paid under subdivision 3 or under a
 92.22 school readiness service agreement paid under section 119B.231, may be in excess of the
 92.23 maximum rate allowed under this subdivision.

92.24 ~~(d)~~ (c) The department shall monitor the effect of this paragraph on provider rates.
 92.25 The county shall pay the provider's full charges for every child in care up to the maximum
 92.26 established. The commissioner shall determine the maximum rate for each type of care
 92.27 on an hourly, full-day, and weekly basis, including special needs and disability care. The
 92.28 maximum payment to a provider for one day of care must not exceed the daily rate. The
 92.29 maximum payment to a provider for one week of care must not exceed the weekly rate.

92.30 ~~(e)~~ (d) Child care providers receiving reimbursement under this chapter must not
 92.31 be paid activity fees or an additional amount above the maximum rates for care provided
 92.32 during nonstandard hours for families receiving assistance.

92.33 ~~(f)~~ (e) When the provider charge is greater than the maximum provider rate allowed,
 92.34 the parent is responsible for payment of the difference in the rates in addition to any
 92.35 family co-payment fee.

93.1 ~~(g)~~ (f) All maximum provider rates changes shall be implemented on the Monday
93.2 following the effective date of the maximum provider rate.

93.3 (g) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum
93.4 registration fees in effect on January 1, 2013, shall remain in effect.

93.5 Sec. 7. Minnesota Statutes 2012, section 119B.13, subdivision 1a, is amended to read:

93.6 Subd. 1a. **Legal nonlicensed family child care provider rates.** (a) Legal
93.7 nonlicensed family child care providers receiving reimbursement under this chapter must
93.8 be paid on an hourly basis for care provided to families receiving assistance.

93.9 (b) The maximum rate paid to legal nonlicensed family child care providers must be
93.10 68 percent of the county maximum hourly rate for licensed family child care providers. In
93.11 counties or county price clusters where the maximum hourly rate for licensed family child
93.12 care providers is higher than the maximum weekly rate for those providers divided by 50,
93.13 the maximum hourly rate that may be paid to legal nonlicensed family child care providers
93.14 is the rate equal to the maximum weekly rate for licensed family child care providers
93.15 divided by 50 and then multiplied by 0.68. The maximum payment to a provider for one
93.16 day of care must not exceed the maximum hourly rate times ten. The maximum payment
93.17 to a provider for one week of care must not exceed the maximum hourly rate times 50.

93.18 (c) A rate which includes a special needs rate paid under subdivision 3 may be in
93.19 excess of the maximum rate allowed under this subdivision.

93.20 (d) Legal nonlicensed family child care providers receiving reimbursement under
93.21 this chapter may not be paid registration fees for families receiving assistance.

93.22 **EFFECTIVE DATE.** This section is effective February 3, 2014.

93.23 Sec. 8. Minnesota Statutes 2012, section 119B.13, subdivision 3a, is amended to read:

93.24 Subd. 3a. **Provider rate differential for accreditation.** A family child care
93.25 provider or child care center shall be paid a 15 percent differential above the maximum
93.26 rate established in subdivision 1, up to the actual provider rate, if the provider or center
93.27 holds a current early childhood development credential or is accredited. For a family
93.28 child care provider, early childhood development credential and accreditation includes
93.29 an individual who has earned a child development associate degree, a child development
93.30 associate credential, a diploma in child development from a Minnesota state technical
93.31 college, or a bachelor's or post baccalaureate degree in early childhood education from
93.32 an accredited college or university, or who is accredited by the National Association for
93.33 Family Child Care or the Competency Based Training and Assessment Program. For a
93.34 child care center, accreditation includes accreditation that meets the following criteria:

94.1 the accrediting organization must demonstrate the use of standards that promote the
94.2 physical, social, emotional, and cognitive development of children. The accreditation
94.3 standards shall include, but are not limited to, positive interactions between adults and
94.4 children, age-appropriate learning activities, a system of tracking children's learning,
94.5 use of assessment to meet children's needs, specific qualifications for staff, a learning
94.6 environment that supports developmentally appropriate experiences for children, health
94.7 and safety requirements, and family engagement strategies. ~~The commissioner of human
94.8 services, in conjunction with the commissioners of education and health, will develop an
94.9 application and approval process based on the criteria in this section and any additional
94.10 criteria. The process developed by the commissioner of human services must address
94.11 periodic reassessment of approved accreditations. The commissioner of human services
94.12 must report the criteria developed, the application, approval, and reassessment processes,
94.13 and any additional recommendations by February 15, 2013, to the chairs and ranking
94.14 minority members of the legislative committees having jurisdiction over early childhood
94.15 issues.~~ Based on an application process developed by the commissioner in conjunction
94.16 with the commissioners of education and health, the Department of Human Services must
94.17 accept applications from accrediting organizations beginning on July 1, 2013, and on an
94.18 annual basis thereafter. The provider rate differential shall be paid to centers holding an
94.19 accreditation from an approved accrediting organization beginning on a billing cycle to be
94.20 determined by the commissioner, no later than the last Monday in February of a calendar
94.21 year. The commissioner shall annually publish a list of approved accrediting organizations.
94.22 An approved accreditation must be reassessed by the commissioner every two years. If an
94.23 approved accrediting organization is determined to no longer meet the approval criteria, the
94.24 organization and centers being paid the differential under that accreditation must be given
94.25 a 90-day notice by the commissioner and the differential payment must end after a 15-day
94.26 notice to affected families and centers as directed in Minnesota Rules, part 3400.0185,
94.27 subparts 3 and 4. The following accreditations shall be recognized for the provider rate
94.28 differential until an approval process is implemented: the National Association for the
94.29 Education of Young Children, the Council on Accreditation, the National Early Childhood
94.30 Program Accreditation, the National School-Age Care Association, or the National Head
94.31 Start Association Program of Excellence. For Montessori programs, accreditation includes
94.32 the American Montessori Society, Association of Montessori International-USA, or the
94.33 National Center for Montessori Education.

94.34 Sec. 9. Minnesota Statutes 2012, section 119B.13, is amended by adding a subdivision
94.35 to read:

95.1 Subd. 3b. **Provider rate differential for Parent Aware.** A family child care
 95.2 provider or child care center shall be paid a 15 percent differential if they hold a three-star
 95.3 Parent Aware rating or a 20 percent differential if they hold a four-star Parent Aware
 95.4 rating. A 15 percent or 20 percent rate differential must be paid above the maximum rate
 95.5 established in subdivision 1, up to the actual provider rate.

95.6 **EFFECTIVE DATE.** This section is effective March 3, 2014.

95.7 Sec. 10. Minnesota Statutes 2012, section 119B.13, is amended by adding a subdivision
 95.8 to read:

95.9 Subd. 3c. **Weekly rate paid for children attending high-quality care.** A licensed
 95.10 child care provider or license-exempt center may be paid up to the applicable weekly
 95.11 maximum rate, not to exceed the provider's actual charge, when the following conditions
 95.12 are met:

95.13 (1) the child is age birth to five years, but not yet in kindergarten;

95.14 (2) the child attends a child care provider that qualifies for the rate differential
 95.15 identified in subdivision 3a or 3b; and

95.16 (3) the applicant's activities qualify for at least 30 hours of care per week under
 95.17 sections 119B.03, 119B.05, 119B.10, and Minnesota Rules, chapter 3400.

95.18 **EFFECTIVE DATE.** This section is effective August 4, 2014.

95.19 Sec. 11. Minnesota Statutes 2012, section 119B.13, subdivision 6, is amended to read:

95.20 **Subd. 6. **Provider payments.**** (a) The provider shall bill for services provided
 95.21 within ten days of the end of the service period. If bills are submitted within ten days of
 95.22 the end of the service period, payments under the child care fund shall be made within 30
 95.23 days of receiving a bill from the provider. Counties or the state may establish policies that
 95.24 make payments on a more frequent basis.

95.25 (b) If a provider has received an authorization of care and been issued a billing form
 95.26 for an eligible family, the bill must be submitted within 60 days of the last date of service on
 95.27 the bill. A bill submitted more than 60 days after the last date of service must be paid if the
 95.28 county determines that the provider has shown good cause why the bill was not submitted
 95.29 within 60 days. Good cause must be defined in the county's child care fund plan under
 95.30 section 119B.08, subdivision 3, and the definition of good cause must include county error.
 95.31 Any bill submitted more than a year after the last date of service on the bill must not be paid.

95.32 (c) If a provider provided care for a time period without receiving an authorization
 95.33 of care and a billing form for an eligible family, payment of child care assistance may only

96.1 be made retroactively for a maximum of six months from the date the provider is issued
96.2 an authorization of care and billing form.

96.3 (d) A county may refuse to issue a child care authorization to a licensed or legal
96.4 nonlicensed provider, revoke an existing child care authorization to a licensed or legal
96.5 nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or
96.6 refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

96.7 (1) the provider admits to intentionally giving the county materially false information
96.8 on the provider's billing forms;

96.9 (2) a county finds by a preponderance of the evidence that the provider intentionally
96.10 gave the county materially false information on the provider's billing forms;

96.11 (3) the provider is in violation of child care assistance program rules, until the
96.12 agency determines those violations have been corrected;

96.13 (4) the provider is operating after receipt of an order of suspension or an order
96.14 of revocation of the provider's license, or the provider has been issued an order citing
96.15 violations of licensing standards that affect the health and safety of children in care due to
96.16 the nature, chronicity, or severity of the licensing violations, until the licensing agency
96.17 determines those violations have been corrected;

96.18 (5) the provider submits false attendance reports or refuses to provide documentation
96.19 of the child's attendance upon request; or

96.20 (6) the provider gives false child care price information.

96.21 The county may withhold the provider's authorization or payment for a period of
96.22 time not to exceed three months beyond the time the condition has been corrected.

96.23 (e) A county's payment policies must be included in the county's child care plan
96.24 under section 119B.08, subdivision 3. If payments are made by the state, in addition to
96.25 being in compliance with this subdivision, the payments must be made in compliance
96.26 with section 16A.124.

96.27 **EFFECTIVE DATE.** This section is effective February 3, 2014.

96.28 Sec. 12. Minnesota Statutes 2012, section 119B.13, subdivision 7, is amended to read:

96.29 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
96.30 must not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding
96.31 holidays, in a fiscal year, or for more than ten consecutive full-day absent days. Legal
96.32 nonlicensed family child care providers must not be reimbursed for absent days. If a child
96.33 attends for part of the time authorized to be in care in a day, but is absent for part of the
96.34 time authorized to be in care in that same day, the absent time must be reimbursed but
96.35 the time must not count toward the ~~ten~~ absent day days limit. Child care providers must

97.1 only be reimbursed for absent days if the provider has a written policy for child absences
97.2 and charges all other families in care for similar absences.

97.3 (b) Notwithstanding paragraph (a), children with documented medical conditions
97.4 that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive
97.5 full-day absent days limit. Absences due to a documented medical condition of a parent
97.6 or sibling who lives in the same residence as the child receiving child care assistance
97.7 do not count against the absent days limit in a fiscal year. Documentation of medical
97.8 conditions must be on the forms and submitted according to the timelines established by
97.9 the commissioner. A public health nurse or school nurse may verify the illness in lieu of
97.10 a medical practitioner. If a provider sends a child home early due to a medical reason,
97.11 including, but not limited to, fever or contagious illness, the child care center director or
97.12 lead teacher may verify the illness in lieu of a medical practitioner.

97.13 ~~(b)~~ (c) Notwithstanding paragraph (a), children in families may exceed the ~~ten~~ absent
97.14 days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school
97.15 or general equivalency diploma; and (3) is a student in a school district or another similar
97.16 program that provides or arranges for child care, parenting support, social services, career
97.17 and employment supports, and academic support to achieve high school graduation, upon
97.18 request of the program and approval of the county. If a child attends part of an authorized
97.19 day, payment to the provider must be for the full amount of care authorized for that day.

97.20 ~~(e)~~ (d) Child care providers must be reimbursed for up to ten federal or state holidays
97.21 or designated holidays per year when the provider charges all families for these days and the
97.22 holiday or designated holiday falls on a day when the child is authorized to be in attendance.
97.23 Parents may substitute other cultural or religious holidays for the ten recognized state and
97.24 federal holidays. Holidays do not count toward the ~~ten~~ absent ~~day~~ days limit.

97.25 ~~(d)~~ (e) A family or child care provider must not be assessed an overpayment for an
97.26 absent day payment unless (1) there was an error in the amount of care authorized for the
97.27 family, (2) all of the allowed full-day absent payments for the child have been paid, or (3)
97.28 the family or provider did not timely report a change as required under law.

97.29 ~~(e)~~ (f) The provider and family shall receive notification of the number of absent
97.30 days used upon initial provider authorization for a family and ongoing notification of the
97.31 number of absent days used as of the date of the notification.

97.32 (g) For purposes of this subdivision, "absent days limit" means 25 full-day absent
97.33 days per child, excluding holidays, in a fiscal year; and ten consecutive full-day absent days.

97.34 **EFFECTIVE DATE.** This section is effective February 1, 2014.

97.35 Sec. 13. Minnesota Statutes 2012, section 245A.07, subdivision 2a, is amended to read:

98.1 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days
98.2 of receipt of the license holder's timely appeal, the commissioner shall request assignment
98.3 of an administrative law judge. The request must include a proposed date, time, and place
98.4 of a hearing. A hearing must be conducted by an administrative law judge within 30
98.5 calendar days of the request for assignment, unless an extension is requested by either
98.6 party and granted by the administrative law judge for good cause. The commissioner shall
98.7 issue a notice of hearing by certified mail or personal service at least ten working days
98.8 before the hearing. The scope of the hearing shall be limited solely to the issue of whether
98.9 the temporary immediate suspension should remain in effect pending the commissioner's
98.10 final order under section 245A.08, regarding a licensing sanction issued under subdivision
98.11 3 following the immediate suspension. The burden of proof in expedited hearings under
98.12 this subdivision shall be limited to the commissioner's demonstration that reasonable
98.13 cause exists to believe that the license holder's actions or failure to comply with applicable
98.14 law or rule poses, or if the actions of other individuals or conditions in the program
98.15 poses an imminent risk of harm to the health, safety, or rights of persons served by the
98.16 program. "Reasonable cause" means there exist specific articulable facts or circumstances
98.17 which provide the commissioner with a reasonable suspicion that there is an imminent
98.18 risk of harm to the health, safety, or rights of persons served by the program. When the
98.19 commissioner has determined there is reasonable cause to order the temporary immediate
98.20 suspension of a license based on a violation of safe sleep requirements, as defined in
98.21 section 245A.1435, the commissioner is not required to demonstrate that an infant died or
98.22 was injured as a result of the safe sleep violations.

98.23 (b) The administrative law judge shall issue findings of fact, conclusions, and a
98.24 recommendation within ten working days from the date of hearing. The parties shall have
98.25 ten calendar days to submit exceptions to the administrative law judge's report. The
98.26 record shall close at the end of the ten-day period for submission of exceptions. The
98.27 commissioner's final order shall be issued within ten working days from the close of the
98.28 record. Within 90 calendar days after a final order affirming an immediate suspension, the
98.29 commissioner shall make a determination regarding whether a final licensing sanction
98.30 shall be issued under subdivision 3. The license holder shall continue to be prohibited
98.31 from operation of the program during this 90-day period.

98.32 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
98.33 final licensing sanction is issued under subdivision 3 and the license holder appeals that
98.34 sanction, the license holder continues to be prohibited from operation of the program
98.35 pending a final commissioner's order under section 245A.08, subdivision 5, regarding the
98.36 final licensing sanction.

99.1 Sec. 14. Minnesota Statutes 2012, section 245A.1435, is amended to read:

99.2 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT**
99.3 **DEATH SYNDROME IN LICENSED PROGRAMS.**

99.4 (a) When a license holder is placing an infant to sleep, the license holder must
99.5 place the infant on the infant's back, unless the license holder has documentation from
99.6 the infant's ~~parent~~ physician directing an alternative sleeping position for the infant. The
99.7 ~~parent~~ physician directive must be on a form approved by the commissioner and must
99.8 ~~include a statement that the parent or legal guardian has read the information provided by~~
99.9 ~~the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance~~
99.10 ~~of placing an infant or child on its back to sleep to reduce the risk of SIDS.~~ remain on file
99.11 at the licensed location. An infant who independently rolls onto its stomach after being
99.12 placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant
99.13 is at least six months of age or the license holder has a signed statement from the parent
99.14 indicating that the infant regularly rolls over at home.

99.15 (b) ~~The license holder must place the infant in a crib directly on a firm mattress with~~
99.16 ~~a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be~~
99.17 ~~dislodged by pulling on the corner of the sheet. The license holder must not place pillows,~~
99.18 ~~quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib~~
99.19 ~~with the infant~~ The license holder must place the infant in a crib directly on a firm mattress
99.20 with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress,
99.21 and overlaps the underside of the mattress so it cannot be dislodged by pulling on the
99.22 corner of the sheet with reasonable effort. The license holder must not place anything in
99.23 the crib with the infant except for the infant's pacifier, as defined in Code of Federal
99.24 Regulations, title 16, part 1511. The requirements of this section apply to license holders
99.25 servicing infants up to and including 12 months younger than one year of age. Licensed
99.26 child care providers must meet the crib requirements under section 245A.146.

99.27 (c) If an infant falls asleep before being placed in a crib, the license holder must
99.28 move the infant to a crib as soon as practicable, and must keep the infant within sight of
99.29 the license holder until the infant is placed in a crib. When an infant falls asleep while
99.30 being held, the license holder must consider the supervision needs of other children in
99.31 care when determining how long to hold the infant before placing the infant in a crib to
99.32 sleep. The sleeping infant must not be in a position where the airway may be blocked or
99.33 with anything covering the infant's face.

99.34 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
99.35 for an infant of any age and is prohibited for any infant who has begun to roll over
99.36 independently. However, with the written consent of a parent or guardian according to this

100.1 paragraph, a license holder may place the infant who has not yet begun to roll over on its
 100.2 own down to sleep in a one-piece sleeper equipped with an attached system that fastens
 100.3 securely only across the upper torso, with no constriction of the hips or legs, to create a
 100.4 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
 100.5 the license holder must obtain informed written consent for the use of swaddling from the
 100.6 parent or guardian of the infant on a form provided by the commissioner and prepared in
 100.7 partnership with the Minnesota Sudden Infant Death Center.

100.8 Sec. 15. Minnesota Statutes 2012, section 245A.144, is amended to read:

100.9 **245A.144 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
 100.10 **DEATH AND SHAKEN-BABY SYNDROME ABUSIVE HEAD TRAUMA FOR**
 100.11 **CHILD FOSTER CARE PROVIDERS.**

100.12 (a) Licensed child foster care providers that care for infants or children through five
 100.13 years of age must document that before staff persons and caregivers assist in the care
 100.14 of infants or children through five years of age, they are instructed on the standards in
 100.15 section 245A.1435 and receive training on reducing the risk of sudden unexpected infant
 100.16 death ~~syndrome~~ and ~~shaken-baby syndrome~~ for abusive head trauma from shaking infants
 100.17 and young children. This section does not apply to emergency relative placement under
 100.18 section 245A.035. The training on reducing the risk of sudden unexpected infant death
 100.19 ~~syndrome~~ and ~~shaken-baby syndrome~~ abusive head trauma may be provided as:

100.20 (1) orientation training to child foster care providers, who care for infants or children
 100.21 through five years of age, under Minnesota Rules, part 2960.3070, subpart 1; or

100.22 (2) in-service training to child foster care providers, who care for infants or children
 100.23 through five years of age, under Minnesota Rules, part 2960.3070, subpart 2.

100.24 (b) Training required under this section (b) must be at least one hour in length and must
 100.25 be completed at least once every five years. At a minimum, the training must address
 100.26 the risk factors related to sudden unexpected infant death ~~syndrome~~ and ~~shaken-baby~~
 100.27 ~~syndrome~~ abusive head trauma, means of reducing the risk of sudden unexpected infant
 100.28 death ~~syndrome~~ and ~~shaken-baby syndrome~~ abusive head trauma, and license holder
 100.29 communication with parents regarding reducing the risk of sudden unexpected infant
 100.30 death ~~syndrome~~ and ~~shaken-baby syndrome~~ abusive head trauma.

100.31 (c) Training for child foster care providers must be approved by the county or
 100.32 private licensing agency that is responsible for monitoring the child foster care provider
 100.33 under section 245A.16. The approved training fulfills, in part, training required under
 100.34 Minnesota Rules, part 2960.3070.

101.1 Sec. 16. Minnesota Statutes 2012, section 245A.1444, is amended to read:

101.2 **245A.1444 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
 101.3 **~~DEATH SYNDROME AND SHAKEN-BABY SYNDROME~~ ABUSIVE HEAD**
 101.4 **TRAUMA BY OTHER PROGRAMS.**

101.5 A licensed chemical dependency treatment program that serves clients with infants
 101.6 or children through five years of age, who sleep at the program and a licensed children's
 101.7 residential facility that serves infants or children through five years of age, must document
 101.8 that before program staff persons or volunteers assist in the care of infants or children
 101.9 through five years of age, they are instructed on the standards in section 245A.1435 and
 101.10 receive training on reducing the risk of sudden unexpected infant death ~~syndrome~~ and
 101.11 ~~shaken baby syndrome~~ abusive head trauma from shaking infants and young children. The
 101.12 training conducted under this section may be used to fulfill training requirements under
 101.13 Minnesota Rules, parts 2960.0100, subpart 3; and 9530.6490, subpart 4, item B.

101.14 This section does not apply to child care centers or family child care programs
 101.15 governed by sections 245A.40 and 245A.50.

101.16 Sec. 17. **[245A.1446] FAMILY CHILD CARE DIAPERING AREA**
 101.17 **DISINFECTION.**

101.18 Notwithstanding Minnesota Rules, part 9502.0435, a family child care provider may
 101.19 disinfect the diaper changing surface with chlorine bleach in a manner consistent with label
 101.20 directions for disinfection or with a surface disinfectant that meets the following criteria:

101.21 (1) the manufacturer's label or instructions state that the product is registered with
 101.22 the United States Environmental Protection Agency;

101.23 (2) the manufacturer's label or instructions state that the disinfectant is effective
 101.24 against Staphylococcus aureus, Salmonella choleraesuis, and Pseudomonas aeruginosa;

101.25 (3) the manufacturer's label or instructions state that the disinfectant is effective with
 101.26 a ten minute or less contact time;

101.27 (4) the disinfectant is clearly labeled by the manufacturer with directions for mixing
 101.28 and use;

101.29 (5) the disinfectant is used only in accordance with the manufacturer's directions; and

101.30 (6) the product does not include triclosan or derivatives of triclosan.

101.31 Sec. 18. **[245A.147] FAMILY CHILD CARE INFANT SLEEP SUPERVISION**
 101.32 **REQUIREMENTS.**

102.1 Subdivision 1. **In-person checks on infants.** (a) License holders that serve infants
102.2 are encouraged to monitor sleeping infants by conducting in-person checks on each infant
102.3 in their care every 30 minutes.

102.4 (b) Upon enrollment of an infant in a family child care program, the license holder is
102.5 encouraged to conduct in-person checks on the sleeping infant every 15 minutes, during
102.6 the first four months of care.

102.7 (c) When an infant has an upper respiratory infection, the license holder is
102.8 encouraged to conduct in-person checks on the sleeping infant every 15 minutes
102.9 throughout the hours of sleep.

102.10 Subd. 2. **Use of audio or visual monitoring devices.** In addition to conducting
102.11 the in-person checks encouraged under subdivision 1, license holders serving infants are
102.12 encouraged to use and maintain an audio or visual monitoring device to monitor each
102.13 sleeping infant in care during all hours of sleep.

102.14 Sec. 19. **[245A.152] CHILD CARE LICENSE HOLDER INSURANCE.**

102.15 (a) A license holder must provide a written notice to all parents or guardians of all
102.16 children to be accepted for care prior to admission stating whether the license holder has
102.17 liability insurance. This notice may be incorporated into and provided on the admission
102.18 form used by the license holder.

102.19 (b) If the license holder has liability insurance:

102.20 (1) the license holder shall inform parents in writing that a current certificate of
102.21 coverage for insurance is available for inspection to all parents or guardians of children
102.22 receiving services and to all parents seeking services from the family child care program;

102.23 (2) the notice must provide the parent or guardian with the date of expiration or
102.24 next renewal of the policy; and

102.25 (3) upon the expiration date of the policy, the license holder must provide a new
102.26 written notice indicating whether the insurance policy has lapsed or whether the license
102.27 holder has renewed the policy.

102.28 If the policy was renewed, the license holder must provide the new expiration date of the
102.29 policy in writing to the parents or guardians.

102.30 (c) If the license holder does not have liability insurance, the license holder must
102.31 provide an annual notice, on a form developed and made available by the commissioner,
102.32 to the parents or guardians of children in care indicating that the license holder does not
102.33 carry liability insurance.

102.34 (d) The license holder must notify all parents and guardians in writing immediately
102.35 of any change in insurance status.

103.1 (e) The license holder must make available upon request the certificate of liability
 103.2 insurance to the parents of children in care, to the commissioner, and to county licensing
 103.3 agents.

103.4 (f) The license holder must document, with the signature of the parent or guardian,
 103.5 that the parent or guardian received the notices required by this section.

103.6 Sec. 20. Minnesota Statutes 2012, section 245A.40, subdivision 5, is amended to read:

103.7 Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~**
 103.8 **abusive head trauma training.** (a) License holders must document that before staff
 103.9 persons and volunteers care for infants, they are instructed on the standards in section
 103.10 245A.1435 and receive training on reducing the risk of sudden unexpected infant death
 103.11 ~~syndrome~~. In addition, license holders must document that before staff persons care for
 103.12 infants or children under school age, they receive training on the risk of ~~shaken baby~~
 103.13 ~~syndrome~~ abusive head trauma from shaking infants and young children. The training
 103.14 in this subdivision may be provided as orientation training under subdivision 1 and
 103.15 in-service training under subdivision 7.

103.16 (b) Sudden unexpected infant death ~~syndrome~~ reduction training required under
 103.17 this subdivision must be at least one-half hour in length and must be completed at least
 103.18 once every ~~five years~~ year. At a minimum, the training must address the risk factors
 103.19 related to sudden unexpected infant death ~~syndrome~~, means of reducing the risk of sudden
 103.20 unexpected infant death ~~syndrome~~ in child care, and license holder communication with
 103.21 parents regarding reducing the risk of sudden unexpected infant death ~~syndrome~~.

103.22 (c) ~~Shaken baby syndrome~~ Abusive head trauma training under this subdivision
 103.23 must be at least one-half hour in length and must be completed at least once every ~~five~~
 103.24 ~~years~~ year. At a minimum, the training must address the risk factors related to ~~shaken~~
 103.25 ~~baby syndrome~~ for shaking infants and young children, means to reduce the risk of ~~shaken~~
 103.26 ~~baby syndrome~~ abusive head trauma in child care, and license holder communication with
 103.27 parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive head trauma.

103.28 (d) The commissioner shall make available for viewing a video presentation on the
 103.29 dangers associated with shaking infants and young children. The video presentation must
 103.30 be part of the orientation and annual in-service training of licensed child care center
 103.31 staff persons caring for children under school age. The commissioner shall provide to
 103.32 child care providers and interested individuals, at cost, copies of a video approved by the
 103.33 commissioner of health under section 144.574 on the dangers associated with shaking
 103.34 infants and young children.

104.1 Sec. 21. Minnesota Statutes 2012, section 245A.50, is amended to read:

104.2 **245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.**

104.3 Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes must
104.4 comply with the training requirements in this section.

104.5 (b) Helpers who assist with care on a regular basis must complete six hours of
104.6 training within one year after the date of initial employment.

104.7 Subd. 2. **Child growth and development and behavior guidance training.** (a) For
104.8 purposes of family and group family child care, the license holder and each adult caregiver
104.9 who provides care in the licensed setting for more than 30 days in any 12-month period
104.10 shall complete and document at least ~~two~~ four hours of child growth and development
104.11 and behavior guidance training within the first year of prior to initial licensure, and before
104.12 caring for children. For purposes of this subdivision, "child growth and development
104.13 training" means training in understanding how children acquire language and develop
104.14 physically, cognitively, emotionally, and socially. "Behavior guidance training" means
104.15 training in the understanding of the functions of child behavior and strategies for managing
104.16 challenging situations. Child growth and development and behavior guidance training
104.17 must be repeated annually. Training curriculum shall be developed or approved by the
104.18 commissioner of human services by January 1, 2014.

104.19 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if
104.20 they:

104.21 (1) have taken a three-credit course on early childhood development within the
104.22 past five years;

104.23 (2) have received a baccalaureate or master's degree in early childhood education or
104.24 school-age child care within the past five years;

104.25 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood
104.26 educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early
104.27 childhood special education teacher, or an elementary teacher with a kindergarten
104.28 endorsement; or

104.29 (4) have received a baccalaureate degree with a Montessori certificate within the
104.30 past five years.

104.31 Subd. 3. **First aid.** (a) When children are present in a family child care home
104.32 governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person
104.33 must be present in the home who has been trained in first aid. The first aid training must
104.34 have been provided by an individual approved to provide first aid instruction. First aid
104.35 training may be less than eight hours and persons qualified to provide first aid training

105.1 include individuals approved as first aid instructors. First aid training must be repeated
105.2 every two years.

105.3 (b) A family child care provider is exempt from the first aid training requirements
105.4 under this subdivision related to any substitute caregiver who provides less than 30 hours
105.5 of care during any 12-month period.

105.6 (c) Video training reviewed and approved by the county licensing agency satisfies
105.7 the training requirement of this subdivision.

105.8 Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family
105.9 child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least
105.10 one staff person must be present in the home who has been trained in cardiopulmonary
105.11 resuscitation (CPR) and in the treatment of obstructed airways that includes CPR
105.12 techniques for infants and children. The CPR training must have been provided by an
105.13 individual approved to provide CPR instruction, must be repeated at least once every ~~three~~
105.14 two years, and must be documented in the staff person's records.

105.15 (b) A family child care provider is exempt from the CPR training requirement in
105.16 this subdivision related to any substitute caregiver who provides less than 30 hours of
105.17 care during any 12-month period.

105.18 (c) ~~Video training reviewed and approved by the county licensing agency satisfies~~
105.19 ~~the training requirement of this subdivision.~~ Persons providing CPR training must use
105.20 CPR training that has been developed:

105.21 (1) by the American Heart Association or the American Red Cross and incorporates
105.22 psychomotor skills to support the instruction; or

105.23 (2) using nationally recognized, evidence-based guidelines for CPR training and
105.24 incorporates psychomotor skills to support the instruction.

105.25 Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~**
105.26 **abusive head trauma training.** (a) License holders must document that before staff
105.27 persons, caregivers, and helpers assist in the care of infants, they are instructed on the
105.28 standards in section 245A.1435 and receive training on reducing the risk of sudden
105.29 unexpected infant death syndrome. In addition, license holders must document that before
105.30 staff persons, caregivers, and helpers assist in the care of infants and children under
105.31 school age, they receive training on reducing the risk of ~~shaken baby syndrome~~ abusive
105.32 head trauma from shaking infants and young children. The training in this subdivision
105.33 may be provided as initial training under subdivision 1 or ongoing annual training under
105.34 subdivision 7.

105.35 (b) Sudden unexpected infant death ~~syndrome~~ reduction training required under this
105.36 subdivision must be at least one-half hour in length and must be completed in person

106.1 at least once every ~~five years~~ two years. On the years when the license holder is not
106.2 receiving the in-person training on sudden unexpected infant death reduction, the license
106.3 holder must receive sudden unexpected infant death reduction training through a video
106.4 of no more than one hour in length developed or approved by the commissioner. At a
106.5 minimum, the training must address the risk factors related to sudden unexpected infant
106.6 death ~~syndrome~~, means of reducing the risk of sudden unexpected infant death ~~syndrome~~
106.7 in child care, and license holder communication with parents regarding reducing the risk
106.8 of sudden unexpected infant death ~~syndrome~~.

106.9 (c) ~~Shaken baby syndrome~~ Abusive head trauma training required under this
106.10 subdivision must be at least one-half hour in length and must be completed at least once
106.11 every ~~five years~~ year. At a minimum, the training must address the risk factors related
106.12 to ~~shaken baby syndrome~~ shaking infants and young children, means of reducing the
106.13 risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder
106.14 communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive
106.15 head trauma.

106.16 (d) Training for family and group family child care providers must be developed
106.17 by the commissioner in conjunction with the Minnesota Sudden Infant Death Center
106.18 and approved by the county licensing agency by the Minnesota Center for Professional
106.19 Development.

106.20 (e) ~~The commissioner shall make available for viewing by all licensed child care~~
106.21 ~~providers a video presentation on the dangers associated with shaking infants and young~~
106.22 ~~children. The video presentation shall be part of the initial and ongoing annual training of~~
106.23 ~~licensed child care providers, caregivers, and helpers caring for children under school age.~~
106.24 ~~The commissioner shall provide to child care providers and interested individuals, at cost,~~
106.25 ~~copies of a video approved by the commissioner of health under section 144.574 on the~~
106.26 ~~dangers associated with shaking infants and young children.~~

106.27 Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license
106.28 holder must comply with all seat belt and child passenger restraint system requirements
106.29 under section 169.685.

106.30 (b) Family and group family child care programs licensed by the Department of
106.31 Human Services that serve a child or children under nine years of age must document
106.32 training that fulfills the requirements in this subdivision.

106.33 (1) Before a license holder, staff person, caregiver, or helper transports a child or
106.34 children under age nine in a motor vehicle, the person placing the child or children in a
106.35 passenger restraint must satisfactorily complete training on the proper use and installation

107.1 of child restraint systems in motor vehicles. Training completed under this subdivision may
107.2 be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

107.3 (2) Training required under this subdivision must be at least one hour in length,
107.4 completed at initial training, and repeated at least once every five years. At a minimum,
107.5 the training must address the proper use of child restraint systems based on the child's
107.6 size, weight, and age, and the proper installation of a car seat or booster seat in the motor
107.7 vehicle used by the license holder to transport the child or children.

107.8 (3) Training under this subdivision must be provided by individuals who are certified
107.9 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
107.10 may obtain a list of certified and approved trainers through the Department of Public
107.11 Safety Web site or by contacting the agency.

107.12 (c) Child care providers that only transport school-age children as defined in section
107.13 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
107.14 subdivision 1, paragraph (e), are exempt from this subdivision.

107.15 Subd. 7. **Training requirements for family and group family child care.** For
107.16 purposes of family and group family child care, the license holder and each primary
107.17 caregiver must complete ~~eight~~ 16 hours of ongoing training each year. For purposes
107.18 of this subdivision, a primary caregiver is an adult caregiver who provides services in
107.19 the licensed setting for more than 30 days in any 12-month period. Repeat of topical
107.20 training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training
107.21 requirement. Additional ongoing training subjects to meet the annual 16-hour training
107.22 requirement must be selected from the following areas:

107.23 (1) "child growth and development training" ~~has the meaning given in~~ under
107.24 subdivision 2, paragraph (a);

107.25 (2) "learning environment and curriculum" ~~includes,~~ including training in
107.26 establishing an environment and providing activities that provide learning experiences to
107.27 meet each child's needs, capabilities, and interests;

107.28 (3) "assessment and planning for individual needs" ~~includes,~~ including training in
107.29 observing and assessing what children know and can do in order to provide curriculum
107.30 and instruction that addresses their developmental and learning needs, including children
107.31 with special needs and bilingual children or children for whom English is not their
107.32 primary language;

107.33 (4) "interactions with children" ~~includes,~~ including training in establishing
107.34 supportive relationships with children, guiding them as individuals and as part of a group;

108.1 (5) "families and communities"~~includes~~, including training in working
108.2 collaboratively with families and agencies or organizations to meet children's needs and to
108.3 encourage the community's involvement;

108.4 (6) "health, safety, and nutrition"~~includes~~, including training in establishing and
108.5 maintaining an environment that ensures children's health, safety, and nourishment,
108.6 including child abuse, maltreatment, prevention, and reporting; home and fire safety; child
108.7 injury prevention; communicable disease prevention and control; first aid; and CPR; ~~and~~

108.8 (7) "program planning and evaluation"~~includes~~, including training in establishing,
108.9 implementing, evaluating, and enhancing program operations; and

108.10 (8) behavior guidance, including training in the understanding of the functions of
108.11 child behavior and strategies for managing behavior.

108.12 Subd. 8. **Other required training requirements.** (a) The training required of
108.13 family and group family child care providers and staff must include training in the cultural
108.14 dynamics of early childhood development and child care. The cultural dynamics and
108.15 disabilities training and skills development of child care providers must be designed to
108.16 achieve outcomes for providers of child care that include, but are not limited to:

108.17 (1) an understanding and support of the importance of culture and differences in
108.18 ability in children's identity development;

108.19 (2) understanding the importance of awareness of cultural differences and
108.20 similarities in working with children and their families;

108.21 (3) understanding and support of the needs of families and children with differences
108.22 in ability;

108.23 (4) developing skills to help children develop unbiased attitudes about cultural
108.24 differences and differences in ability;

108.25 (5) developing skills in culturally appropriate caregiving; and

108.26 (6) developing skills in appropriate caregiving for children of different abilities.

108.27 The commissioner shall approve the curriculum for cultural dynamics and disability
108.28 training.

108.29 (b) The provider must meet the training requirement in section 245A.14, subdivision
108.30 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child
108.31 care or group family child care home to use the swimming pool located at the home.

108.32 Subd. 9. **Supervising for safety; training requirement.** Effective July 1, 2014,
108.33 all family child care license holders and each adult caregiver who provides care in the
108.34 licensed family child care home for more than 30 days in any 12-month period shall
108.35 complete and document at least six hours of approved training on supervising for safety
108.36 prior to initial licensure, and before caring for children. At least two hours of training

109.1 on supervising for safety must be repeated annually. For purposes of this subdivision,
 109.2 "supervising for safety" includes supervision basics, supervision outdoors, equipment and
 109.3 materials, illness, injuries, and disaster preparedness. The commissioner shall develop
 109.4 the supervising for safety curriculum by January 1, 2014.

109.5 Subd. 10. **Approved training.** County licensing staff must accept training approved
 109.6 by the Minnesota Center for Professional Development, including:

109.7 (1) face-to-face or classroom training;

109.8 (2) online training; and

109.9 (3) relationship-based professional development, such as mentoring, coaching,
 109.10 and consulting.

109.11 Subd. 11. **Provider training.** New and increased training requirements under this
 109.12 section must not be imposed on providers until the commissioner establishes statewide
 109.13 accessibility to the required provider training.

109.14 Sec. 22. Minnesota Statutes 2012, section 252.27, subdivision 2a, is amended to read:

109.15 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
 109.16 child, including a child determined eligible for medical assistance without consideration of
 109.17 parental income, must contribute to the cost of services used by making monthly payments
 109.18 on a sliding scale based on income, unless the child is married or has been married, parental
 109.19 rights have been terminated, or the child's adoption is subsidized according to section
 109.20 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial
 109.21 or full payment for medical services provided for diagnostic, therapeutic, curing, treating,
 109.22 mitigating, rehabilitation, maintenance, and personal care services as defined in United
 109.23 States Code, title 26, section 213, needed by the child with a chronic illness or disability.

109.24 (b) For households with adjusted gross income equal to or greater than ~~100~~ 275
 109.25 percent of federal poverty guidelines, the parental contribution shall be computed by
 109.26 applying the following schedule of rates to the adjusted gross income of the natural or
 109.27 adoptive parents:

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

109.31 ~~(2)~~ (1) if the adjusted gross income is equal to or greater than ~~175~~ 275 percent
 109.32 of federal poverty guidelines and less than or equal to 545 percent of federal poverty
 109.33 guidelines, the parental contribution shall be determined using a sliding fee scale
 109.34 established by the commissioner of human services which begins at ~~one~~ 2.76 percent of
 109.35 adjusted gross income at ~~175~~ 275 percent of federal poverty guidelines and increases to

110.1 7.5 percent of adjusted gross income for those with adjusted gross income up to 545
110.2 percent of federal poverty guidelines;

110.3 ~~(3)~~ (2) if the adjusted gross income is greater than 545 percent of federal poverty
110.4 guidelines and less than 675 percent of federal poverty guidelines, the parental
110.5 contribution shall be 7.5 percent of adjusted gross income;

110.6 ~~(4)~~ (3) if the adjusted gross income is equal to or greater than 675 percent of federal
110.7 poverty guidelines and less than 975 percent of federal poverty guidelines, the parental
110.8 contribution shall be determined using a sliding fee scale established by the commissioner
110.9 of human services which begins at 7.5 percent of adjusted gross income at 675 percent of
110.10 federal poverty guidelines and increases to ten percent of adjusted gross income for those
110.11 with adjusted gross income up to 975 percent of federal poverty guidelines; and

110.12 ~~(5)~~ (4) if the adjusted gross income is equal to or greater than 975 percent of federal
110.13 poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

110.14 If the child lives with the parent, the annual adjusted gross income is reduced by
110.15 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
110.16 specified in section 256B.35, the parent is responsible for the personal needs allowance
110.17 specified under that section in addition to the parental contribution determined under this
110.18 section. The parental contribution is reduced by any amount required to be paid directly to
110.19 the child pursuant to a court order, but only if actually paid.

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

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

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

111.1 taxable income if the parent paid for the parent's fees through an employer's health care
111.2 flexible spending account under the Internal Revenue Code, section 125, and that the
111.3 parent is responsible for paying the taxes owed on the amount reimbursed.

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

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

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

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

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

111.30 (1) the parent applied for insurance for the child;

111.31 (2) the insurer denied insurance;

111.32 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
111.33 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
111.34 commerce, or litigated the complaint or appeal; and

111.35 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

111.36 For purposes of this section, "insurance" has the meaning given in paragraph (h).

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

112.7 (j) ~~Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,~~
112.8 ~~2015, the parental contribution shall be computed by applying the following contribution~~
112.9 ~~schedule to the adjusted gross income of the natural or adoptive parents:~~

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

112.13 (2) ~~if the adjusted gross income is equal to or greater than 175 percent of federal~~
112.14 ~~poverty guidelines and less than or equal to 525 percent of federal poverty guidelines,~~
112.15 ~~the parental contribution shall be determined using a sliding fee scale established by the~~
112.16 ~~commissioner of human services which begins at one percent of adjusted gross income~~
112.17 ~~at 175 percent of federal poverty guidelines and increases to eight percent of adjusted~~
112.18 ~~gross income for those with adjusted gross income up to 525 percent of federal poverty~~
112.19 ~~guidelines;~~

112.20 (3) ~~if the adjusted gross income is greater than 525 percent of federal poverty~~
112.21 ~~guidelines and less than 675 percent of federal poverty guidelines, the parental~~
112.22 ~~contribution shall be 9.5 percent of adjusted gross income;~~

112.23 (4) ~~if the adjusted gross income is equal to or greater than 675 percent of federal~~
112.24 ~~poverty guidelines and less than 900 percent of federal poverty guidelines, the parental~~
112.25 ~~contribution shall be determined using a sliding fee scale established by the commissioner~~
112.26 ~~of human services which begins at 9.5 percent of adjusted gross income at 675 percent of~~
112.27 ~~federal poverty guidelines and increases to 12 percent of adjusted gross income for those~~
112.28 ~~with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

112.29 (5) ~~if the adjusted gross income is equal to or greater than 900 percent of federal~~
112.30 ~~poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross~~
112.31 ~~income. If the child lives with the parent, the annual adjusted gross income is reduced by~~
112.32 ~~\$2,400 prior to calculating the parental contribution. If the child resides in an institution~~
112.33 ~~specified in section 256B.35, the parent is responsible for the personal needs allowance~~
112.34 ~~specified under that section in addition to the parental contribution determined under this~~
112.35 ~~section. The parental contribution is reduced by any amount required to be paid directly to~~
112.36 ~~the child pursuant to a court order, but only if actually paid.~~

113.1 **EFFECTIVE DATE.** Paragraph (b) is effective January 1, 2014. Paragraph (j)
113.2 is effective July 1, 2013.

113.3 Sec. 23. Minnesota Statutes 2012, section 256.98, subdivision 8, is amended to read:

113.4 Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of
113.5 wrongfully obtaining assistance by a federal or state court or by an administrative hearing
113.6 determination, or waiver thereof, through a disqualification consent agreement, or as part
113.7 of any approved diversion plan under section 401.065, or any court-ordered stay which
113.8 carries with it any probationary or other conditions, in the Minnesota family investment
113.9 program and any affiliated program to include the diversionary work program and the
113.10 work participation cash benefit program, the food stamp or food support program, the
113.11 general assistance program, the group residential housing program, or the Minnesota
113.12 supplemental aid program shall be disqualified from that program. In addition, any person
113.13 disqualified from the Minnesota family investment program shall also be disqualified from
113.14 the food stamp or food support program. The needs of that individual shall not be taken
113.15 into consideration in determining the grant level for that assistance unit:

- 113.16 (1) for one year after the first offense;
113.17 (2) for two years after the second offense; and
113.18 (3) permanently after the third or subsequent offense.

113.19 The period of program disqualification shall begin on the date stipulated on the
113.20 advance notice of disqualification without possibility of postponement for administrative
113.21 stay or administrative hearing and shall continue through completion unless and until the
113.22 findings upon which the sanctions were imposed are reversed by a court of competent
113.23 jurisdiction. The period for which sanctions are imposed is not subject to review. The
113.24 sanctions provided under this subdivision are in addition to, and not in substitution
113.25 for, any other sanctions that may be provided for by law for the offense involved. A
113.26 disqualification established through hearing or waiver shall result in the disqualification
113.27 period beginning immediately unless the person has become otherwise ineligible for
113.28 assistance. If the person is ineligible for assistance, the disqualification period begins
113.29 when the person again meets the eligibility criteria of the program from which they were
113.30 disqualified and makes application for that program.

113.31 (b) A family receiving assistance through child care assistance programs under
113.32 chapter 119B with a family member who is found to be guilty of wrongfully obtaining child
113.33 care assistance by a federal court, state court, or an administrative hearing determination
113.34 or waiver, through a disqualification consent agreement, as part of an approved diversion
113.35 plan under section 401.065, or a court-ordered stay with probationary or other conditions,

114.1 is disqualified from child care assistance programs. The disqualifications must be for
114.2 periods of ~~three months, six months, and~~ one year and two years for the first, and
114.3 ~~second, and third~~ offenses, respectively. Subsequent violations must result in permanent
114.4 disqualification. During the disqualification period, disqualification from any child care
114.5 program must extend to all child care programs and must be immediately applied.

114.6 (c) A provider caring for children receiving assistance through child care assistance
114.7 programs under chapter 119B is disqualified from receiving payment for child care
114.8 services from the child care assistance program under chapter 119B when the provider is
114.9 found to have wrongfully obtained child care assistance by a federal court, state court,
114.10 or an administrative hearing determination or waiver under section 256.046, through
114.11 a disqualification consent agreement, as part of an approved diversion plan under
114.12 section 401.065, or a court-ordered stay with probationary or other conditions. The
114.13 disqualification must be for a period of one year for the first offense and two years for
114.14 the second offense. Any subsequent violation must result in permanent disqualification.
114.15 The disqualification period must be imposed immediately after a determination is made
114.16 under this paragraph. During the disqualification period, the provider is disqualified from
114.17 receiving payment from any child care program under chapter 119B.

114.18 (d) Any person found to be guilty of wrongfully obtaining general assistance
114.19 medical care, MinnesotaCare for adults without children, and upon federal approval, all
114.20 categories of medical assistance and remaining categories of MinnesotaCare, except
114.21 for children through age 18, by a federal or state court or by an administrative hearing
114.22 determination, or waiver thereof, through a disqualification consent agreement, or as part
114.23 of any approved diversion plan under section 401.065, or any court-ordered stay which
114.24 carries with it any probationary or other conditions, is disqualified from that program. The
114.25 period of disqualification is one year after the first offense, two years after the second
114.26 offense, and permanently after the third or subsequent offense. The period of program
114.27 disqualification shall begin on the date stipulated on the advance notice of disqualification
114.28 without possibility of postponement for administrative stay or administrative hearing
114.29 and shall continue through completion unless and until the findings upon which the
114.30 sanctions were imposed are reversed by a court of competent jurisdiction. The period for
114.31 which sanctions are imposed is not subject to review. The sanctions provided under this
114.32 subdivision are in addition to, and not in substitution for, any other sanctions that may be
114.33 provided for by law for the offense involved.

114.34 **EFFECTIVE DATE.** This section is effective February 3, 2014.

114.35 Sec. 24. Minnesota Statutes 2012, section 256J.08, subdivision 24, is amended to read:

115.1 Subd. 24. **Disregard.** "Disregard" means earned income that is not counted when
115.2 ~~determining initial eligibility~~ in the initial income test in section 256J.21, subdivision 3,
115.3 or income that is not counted when determining ongoing eligibility and calculating the
115.4 amount of the assistance payment for participants. ~~The commissioner shall determine~~
115.5 ~~the amount of the disregard according to section 256J.24, subdivision 10~~ for ongoing
115.6 eligibility shall be 50 percent of gross earned income.

115.7 **EFFECTIVE DATE.** This section is effective October 1, 2014, or upon approval
115.8 from the United States Department of Agriculture, whichever is later.

115.9 Sec. 25. Minnesota Statutes 2012, section 256J.21, subdivision 2, is amended to read:

115.10 Subd. 2. **Income exclusions.** The following must be excluded in determining a
115.11 family's available income:

115.12 (1) payments for basic care, difficulty of care, and clothing allowances received for
115.13 providing family foster care to children or adults under Minnesota Rules, parts 9555.5050
115.14 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used
115.15 for care and maintenance of a third-party beneficiary who is not a household member;

115.16 (2) reimbursements for employment training received through the Workforce
115.17 Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

115.18 (3) reimbursement for out-of-pocket expenses incurred while performing volunteer
115.19 services, jury duty, employment, or informal carpooling arrangements directly related to
115.20 employment;

115.21 (4) all educational assistance, except the county agency must count graduate student
115.22 teaching assistantships, fellowships, and other similar paid work as earned income and,
115.23 after allowing deductions for any unmet and necessary educational expenses, shall
115.24 count scholarships or grants awarded to graduate students that do not require teaching
115.25 or research as unearned income;

115.26 (5) loans, regardless of purpose, from public or private lending institutions,
115.27 governmental lending institutions, or governmental agencies;

115.28 (6) loans from private individuals, regardless of purpose, provided an applicant or
115.29 participant documents that the lender expects repayment;

115.30 (7)(i) state income tax refunds; and

115.31 (ii) federal income tax refunds;

115.32 (8)(i) federal earned income credits;

115.33 (ii) Minnesota working family credits;

115.34 (iii) state homeowners and renters credits under chapter 290A; and

115.35 (iv) federal or state tax rebates;

- 116.1 (9) funds received for reimbursement, replacement, or rebate of personal or real
116.2 property when these payments are made by public agencies, awarded by a court, solicited
116.3 through public appeal, or made as a grant by a federal agency, state or local government,
116.4 or disaster assistance organizations, subsequent to a presidential declaration of disaster;
- 116.5 (10) the portion of an insurance settlement that is used to pay medical, funeral, and
116.6 burial expenses, or to repair or replace insured property;
- 116.7 (11) reimbursements for medical expenses that cannot be paid by medical assistance;
- 116.8 (12) payments by a vocational rehabilitation program administered by the state
116.9 under chapter 268A, except those payments that are for current living expenses;
- 116.10 (13) in-kind income, including any payments directly made by a third party to a
116.11 provider of goods and services;
- 116.12 (14) assistance payments to correct underpayments, but only for the month in which
116.13 the payment is received;
- 116.14 (15) payments for short-term emergency needs under section 256J.626, subdivision 2;
- 116.15 (16) funeral and cemetery payments as provided by section 256.935;
- 116.16 (17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in
116.17 a calendar month;
- 116.18 (18) any form of energy assistance payment made through Public Law 97-35,
116.19 Low-Income Home Energy Assistance Act of 1981, payments made directly to energy
116.20 providers by other public and private agencies, and any form of credit or rebate payment
116.21 issued by energy providers;
- 116.22 (19) Supplemental Security Income (SSI), including retroactive SSI payments and
116.23 other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;
- 116.24 (20) Minnesota supplemental aid, including retroactive payments;
- 116.25 (21) proceeds from the sale of real or personal property;
- 116.26 (22) state adoption assistance payments under section 259.67, and up to an equal
116.27 amount of county adoption assistance payments;
- 116.28 (23) state-funded family subsidy program payments made under section 252.32 to
116.29 help families care for children with developmental disabilities, consumer support grant
116.30 funds under section 256.476, and resources and services for a disabled household member
116.31 under one of the home and community-based waiver services programs under chapter 256B;
- 116.32 (24) interest payments and dividends from property that is not excluded from and
116.33 that does not exceed the asset limit;
- 116.34 (25) rent rebates;

- 117.1 (26) income earned by a minor caregiver, minor child through age 6, or a minor
117.2 child who is at least a half-time student in an approved elementary or secondary education
117.3 program;
- 117.4 (27) income earned by a caregiver under age 20 who is at least a half-time student in
117.5 an approved elementary or secondary education program;
- 117.6 (28) MFIP child care payments under section 119B.05;
- 117.7 (29) all other payments made through MFIP to support a caregiver's pursuit of
117.8 greater economic stability;
- 117.9 (30) income a participant receives related to shared living expenses;
- 117.10 (31) reverse mortgages;
- 117.11 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title
117.12 42, chapter 13A, sections 1771 to 1790;
- 117.13 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
117.14 United States Code, title 42, chapter 13A, section 1786;
- 117.15 (34) benefits from the National School Lunch Act, United States Code, title 42,
117.16 chapter 13, sections 1751 to 1769e;
- 117.17 (35) relocation assistance for displaced persons under the Uniform Relocation
117.18 Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title
117.19 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States
117.20 Code, title 12, chapter 13, sections 1701 to 1750jj;
- 117.21 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter
117.22 12, part 2, sections 2271 to 2322;
- 117.23 (37) war reparations payments to Japanese Americans and Aleuts under United
117.24 States Code, title 50, sections 1989 to 1989d;
- 117.25 (38) payments to veterans or their dependents as a result of legal settlements
117.26 regarding Agent Orange or other chemical exposure under Public Law 101-239, section
117.27 10405, paragraph (a)(2)(E);
- 117.28 (39) income that is otherwise specifically excluded from MFIP consideration in
117.29 federal law, state law, or federal regulation;
- 117.30 (40) security and utility deposit refunds;
- 117.31 (41) American Indian tribal land settlements excluded under Public Laws 98-123,
117.32 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech
117.33 Lake, and Mille Lacs reservations and payments to members of the White Earth Band,
117.34 under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

118.1 (42) all income of the minor parent's parents and stepparents when determining the
118.2 grant for the minor parent in households that include a minor parent living with parents or
118.3 stepparents on MFIP with other children;

118.4 (43) income of the minor parent's parents and stepparents equal to 200 percent of the
118.5 federal poverty guideline for a family size not including the minor parent and the minor
118.6 parent's child in households that include a minor parent living with parents or stepparents
118.7 not on MFIP when determining the grant for the minor parent. The remainder of income is
118.8 deemed as specified in section 256J.37, subdivision 1b;

118.9 (44) payments made to children eligible for relative custody assistance under section
118.10 257.85;

118.11 (45) vendor payments for goods and services made on behalf of a client unless the
118.12 client has the option of receiving the payment in cash;

118.13 (46) the principal portion of a contract for deed payment; ~~and~~

118.14 (47) cash payments to individuals enrolled for full-time service as a volunteer under
118.15 AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps
118.16 National, and AmeriCorps NCCC; and

118.17 (48) housing assistance grants under section 256J.35, paragraph (a).

118.18 Sec. 26. Minnesota Statutes 2012, section 256J.21, subdivision 3, is amended to read:

118.19 Subd. 3. **Initial income test.** The county agency shall determine initial eligibility
118.20 by considering all earned and unearned income that is not excluded under subdivision 2.
118.21 To be eligible for MFIP, the assistance unit's countable income minus the disregards in
118.22 paragraphs (a) and (b) must be below the ~~transitional standard of assistance~~ family wage
118.23 level according to section 256J.24 for that size assistance unit.

118.24 (a) The initial eligibility determination must disregard the following items:

118.25 (1) the employment disregard is 18 percent of the gross earned income whether or
118.26 not the member is working full time or part time;

118.27 (2) dependent care costs must be deducted from gross earned income for the actual
118.28 amount paid for dependent care up to a maximum of \$200 per month for each child less
118.29 than two years of age, and \$175 per month for each child two years of age and older under
118.30 this chapter and chapter 119B;

118.31 (3) all payments made according to a court order for spousal support or the support
118.32 of children not living in the assistance unit's household shall be disregarded from the
118.33 income of the person with the legal obligation to pay support, provided that, if there has
118.34 been a change in the financial circumstances of the person with the legal obligation to pay

119.1 support since the support order was entered, the person with the legal obligation to pay
119.2 support has petitioned for a modification of the support order; and

119.3 (4) an allocation for the unmet need of an ineligible spouse or an ineligible child
119.4 under the age of 21 for whom the caregiver is financially responsible and who lives with
119.5 the caregiver according to section 256J.36.

119.6 (b) Notwithstanding paragraph (a), when determining initial eligibility for applicant
119.7 units when at least one member has received MFIP in this state within four months of
119.8 the most recent application for MFIP, apply the disregard as defined in section 256J.08,
119.9 subdivision 24, for all unit members.

119.10 After initial eligibility is established, the assistance payment calculation is based on
119.11 the monthly income test.

119.12 **EFFECTIVE DATE.** This section is effective October 1, 2014, or upon approval
119.13 from the United States Department of Agriculture, whichever is later.

119.14 Sec. 27. Minnesota Statutes 2012, section 256J.24, subdivision 5, is amended to read:

119.15 Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based
119.16 on the number of persons in the assistance unit eligible for both food and cash assistance
119.17 ~~unless the restrictions in subdivision 6 on the birth of a child apply.~~ The amount of the
119.18 transitional standard is published annually by the Department of Human Services.

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

119.20 Sec. 28. Minnesota Statutes 2012, section 256J.24, subdivision 7, is amended to read:

119.21 Subd. 7. **Family wage level.** The family wage level is 110 percent of the transitional
119.22 standard under subdivision 5 or 6, ~~when applicable, and is the standard used when there is~~
119.23 ~~earned income in the assistance unit. As specified in section 256J.21.~~ If there is earned
119.24 income in the assistance unit, earned income is subtracted from the family wage level to
119.25 determine the amount of the assistance payment, as specified in section 256J.21. The
119.26 assistance payment may not exceed the transitional standard under subdivision 5 or 6,
119.27 or the shared household standard under subdivision 9, whichever is applicable, for the
119.28 assistance unit.

119.29 **EFFECTIVE DATE.** This section is effective October 1, 2014, or upon approval
119.30 from the United States Department of Agriculture, whichever is later.

120.1 Sec. 29. Minnesota Statutes 2012, section 256J.35, is amended to read:

120.2 **256J.35 AMOUNT OF ASSISTANCE PAYMENT.**

120.3 Except as provided in paragraphs (a) to ~~(e)~~ (d), the amount of an assistance payment
120.4 is equal to the difference between the MFIP standard of need or the Minnesota family
120.5 wage level in section 256J.24 and countable income.

120.6 (a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing
120.7 assistance grant of \$110 per month, unless:

120.8 (1) the housing assistance unit is currently receiving public and assisted rental
120.9 subsidies provided through the Department of Housing and Urban Development (HUD)
120.10 and is subject to section 256J.37, subdivision 3a; or

120.11 (2) the assistance unit is a child-only case under section 256J.88.

120.12 ~~(a)~~ (b) When MFIP eligibility exists for the month of application, the amount of
120.13 the assistance payment for the month of application must be prorated from the date of
120.14 application or the date all other eligibility factors are met for that applicant, whichever is
120.15 later. This provision applies when an applicant loses at least one day of MFIP eligibility.

120.16 ~~(b)~~ (c) MFIP overpayments to an assistance unit must be recouped according to
120.17 section 256J.38, subdivision 4.

120.18 ~~(e)~~ (d) An initial assistance payment must not be made to an applicant who is not
120.19 eligible on the date payment is made.

120.20 Sec. 30. Minnesota Statutes 2012, section 256J.621, is amended to read:

120.21 **256J.621 WORK PARTICIPATION CASH BENEFITS.**

120.22 Subdivision 1. Program characteristics. (a) Effective October 1, 2009, upon
120.23 exiting the diversionary work program (DWP) or upon terminating the Minnesota family
120.24 investment program with earnings, a participant who is employed may be eligible for work
120.25 participation cash benefits of \$25 per month to assist in meeting the family's basic needs
120.26 as the participant continues to move toward self-sufficiency.

120.27 (b) To be eligible for work participation cash benefits, the participant shall not
120.28 receive MFIP or diversionary work program assistance during the month and the
120.29 participant or participants must meet the following work requirements:

120.30 (1) if the participant is a single caregiver and has a child under six years of age, the
120.31 participant must be employed at least 87 hours per month;

120.32 (2) if the participant is a single caregiver and does not have a child under six years of
120.33 age, the participant must be employed at least 130 hours per month; or

120.34 (3) if the household is a two-parent family, at least one of the parents must be
120.35 employed 130 hours per month.

121.1 Whenever a participant exits the diversionary work program or is terminated from
 121.2 MFIP and meets the other criteria in this section, work participation cash benefits are
 121.3 available for up to 24 consecutive months.

121.4 (c) Expenditures on the program are maintenance of effort state funds under
 121.5 a separate state program for participants under paragraph (b), clauses (1) and (2).
 121.6 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
 121.7 funds. Months in which a participant receives work participation cash benefits under this
 121.8 section do not count toward the participant's MFIP 60-month time limit.

121.9 Subd. 2. **Program suspension.** (a) Effective December 1, 2014, the work
 121.10 participation cash benefits program shall be suspended.

121.11 (b) The commissioner of human services may reinstate the work participation cash
 121.12 benefits program if the United States Department of Human Services determines that the
 121.13 state of Minnesota did not meet the federal TANF work participation rate and sends a
 121.14 notice of penalty to reduce Minnesota's federal TANF block grant authorized under title I
 121.15 of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation
 121.16 Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.

121.17 (c) The commissioner shall notify the chairs and ranking minority members of the
 121.18 legislative committees with jurisdiction over human services policy and finance of the
 121.19 potential penalty and the commissioner's plans to reinstate the work participation cash
 121.20 benefit program within 30 days of the date the commissioner receives notification that
 121.21 the state failed to meet the federal work participation rate.

121.22 Sec. 31. Minnesota Statutes 2012, section 256J.626, subdivision 7, is amended to read:

121.23 Subd. 7. **Performance base funds.** (a) For the purpose of this section, the following
 121.24 terms have the meanings given:

121.25 (1) "Caseload Reduction Credit" (CRC) means the measure of how much Minnesota
 121.26 TANF and separate state program caseload has fallen relative to federal fiscal year 2005
 121.27 based on caseload data from October 1 to September 30.

121.28 (2) "TANF participation rate target" means a 50 percent participation rate reduced by
 121.29 the CRC for the previous year.

121.30 (b) (a) For calendar year 2010 2016 and yearly thereafter, each county and tribe will
 121.31 must be allocated 95 100 percent of their initial calendar year allocation. Allocations for
 121.32 counties and tribes will must be allocated additional funds adjusted based on performance
 121.33 as follows:

121.34 (1) a county or tribe that achieves the TANF participation rate target or a five
 121.35 percentage point improvement over the previous year's TANF participation rate under

122.1 ~~section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for~~
122.2 ~~the most recent year for which the measurements are available, will receive an additional~~
122.3 ~~allocation equal to 2.5 percent of its initial allocation;~~

122.4 ~~(2) (1) a county or tribe that performs within or above its range of expected~~
122.5 ~~performance on the annualized three-year self-support index under section 256J.751,~~
122.6 ~~subdivision 2, clause (6), will must receive an additional allocation equal to 2.5 percent of~~
122.7 ~~its initial allocation; and~~

122.8 ~~(3) a county or tribe that does not achieve the TANF participation rate target or~~
122.9 ~~a five percentage point improvement over the previous year's TANF participation rate~~
122.10 ~~under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive~~
122.11 ~~months for the most recent year for which the measurements are available, will not~~
122.12 ~~receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear~~
122.13 ~~improvement plan with the commissioner; or~~

122.14 ~~(4) (2) a county or tribe that does not perform within or above performs below its~~
122.15 ~~range of expected performance on the annualized three-year self-support index under~~
122.16 ~~section 256J.751, subdivision 2, clause (6), will not receive an additional allocation equal~~
122.17 ~~to 2.5 percent of its initial allocation until after negotiating for two consecutive years must~~
122.18 ~~negotiate a multiyear improvement plan with the commissioner. If no improvement is~~
122.19 ~~shown by the end of the multiyear plan, the county's or tribe's allocation must be decreased~~
122.20 ~~by 2.5 percent. The decrease must remain in effect until the county or tribe performs~~
122.21 ~~within or above its range of expected performance.~~

122.22 ~~(e) (b) For calendar year ~~2009~~ 2016 and yearly thereafter, performance-based funds~~
122.23 ~~for a federally approved tribal TANF program in which the state and tribe have in place a~~
122.24 ~~contract under section 256.01, addressing consolidated funding, will must be allocated~~
122.25 ~~as follows:~~

122.26 ~~(1) a tribe that achieves the participation rate approved in its federal TANF plan~~
122.27 ~~using the average of 12 consecutive months for the most recent year for which the~~
122.28 ~~measurements are available, will receive an additional allocation equal to 2.5 percent of~~
122.29 ~~its initial allocation; and~~

122.30 ~~(2) (1) a tribe that performs within or above its range of expected performance on the~~
122.31 ~~annualized three-year self-support index under section 256J.751, subdivision 2, clause (6),~~
122.32 ~~will must receive an additional allocation equal to 2.5 percent of its initial allocation; or~~

122.33 ~~(3) a tribe that does not achieve the participation rate approved in its federal TANF~~
122.34 ~~plan using the average of 12 consecutive months for the most recent year for which the~~
122.35 ~~measurements are available, will not receive an additional allocation equal to 2.5 percent~~

123.1 ~~of its initial allocation until after negotiating a multiyear improvement plan with the~~
 123.2 ~~commissioner; or~~

123.3 ~~(4) (2) a tribe that does not perform within or above~~ performs below its range of
 123.4 expected performance on the annualized three-year self-support index under section
 123.5 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to~~
 123.6 ~~2.5 percent until after negotiating~~ for two consecutive years must negotiate a multiyear
 123.7 improvement plan with the commissioner. If no improvement is shown by the end of the
 123.8 multiyear plan, the tribe's allocation must be decreased by 2.5 percent. The decrease must
 123.9 remain in effect until the tribe performs within or above its range of expected performance.

123.10 ~~(d) (c)~~ Funds remaining unallocated after the performance-based allocations
 123.11 in paragraph ~~(b) (a)~~ are available to the commissioner for innovation projects under
 123.12 subdivision 5.

123.13 ~~(1) (d)~~ If available funds are insufficient to meet county and tribal allocations under
 123.14 ~~paragraph paragraphs (a) and (b), the commissioner may make available for allocation~~
 123.15 ~~funds that are unobligated and available from the innovation projects through the end of~~
 123.16 ~~the current biennium~~ shall proportionally prorate funds to counties and tribes that qualify
 123.17 for a bonus under paragraphs (a), clause (1), and (b), clause (2).

123.18 ~~(2) If after the application of clause (1) funds remain insufficient to meet county and~~
 123.19 ~~tribal allocations under paragraph (b), the commissioner must proportionally reduce the~~
 123.20 ~~allocation of each county and tribe with respect to their maximum allocation available~~
 123.21 ~~under paragraph (b).~~

123.22 Sec. 32. **[256J.78] TANF DEMONSTRATION PROJECTS OR WAIVER FROM**
 123.23 **FEDERAL RULES AND REGULATIONS.**

123.24 Subdivision 1. Duties of the commissioner. The commissioner of human services
 123.25 may pursue TANF demonstration projects or waivers of TANF requirements from the
 123.26 United States Department of Health and Human Services as needed to allow the state to
 123.27 build a more results-oriented Minnesota Family Investment Program to better meet the
 123.28 needs of Minnesota families.

123.29 Subd. 2. Purpose. The purpose of the TANF demonstration projects or waivers is to:

123.30 (1) replace the federal TANF process measure and its complex administrative
 123.31 requirements with state-developed outcomes measures that track adult employment and
 123.32 exits from MFIP cash assistance;

123.33 (2) simplify programmatic and administrative requirements; and

123.34 (3) make other policy or programmatic changes that improve the performance of the
 123.35 program and the outcomes for participants.

124.1 Subd. 3. Report to legislature. The commissioner shall report to the members of
124.2 the legislative committees having jurisdiction over human services issues by March 1,
124.3 2014, regarding the progress of this waiver or demonstration project.

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

124.5 Sec. 33. Minnesota Statutes 2012, section 256K.45, is amended to read:

124.6 **256K.45 RUNAWAY AND HOMELESS YOUTH ACT.**

124.7 Subdivision 1. Grant program established. The commissioner of human services
124.8 shall establish a Homeless Youth Act fund and award grants to providers who are
124.9 committed to serving homeless youth and youth at risk of homelessness, to provide
124.10 street and community outreach and drop-in programs, emergency shelter programs,
124.11 and integrated supportive housing and transitional living programs, consistent with the
124.12 program descriptions in this act to reduce the incidence of homelessness among youth.

124.13 ~~Subdivision 1.~~ Subd. 1a. Definitions. (a) The definitions in this subdivision apply
124.14 to this section.

124.15 (b) "Commissioner" means the commissioner of human services.

124.16 (c) "Homeless youth" means a person 21 years of age or younger who is
124.17 unaccompanied by a parent or guardian and is without shelter where appropriate care and
124.18 supervision are available, whose parent or legal guardian is unable or unwilling to provide
124.19 shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The
124.20 following are not fixed, regular, or adequate nighttime residences:

124.21 (1) a supervised publicly or privately operated shelter designed to provide temporary
124.22 living accommodations;

124.23 (2) an institution or a publicly or privately operated shelter designed to provide
124.24 temporary living accommodations;

124.25 (3) transitional housing;

124.26 (4) a temporary placement with a peer, friend, or family member that has not offered
124.27 permanent residence, a residential lease, or temporary lodging for more than 30 days; or

124.28 (5) a public or private place not designed for, nor ordinarily used as, a regular
124.29 sleeping accommodation for human beings.

124.30 Homeless youth does not include persons incarcerated or otherwise detained under
124.31 federal or state law.

124.32 (d) "Youth at risk of homelessness" means a person 21 years of age or younger
124.33 whose status or circumstances indicate a significant danger of experiencing homelessness
124.34 in the near future. Status or circumstances that indicate a significant danger may include:

125.1 (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3)
125.2 youth whose parents or primary caregivers are or were previously homeless; (4) youth
125.3 who are exposed to abuse and neglect in their homes; (5) youth who experience conflict
125.4 with parents due to chemical or alcohol dependency, mental health disabilities, or other
125.5 disabilities; and (6) runaways.

125.6 (e) "Runaway" means an unmarried child under the age of 18 years who is absent
125.7 from the home of a parent or guardian or other lawful placement without the consent of
125.8 the parent, guardian, or lawful custodian.

125.9 Subd. 2. **Homeless and runaway youth report.** The commissioner shall ~~develop a~~
125.10 ~~report for homeless youth, youth at risk of homelessness, and runaways. The report shall~~
125.11 ~~include coordination of services as defined under subdivisions 3 to 5~~ prepare a biennial
125.12 report, beginning in February 2015, which provides meaningful information to the
125.13 legislative committees having jurisdiction over the issue of homeless youth, that includes,
125.14 but is not limited to: (1) a list of the areas of the state with the greatest need for services
125.15 and housing for homeless youth, and the level and nature of the needs identified; (2) details
125.16 about grants made; (3) the distribution of funds throughout the state based on population
125.17 need; (4) follow-up information, if available, on the status of homeless youth and whether
125.18 they have stable housing two years after services are provided; and (5) any other outcomes
125.19 for populations served to determine the effectiveness of the programs and use of funding.

125.20 Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in
125.21 centers must provide walk-in access to crisis intervention and ongoing supportive services
125.22 including one-to-one case management services on a self-referral basis. Street and
125.23 community outreach programs must locate, contact, and provide information, referrals,
125.24 and services to homeless youth, youth at risk of homelessness, and runaways. Information,
125.25 referrals, and services provided may include, but are not limited to:

- 125.26 (1) family reunification services;
- 125.27 (2) conflict resolution or mediation counseling;
- 125.28 (3) assistance in obtaining temporary emergency shelter;
- 125.29 (4) assistance in obtaining food, clothing, medical care, or mental health counseling;
- 125.30 (5) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse,
125.31 sexually transmitted diseases, and pregnancy;
- 125.32 (6) referrals to other agencies that provide support services to homeless youth,
125.33 youth at risk of homelessness, and runaways;
- 125.34 (7) assistance with education, employment, and independent living skills;
- 125.35 (8) aftercare services;

126.1 (9) specialized services for highly vulnerable runaways and homeless youth,
126.2 including teen parents, emotionally disturbed and mentally ill youth, and sexually
126.3 exploited youth; and

126.4 (10) homelessness prevention.

126.5 Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must
126.6 provide homeless youth and runaways with referral and walk-in access to emergency,
126.7 short-term residential care. The program shall provide homeless youth and runaways with
126.8 safe, dignified shelter, including private shower facilities, beds, and at least one meal each
126.9 day; and shall assist a runaway and homeless youth with reunification with the family or
126.10 legal guardian when required or appropriate.

126.11 (b) The services provided at emergency shelters may include, but are not limited to:

126.12 (1) family reunification services;

126.13 (2) individual, family, and group counseling;

126.14 (3) assistance obtaining clothing;

126.15 (4) access to medical and dental care and mental health counseling;

126.16 (5) education and employment services;

126.17 (6) recreational activities;

126.18 (7) advocacy and referral services;

126.19 (8) independent living skills training;

126.20 (9) aftercare and follow-up services;

126.21 (10) transportation; and

126.22 (11) homelessness prevention.

126.23 Subd. 5. **Supportive housing and transitional living programs.** Transitional
126.24 living programs must help homeless youth and youth at risk of homelessness to find and
126.25 maintain safe, dignified housing. The program may also provide rental assistance and
126.26 related supportive services, or refer youth to other organizations or agencies that provide
126.27 such services. Services provided may include, but are not limited to:

126.28 (1) educational assessment and referrals to educational programs;

126.29 (2) career planning, employment, work skill training, and independent living skills
126.30 training;

126.31 (3) job placement;

126.32 (4) budgeting and money management;

126.33 (5) assistance in securing housing appropriate to needs and income;

126.34 (6) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse,
126.35 sexually transmitted diseases, and pregnancy;

126.36 (7) referral for medical services or chemical dependency treatment;

- 127.1 (8) parenting skills;
- 127.2 (9) self-sufficiency support services or life skill training;
- 127.3 (10) aftercare and follow-up services; and
- 127.4 (11) homelessness prevention.

127.5 Subd. 6. **Funding.** ~~Any Funds appropriated for this section may be expended on~~
127.6 ~~programs described under subdivisions 3 to 5, technical assistance, and capacity building.~~
127.7 ~~Up to four percent of funds appropriated may be used for the purpose of monitoring and~~
127.8 ~~evaluating runaway and homeless youth programs receiving funding under this section.~~
127.9 ~~Funding shall be directed to meet the greatest need, with a significant share of the funding~~
127.10 ~~focused on homeless youth providers in greater Minnesota to meet the greatest need~~
127.11 ~~on a statewide basis.~~

127.12 Sec. 34. Minnesota Statutes 2012, section 256M.40, subdivision 1, is amended to read:

127.13 Subdivision 1. **Formula.** The commissioner shall allocate state funds appropriated
127.14 under this chapter to each county board on a calendar year basis in an amount determined
127.15 according to the formula in paragraphs (a) to (e).

127.16 (a) For calendar years 2011 and 2012, the commissioner shall allocate available
127.17 funds to each county in proportion to that county's share in calendar year 2010.

127.18 (b) For calendar year 2013 and each calendar year thereafter, the commissioner shall
127.19 allocate available funds to each county as follows:

127.20 (1) 75 percent must be distributed on the basis of the county share in calendar year
127.21 2012;

127.22 (2) five percent must be distributed on the basis of the number of persons residing in
127.23 the county as determined by the most recent data of the state demographer;

127.24 (3) ten percent must be distributed on the basis of the number of vulnerable children
127.25 that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, and in
127.26 the county as determined by the most recent data of the commissioner; and

127.27 (4) ten percent must be distributed on the basis of the number of vulnerable adults
127.28 that are subjects of reports under section 626.557 in the county as determined by the most
127.29 recent data of the commissioner.

127.30 (c) ~~For calendar year 2014, the commissioner shall allocate available funds to each~~
127.31 ~~county as follows:~~

127.32 (1) ~~50 percent must be distributed on the basis of the county share in calendar year~~
127.33 ~~2012;~~

127.34 (2) ~~Ten percent must be distributed on the basis of the number of persons residing in~~
127.35 ~~the county as determined by the most recent data of the state demographer;~~

128.1 ~~(3) 20 percent must be distributed on the basis of the number of vulnerable children~~
128.2 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
128.3 ~~county as determined by the most recent data of the commissioner; and~~

128.4 ~~(4) 20 percent must be distributed on the basis of the number of vulnerable adults~~
128.5 ~~that are subjects of reports under section 626.557 in the county as determined by the~~
128.6 ~~most recent data of the commissioner. The commissioner is precluded from changing the~~
128.7 ~~formula under this subdivision or recommending a change to the legislature without~~
128.8 ~~public review and input.~~

128.9 ~~(d) For calendar year 2015, the commissioner shall allocate available funds to each~~
128.10 ~~county as follows:~~

128.11 ~~(1) 25 percent must be distributed on the basis of the county share in calendar year~~
128.12 ~~2012;~~

128.13 ~~(2) 15 percent must be distributed on the basis of the number of persons residing in~~
128.14 ~~the county as determined by the most recent data of the state demographer;~~

128.15 ~~(3) 30 percent must be distributed on the basis of the number of vulnerable children~~
128.16 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
128.17 ~~county as determined by the most recent data of the commissioner; and~~

128.18 ~~(4) 30 percent must be distributed on the basis of the number of vulnerable adults~~
128.19 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
128.20 ~~recent data of the commissioner.~~

128.21 ~~(e) For calendar year 2016 and each calendar year thereafter, the commissioner shall~~
128.22 ~~allocate available funds to each county as follows:~~

128.23 ~~(1) 20 percent must be distributed on the basis of the number of persons residing in~~
128.24 ~~the county as determined by the most recent data of the state demographer;~~

128.25 ~~(2) 40 percent must be distributed on the basis of the number of vulnerable children~~
128.26 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
128.27 ~~county as determined by the most recent data of the commissioner; and~~

128.28 ~~(3) 40 percent must be distributed on the basis of the number of vulnerable adults~~
128.29 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
128.30 ~~recent data of the commissioner.~~

128.31 Sec. 35. Minnesota Statutes 2012, section 257.0755, subdivision 1, is amended to read:

128.32 Subdivision 1. **Creation.** ~~One~~ Each ombudsperson shall operate independently from
128.33 but in collaboration with each of the following groups the community-specific board that
128.34 appointed the ombudsperson under section 257.0768: the Indian Affairs Council, the

129.1 Council on Affairs of Chicano/Latino people, the Council on Black Minnesotans, and
129.2 the Council on Asian-Pacific Minnesotans.

129.3 Sec. 36. Minnesota Statutes 2012, section 259A.20, subdivision 4, is amended to read:

129.4 Subd. 4. **Reimbursement for special nonmedical expenses.** (a) Reimbursement
129.5 for special nonmedical expenses is available to children, except those eligible for adoption
129.6 assistance based on being an at-risk child.

129.7 (b) Reimbursements under this paragraph shall be made only after the adoptive
129.8 parent documents that the requested service was denied by the local social service agency,
129.9 community agencies, the local school district, the local public health department, the
129.10 parent's insurance provider, or the child's program. The denial must be for an eligible
129.11 service or qualified item under the program requirements of the applicable agency or
129.12 organization.

129.13 (c) Reimbursements must be previously authorized, adhere to the requirements and
129.14 procedures prescribed by the commissioner, and be limited to:

129.15 (1) child care for a child age 12 and younger, or for a child age 13 or 14 who has a
129.16 documented disability that requires special instruction for and services by the child care
129.17 provider. Child care reimbursements may be made if all available adult caregivers are
129.18 employed, unemployed due to a disability as defined in section 259A.01, subdivision 14,
129.19 or attending educational or vocational training programs. Documentation from a qualified
129.20 expert that is dated within the last 12 months must be provided to verify the disability. If a
129.21 parent is attending an educational or vocational training program, child care reimbursement
129.22 is limited to no more than the time necessary to complete the credit requirements for an
129.23 associate or baccalaureate degree as determined by the educational institution. Child
129.24 care reimbursement is not limited for an adoptive parent completing basic or remedial
129.25 education programs needed to prepare for postsecondary education or employment;

129.26 (2) respite care provided for the relief of the child's parent up to 504 hours of respite
129.27 care annually;

129.28 (3) camping up to 14 days per state fiscal year for a child to attend a special needs
129.29 camp. The camp must be accredited by the American Camp Association as a special needs
129.30 camp in order to be eligible for camp reimbursement;

129.31 (4) postadoption counseling to promote the child's integration into the adoptive
129.32 family that is provided by the placing agency during the first year following the date of the
129.33 adoption decree. Reimbursement is limited to 12 sessions of postadoption counseling;

129.34 (5) family counseling that is required to meet the child's special needs.
129.35 Reimbursement is limited to the prorated portion of the counseling fees allotted to the

130.1 family when the adoptive parent's health insurance or Medicaid pays for the child's
130.2 counseling but does not cover counseling for the rest of the family members;

130.3 (6) home modifications to accommodate the child's special needs upon which
130.4 eligibility for adoption assistance was approved. Reimbursement is limited to once every
130.5 five years per child;

130.6 (7) vehicle modifications to accommodate the child's special needs upon which
130.7 eligibility for adoption assistance was approved. Reimbursement is limited to once every
130.8 five years per family; and

130.9 (8) burial expenses up to \$1,000, if the special needs, upon which eligibility for
130.10 adoption assistance was approved, resulted in the death of the child.

130.11 (d) The adoptive parent shall submit statements for expenses incurred between July
130.12 1 and June 30 of a given fiscal year to the state adoption assistance unit within 60 days
130.13 after the end of the fiscal year in order for reimbursement to occur.

130.14 Sec. 37. Minnesota Statutes 2012, section 260B.007, subdivision 6, is amended to read:

130.15 Subd. 6. **Delinquent child.** (a) Except as otherwise provided in paragraphs (b)
130.16 and (c), "delinquent child" means a child:

130.17 (1) who has violated any state or local law, except as provided in section 260B.225,
130.18 subdivision 1, and except for juvenile offenders as described in subdivisions 16 to 18;

130.19 (2) who has violated a federal law or a law of another state and whose case has been
130.20 referred to the juvenile court if the violation would be an act of delinquency if committed
130.21 in this state or a crime or offense if committed by an adult;

130.22 (3) who has escaped from confinement to a state juvenile correctional facility after
130.23 being committed to the custody of the commissioner of corrections; or

130.24 (4) who has escaped from confinement to a local juvenile correctional facility after
130.25 being committed to the facility by the court.

130.26 (b) The term delinquent child does not include a child alleged to have committed
130.27 murder in the first degree after becoming 16 years of age, but the term delinquent child
130.28 does include a child alleged to have committed attempted murder in the first degree.

130.29 (c) The term delinquent child does not include a child ~~under the age of 16 years~~
130.30 alleged to have engaged in conduct which would, if committed by an adult, violate any
130.31 federal, state, or local law relating to being hired, offering to be hired, or agreeing to be
130.32 hired by another individual to engage in sexual penetration or sexual conduct.

130.33 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
130.34 offenses committed on or after that date.

131.1 Sec. 38. Minnesota Statutes 2012, section 260B.007, subdivision 16, is amended to read:

131.2 Subd. 16. **Juvenile petty offender; juvenile petty offense.** (a) "Juvenile petty
131.3 offense" includes a juvenile alcohol offense, a juvenile controlled substance offense,
131.4 a violation of section 609.685, or a violation of a local ordinance, which by its terms
131.5 prohibits conduct by a child under the age of 18 years which would be lawful conduct if
131.6 committed by an adult.

131.7 (b) Except as otherwise provided in paragraph (c), "juvenile petty offense" also
131.8 includes an offense that would be a misdemeanor if committed by an adult.

131.9 (c) "Juvenile petty offense" does not include any of the following:

131.10 (1) a misdemeanor-level violation of section 518B.01, 588.20, 609.224, 609.2242,
131.11 609.324, subdivision 2 or 3, 609.5632, 609.576, 609.66, 609.746, 609.748, 609.79,
131.12 or 617.23;

131.13 (2) a major traffic offense or an adult court traffic offense, as described in section
131.14 260B.225;

131.15 (3) a misdemeanor-level offense committed by a child whom the juvenile court
131.16 previously has found to have committed a misdemeanor, gross misdemeanor, or felony
131.17 offense; or

131.18 (4) a misdemeanor-level offense committed by a child whom the juvenile court
131.19 has found to have committed a misdemeanor-level juvenile petty offense on two or
131.20 more prior occasions, unless the county attorney designates the child on the petition
131.21 as a juvenile petty offender notwithstanding this prior record. As used in this clause,
131.22 "misdemeanor-level juvenile petty offense" includes a misdemeanor-level offense that
131.23 would have been a juvenile petty offense if it had been committed on or after July 1, 1995.

131.24 (d) A child who commits a juvenile petty offense is a "juvenile petty offender." The
131.25 term juvenile petty offender does not include a child ~~under the age of 16 years~~ alleged
131.26 to have violated any law relating to being hired, offering to be hired, or agreeing to be
131.27 hired by another individual to engage in sexual penetration or sexual conduct which, if
131.28 committed by an adult, would be a misdemeanor.

131.29 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
131.30 offenses committed on or after that date.

131.31 Sec. 39. Minnesota Statutes 2012, section 260C.007, subdivision 6, is amended to read:

131.32 Subd. 6. **Child in need of protection or services.** "Child in need of protection or
131.33 services" means a child who is in need of protection or services because the child:

131.34 (1) is abandoned or without parent, guardian, or custodian;

132.1 (2)(i) has been a victim of physical or sexual abuse as defined in section 626.556,
132.2 subdivision 2, (ii) resides with or has resided with a victim of child abuse as defined in
132.3 subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or
132.4 would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or
132.5 child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment
132.6 as defined in subdivision 15;

132.7 (3) is without necessary food, clothing, shelter, education, or other required care
132.8 for the child's physical or mental health or morals because the child's parent, guardian,
132.9 or custodian is unable or unwilling to provide that care;

132.10 (4) is without the special care made necessary by a physical, mental, or emotional
132.11 condition because the child's parent, guardian, or custodian is unable or unwilling to
132.12 provide that care;

132.13 (5) is medically neglected, which includes, but is not limited to, the withholding of
132.14 medically indicated treatment from a disabled infant with a life-threatening condition. The
132.15 term "withholding of medically indicated treatment" means the failure to respond to the
132.16 infant's life-threatening conditions by providing treatment, including appropriate nutrition,
132.17 hydration, and medication which, in the treating physician's or physicians' reasonable
132.18 medical judgment, will be most likely to be effective in ameliorating or correcting all
132.19 conditions, except that the term does not include the failure to provide treatment other
132.20 than appropriate nutrition, hydration, or medication to an infant when, in the treating
132.21 physician's or physicians' reasonable medical judgment:

132.22 (i) the infant is chronically and irreversibly comatose;

132.23 (ii) the provision of the treatment would merely prolong dying, not be effective in
132.24 ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be
132.25 futile in terms of the survival of the infant; or

132.26 (iii) the provision of the treatment would be virtually futile in terms of the survival
132.27 of the infant and the treatment itself under the circumstances would be inhumane;

132.28 (6) is one whose parent, guardian, or other custodian for good cause desires to be
132.29 relieved of the child's care and custody, including a child who entered foster care under a
132.30 voluntary placement agreement between the parent and the responsible social services
132.31 agency under section 260C.227;

132.32 (7) has been placed for adoption or care in violation of law;

132.33 (8) is without proper parental care because of the emotional, mental, or physical
132.34 disability, or state of immaturity of the child's parent, guardian, or other custodian;

133.1 (9) is one whose behavior, condition, or environment is such as to be injurious or
 133.2 dangerous to the child or others. An injurious or dangerous environment may include, but
 133.3 is not limited to, the exposure of a child to criminal activity in the child's home;

133.4 (10) is experiencing growth delays, which may be referred to as failure to thrive, that
 133.5 have been diagnosed by a physician and are due to parental neglect;

133.6 (11) ~~has engaged in prostitution as defined in section 609.321, subdivision 9~~ is a
 133.7 sexually exploited youth;

133.8 (12) has committed a delinquent act or a juvenile petty offense before becoming
 133.9 ten years old;

133.10 (13) is a runaway;

133.11 (14) is a habitual truant;

133.12 (15) has been found incompetent to proceed or has been found not guilty by reason
 133.13 of mental illness or mental deficiency in connection with a delinquency proceeding, a
 133.14 certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a
 133.15 proceeding involving a juvenile petty offense; or

133.16 (16) has a parent whose parental rights to one or more other children were
 133.17 involuntarily terminated or whose custodial rights to another child have been involuntarily
 133.18 transferred to a relative and there is a case plan prepared by the responsible social services
 133.19 agency documenting a compelling reason why filing the termination of parental rights
 133.20 petition under section 260C.301, subdivision 3, is not in the best interests of the child; ~~or~~

133.21 ~~(17) is a sexually exploited youth.~~

133.22 **EFFECTIVE DATE.** This section is effective August 1, 2014.

133.23 Sec. 40. Minnesota Statutes 2012, section 260C.007, subdivision 31, is amended to read:

133.24 Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an
 133.25 individual who:

133.26 (1) is alleged to have engaged in conduct which would, if committed by an adult,
 133.27 violate any federal, state, or local law relating to being hired, offering to be hired, or
 133.28 agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

133.29 (2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345,
 133.30 609.3451, 609.3453, 609.352, 617.246, or 617.247;

133.31 (3) is a victim of a crime described in United States Code, title 18, section 2260;
 133.32 2421; 2422; 2423; 2425; 2425A; or 2256; or

133.33 (4) is a sex trafficking victim as defined in section 609.321, subdivision 7b.

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

134.1 Sec. 41. Minnesota Statutes 2012, section 518A.60, is amended to read:

134.2 **518A.60 COLLECTION; ARREARS ONLY.**

134.3 (a) Remedies available for the collection and enforcement of support in this chapter
134.4 and chapters 256, 257, 518, and 518C also apply to cases in which the child or children
134.5 for whom support is owed are emancipated and the obligor owes past support or has an
134.6 accumulated arrearage as of the date of the youngest child's emancipation. Child support
134.7 arrearages under this section include arrearages for child support, medical support, child
134.8 care, pregnancy and birth expenses, and unreimbursed medical expenses as defined in
134.9 section 518A.41, subdivision 1, paragraph (h).

134.10 (b) This section applies retroactively to any support arrearage that accrued on or
134.11 before June 3, 1997, and to all arrearages accruing after June 3, 1997.

134.12 (c) Past support or pregnancy and confinement expenses ordered for which the
134.13 obligor has specific court ordered terms for repayment may not be enforced using
134.14 drivers' and occupational or professional license suspension, credit bureau reporting, and
134.15 additional income withholding under section 518A.53, subdivision 10, paragraph (a),
134.16 unless the obligor fails to comply with the terms of the court order for repayment.

134.17 (d) If an arrearage exists at the time a support order would otherwise terminate
134.18 and section 518A.53, subdivision 10, paragraph (c), does not apply to this section, the
134.19 arrearage shall be repaid in an amount equal to the current support order until all arrears
134.20 have been paid in full, absent a court order to the contrary.

134.21 (e) If an arrearage exists according to a support order which fails to establish a
134.22 monthly support obligation in a specific dollar amount, the public authority, if it provides
134.23 child support services, or the obligee, may establish a payment agreement which shall
134.24 equal what the obligor would pay for current support after application of section 518A.34,
134.25 plus an additional 20 percent of the current support obligation, until all arrears have been
134.26 paid in full. If the obligor fails to enter into or comply with a payment agreement, the
134.27 public authority, if it provides child support services, or the obligee, may move the district
134.28 court or child support magistrate, if section 484.702 applies, for an order establishing
134.29 repayment terms.

134.30 (f) If there is no longer a current support order because all of the children of the
134.31 order are emancipated, the public authority may discontinue child support services and
134.32 close its case under title IV-D of the Social Security Act if:

134.33 (1) the arrearage is under \$500; or

134.34 (2) the arrearage is considered unenforceable by the public authority because there
134.35 have been no collections for three years, and all administrative and legal remedies have
134.36 been attempted or are determined by the public authority to be ineffective because the

135.1 obligor is unable to pay, the obligor has no known income or assets, and there is no
135.2 reasonable prospect that the obligor will be able to pay in the foreseeable future.

135.3 (g) At least 60 calendar days before the discontinuation of services under paragraph
135.4 (f), the public authority must mail a written notice to the obligee and obligor at the
135.5 obligee's and obligor's last known addresses that the public authority intends to close the
135.6 child support enforcement case and explaining each party's rights. Seven calendar days
135.7 after the first notice is mailed, the public authority must mail a second notice under this
135.8 paragraph to the obligee.

135.9 (h) The case must be kept open if the obligee responds before case closure and
135.10 provides information that could reasonably lead to collection of arrears. If the case is
135.11 closed, the obligee may later request that the case be reopened by completing a new
135.12 application for services, if there is a change in circumstances that could reasonably lead to
135.13 the collection of arrears.

135.14 Sec. 42. Laws 1998, chapter 407, article 6, section 116, is amended to read:

135.15 Sec. 116. **EBT TRANSACTION COSTS; ~~APPROVAL FROM LEGISLATURE.~~**

135.16 The commissioner of human services shall ~~request and receive approval from the~~
135.17 ~~legislature before adjusting the payment to~~ not subsidize retailers for electronic benefit
135.18 transfer ~~transaction costs~~ Supplemental Nutrition Assistance Program transactions.

135.19 **EFFECTIVE DATE.** This section is effective 30 days after the commissioner
135.20 notifies retailers of the termination of their agreement with the state. The commissioner of
135.21 human services must notify the revisor of statutes of that date.

135.22 Sec. 43. Laws 2011, First Special Session chapter 9, article 1, section 3, the effective
135.23 date, is amended to read:

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

135.25 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2013.

135.26 Sec. 44. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET**
135.27 **EXCLUSION.**

135.28 (a) The commissioner of human services shall not count conditional cash transfers
135.29 made to families participating in a family independence demonstration as income or
135.30 assets for purposes of determining or redetermining eligibility for child care assistance
135.31 programs under Minnesota Statutes, chapter 119B; general assistance under Minnesota
135.32 Statutes, chapter 256D; group residential housing under Minnesota Statutes, chapter 256I;

136.1 the Minnesota family investment program, work benefit program, or diversionary work
136.2 program under Minnesota Statutes, chapter 256J, during the duration of the demonstration.

136.3 (b) The commissioner of human services shall not count conditional cash transfers
136.4 made to families participating in a family independence demonstration as income or assets
136.5 for purposes of determining or redetermining eligibility for medical assistance under
136.6 Minnesota Statutes, chapter 256B, and MinnesotaCare under Minnesota Statutes, chapter
136.7 256L, except that for enrollees subject to a modified adjusted gross income calculation to
136.8 determine eligibility, the conditional cash transfer payments shall be counted as income if
136.9 they are included on the enrollee's federal tax return as income, or if the payments can be
136.10 taken into account in the month of receipt as a lump sum payment.

136.11 (c) The commissioner of the Minnesota Housing Finance Agency shall not count
136.12 conditional cash transfers made to families participating in a family independence
136.13 demonstration as income or assets for purposes of determining or redetermining eligibility
136.14 for housing assistance programs under Minnesota Statutes, section 462A.201, during
136.15 the duration of the demonstration.

136.16 (d) For the purposes of this section:

136.17 (1) "conditional cash transfer" means a payment made to a participant in a family
136.18 independence demonstration by a sponsoring organization to incent, support, or facilitate
136.19 participation; and

136.20 (2) "family independence demonstration" means an initiative sponsored or
136.21 cosponsored by a governmental or nongovernmental organization, the goal of which is
136.22 to facilitate individualized goal-setting and peer support for cohorts of no more than 12
136.23 families each toward the development of financial and nonfinancial assets that enable the
136.24 participating families to achieve financial independence.

136.25 (e) The citizens league shall provide a report to the legislative committees having
136.26 jurisdiction over human services issues by July 1, 2016, informing the legislature on the
136.27 progress and outcomes of the demonstration under this section.

136.28 **Sec. 45. REDUCTION OF YOUTH HOMELESSNESS.**

136.29 (a) The Minnesota Interagency Council on Homelessness established under the
136.30 authority of Minnesota Statutes, section 462A.29, as it updates its statewide plan to
136.31 prevent and end homelessness, shall make recommendations on strategies to reduce the
136.32 number of youth experiencing homelessness and to prevent homelessness for youth who
136.33 are at risk of becoming homeless.

136.34 (b) Recommended strategies must take into consideration, to the extent feasible,
136.35 issues that contribute to or reduce youth homelessness including, but not limited to, mental

137.1 health, chemical dependency, trafficking of youth for sex or other purposes, exiting foster
137.2 care, and involvement in gangs. The recommended strategies must include supportive
137.3 services as outlined in Minnesota Statutes, section 256K.45, subdivision 5.

137.4 (c) The council shall provide an update on the status of its work by December 1,
137.5 2014, to the legislative committees with jurisdiction over housing, homelessness, and
137.6 matters pertaining to youth. If the council determines legislative action is required to
137.7 implement recommended strategies, the council shall submit proposals to the legislature at
137.8 the earliest possible opportunity.

137.9 **Sec. 46. HOUSING ASSISTANCE GRANTS; FORECASTED PROGRAM.**

137.10 Beginning July 1, 2015, housing assistance grants under Minnesota Statutes, section
137.11 256J.35, paragraph (a), must be a forecasted program and the commissioner, with the
137.12 approval of the commissioner of management and budget, may transfer unencumbered
137.13 appropriation balances within fiscal years of each biennium with other forecasted
137.14 programs of the Department of Human Services. The commissioner shall inform the
137.15 chairs and ranking minority members of the senate Health and Human Services Finance
137.16 Division and the house of representatives Health and Human Services Finance committee
137.17 quarterly about transfers made under this provision.

137.18 **Sec. 47. PLAN FOR GROUP RESIDENTIAL HOUSING SPECIALTY RATE**
137.19 **AND BANKED BEDS.**

137.20 The commissioner of human services, in consultation with and cooperation of the
137.21 counties, shall review the statewide number and status of group residential housing beds
137.22 with rates in excess of the MSA equivalent rate, including banked supplemental service
137.23 rate beds. The commissioner shall study the type and amount of supplemental services
137.24 delivered or planned for development, and develop a plan for rate setting criteria and
137.25 an efficient use of these beds. The commissioner shall review the performance of all
137.26 programs that receive supplemental service rates. The plan must require that all beds
137.27 receiving supplemental service rates address critical service needs and must establish
137.28 quality performance requirements for beds receiving supplemental service rates. The
137.29 commissioner shall present the written plan no later than February 1, 2014, to the chairs
137.30 and ranking minority members of the house of representatives and senate finance and
137.31 policy committees and divisions with jurisdiction over the Department of Human Services.

137.32 **Sec. 48. REPEALER.**

137.33 (a) Minnesota Statutes 2012, section 256J.24, is repealed January 1, 2015.

138.1 (b) Minnesota Statutes 2012, section 609.093, is repealed effective the day following
138.2 final enactment.

138.3 ARTICLE 4

138.4 STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES

138.5 Section 1. Minnesota Statutes 2012, section 245.462, subdivision 20, is amended to read:

138.6 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain
138.7 or a clinically significant disorder of thought, mood, perception, orientation, memory, or
138.8 behavior that is detailed in a diagnostic codes list published by the commissioner, and that
138.9 seriously limits a person's capacity to function in primary aspects of daily living such as
138.10 personal relations, living arrangements, work, and recreation.

138.11 (b) An "adult with acute mental illness" means an adult who has a mental illness that
138.12 is serious enough to require prompt intervention.

138.13 (c) For purposes of case management and community support services, a "person
138.14 with serious and persistent mental illness" means an adult who has a mental illness and
138.15 meets at least one of the following criteria:

138.16 (1) the adult has undergone two or more episodes of inpatient care for a mental
138.17 illness within the preceding 24 months;

138.18 (2) the adult has experienced a continuous psychiatric hospitalization or residential
138.19 treatment exceeding six months' duration within the preceding 12 months;

138.20 (3) the adult has been treated by a crisis team two or more times within the preceding
138.21 24 months;

138.22 (4) the adult:

138.23 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression,
138.24 schizoaffective disorder, or borderline personality disorder;

138.25 (ii) indicates a significant impairment in functioning; and

138.26 (iii) has a written opinion from a mental health professional, in the last three years,
138.27 stating that the adult is reasonably likely to have future episodes requiring inpatient or
138.28 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
138.29 management or community support services are provided;

138.30 (5) the adult has, in the last three years, been committed by a court as a person who is
138.31 mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; ~~or~~

138.32 (6) the adult (i) was eligible under clauses (1) to (5), but the specified time period
138.33 has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and

138.34 (ii) has a written opinion from a mental health professional, in the last three years, stating
138.35 that the adult is reasonably likely to have future episodes requiring inpatient or residential

139.1 treatment, of a frequency described in clause (1) or (2), unless ongoing case management
139.2 or community support services are provided; or
139.3 (7) the adult was eligible as a child under section 245.4871, subdivision 6, and is
139.4 age 21 or younger.

139.5 Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

139.6 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with
139.7 the exception of the placement of a Minnesota specialty treatment facility as defined in
139.8 paragraph (c), must be developed under the direction of the county board, or multiple
139.9 county boards acting jointly, as the local mental health authority. The planning process
139.10 for each pilot shall include, but not be limited to, mental health consumers, families,
139.11 advocates, local mental health advisory councils, local and state providers, representatives
139.12 of state and local public employee bargaining units, and the department of human services.
139.13 As part of the planning process, the county board or boards shall designate a managing
139.14 entity responsible for receipt of funds and management of the pilot project.

139.15 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a
139.16 request for proposal for regions in which a need has been identified for services.

139.17 (c) For purposes of this section, "Minnesota specialty treatment facility" is defined
139.18 as an intensive rehabilitative mental health service under section 256B.0622, subdivision
139.19 2, paragraph (b).

139.20 Sec. 3. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

139.21 Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the
139.22 commissioner shall facilitate integration of funds or other resources as needed and
139.23 requested by each project. These resources may include:

139.24 (1) residential services funds administered under Minnesota Rules, parts 9535.2000
139.25 to 9535.3000, in an amount to be determined by mutual agreement between the project's
139.26 managing entity and the commissioner of human services after an examination of the
139.27 county's historical utilization of facilities located both within and outside of the county
139.28 and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

139.29 (2) community support services funds administered under Minnesota Rules, parts
139.30 9535.1700 to 9535.1760;

139.31 (3) other mental health special project funds;

139.32 (4) medical assistance, general assistance medical care, MinnesotaCare and group
139.33 residential housing if requested by the project's managing entity, and if the commissioner
139.34 determines this would be consistent with the state's overall health care reform efforts; ~~and~~

140.1 (5) regional treatment center resources consistent with section 246.0136, subdivision
140.2 1; and

140.3 (6) funds transferred from section 246.18, subdivision 8, for grants to providers to
140.4 participate in mental health specialty treatment services, awarded to providers through
140.5 a request for proposal process.

140.6 (b) The commissioner shall consider the following criteria in awarding start-up and
140.7 implementation grants for the pilot projects:

140.8 (1) the ability of the proposed projects to accomplish the objectives described in
140.9 subdivision 2;

140.10 (2) the size of the target population to be served; and

140.11 (3) geographical distribution.

140.12 (c) The commissioner shall review overall status of the projects initiatives at least
140.13 every two years and recommend any legislative changes needed by January 15 of each
140.14 odd-numbered year.

140.15 (d) The commissioner may waive administrative rule requirements which are
140.16 incompatible with the implementation of the pilot project.

140.17 (e) The commissioner may exempt the participating counties from fiscal sanctions
140.18 for noncompliance with requirements in laws and rules which are incompatible with the
140.19 implementation of the pilot project.

140.20 (f) The commissioner may award grants to an entity designated by a county board or
140.21 group of county boards to pay for start-up and implementation costs of the pilot project.

140.22 Sec. 4. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

140.23 Subd. 2. **General provisions.** (a) In the design and implementation of reforms to
140.24 the mental health system, the commissioner shall:

140.25 (1) consult with consumers, families, counties, tribes, advocates, providers, and
140.26 other stakeholders;

140.27 (2) bring to the legislature, and the State Advisory Council on Mental Health, by
140.28 January 15, 2008, recommendations for legislation to update the role of counties and to
140.29 clarify the case management roles, functions, and decision-making authority of health
140.30 plans and counties, and to clarify county retention of the responsibility for the delivery of
140.31 social services as required under subdivision 3, paragraph (a);

140.32 (3) withhold implementation of any recommended changes in case management
140.33 roles, functions, and decision-making authority until after the release of the report due
140.34 January 15, 2008;

141.1 (4) ensure continuity of care for persons affected by these reforms including
141.2 ensuring client choice of provider by requiring broad provider networks and developing
141.3 mechanisms to facilitate a smooth transition of service responsibilities;

141.4 (5) provide accountability for the efficient and effective use of public and private
141.5 resources in achieving positive outcomes for consumers;

141.6 (6) ensure client access to applicable protections and appeals; and

141.7 (7) make budget transfers necessary to implement the reallocation of services and
141.8 client responsibilities between counties and health care programs that do not increase the
141.9 state and county costs and efficiently allocate state funds.

141.10 (b) When making transfers under paragraph (a) necessary to implement movement
141.11 of responsibility for clients and services between counties and health care programs,
141.12 the commissioner, in consultation with counties, shall ensure that any transfer of state
141.13 grants to health care programs, including the value of case management transfer grants
141.14 under section 256B.0625, subdivision 20, does not exceed the value of the services being
141.15 transferred for the latest 12-month period for which data is available. The commissioner
141.16 may make quarterly adjustments based on the availability of additional data during the
141.17 first four quarters after the transfers first occur. If case management transfer grants under
141.18 section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior
141.19 to repeal, exceeds the value of the services being transferred, the difference becomes an
141.20 ongoing part of each county's adult ~~and children's~~ mental health grants under sections
141.21 245.4661, ~~245.4889~~, and 256E.12.

141.22 (c) This appropriation is not authorized to be expended after December 31, 2010,
141.23 unless approved by the legislature.

141.24 Sec. 5. Minnesota Statutes 2012, section 245.4871, subdivision 26, is amended to read:

141.25 Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a person
141.26 providing services to children with emotional disturbances. A mental health practitioner
141.27 must have training and experience in working with children. A mental health practitioner
141.28 must be qualified in at least one of the following ways:

141.29 (1) holds a bachelor's degree in one of the behavioral sciences or related fields from
141.30 an accredited college or university and:

141.31 (i) has at least 2,000 hours of supervised experience in the delivery of mental health
141.32 services to children with emotional disturbances; or

141.33 (ii) is fluent in the non-English language of the ethnic group to which at least 50
141.34 percent of the practitioner's clients belong, completes 40 hours of training in the delivery
141.35 of services to children with emotional disturbances, and receives clinical supervision from

142.1 a mental health professional at least once a week until the requirement of 2,000 hours
142.2 of supervised experience is met;

142.3 (2) has at least 6,000 hours of supervised experience in the delivery of mental
142.4 health services to children with emotional disturbances; hours worked as a mental health
142.5 behavioral aide I or II under section 256B.0943, subdivision 7, may be included in the
142.6 6,000 hours of experience;

142.7 (3) is a graduate student in one of the behavioral sciences or related fields and is
142.8 formally assigned by an accredited college or university to an agency or facility for
142.9 clinical training; or

142.10 (4) holds a master's or other graduate degree in one of the behavioral sciences or
142.11 related fields from an accredited college or university ~~and has less than 4,000 hours~~
142.12 ~~post-master's experience in the treatment of emotional disturbance.~~

142.13 Sec. 6. Minnesota Statutes 2012, section 245.4875, subdivision 8, is amended to read:

142.14 Subd. 8. **Transition services.** The county board may continue to provide mental
142.15 health services as defined in sections 245.487 to 245.4889 to persons over 18 years of
142.16 age, but under 21 years of age, if the person was receiving case management or family
142.17 community support services prior to age 18, and if one of the following conditions is met:

142.18 (1) the person is receiving special education services through the local school
142.19 district; ~~or~~

142.20 (2) it is in the best interest of the person to continue services defined in sections
142.21 245.487 to 245.4889; or

142.22 (3) the person is requesting services and the services are medically necessary.

142.23 Sec. 7. Minnesota Statutes 2012, section 245.4881, subdivision 1, is amended to read:

142.24 Subdivision 1. **Availability of case management services.** (a) The county board
142.25 shall provide case management services for each child with severe emotional disturbance
142.26 who is a resident of the county and the child's family who request or consent to the services.
142.27 Case management services ~~may be continued~~ must be offered to be provided for a child with
142.28 a serious emotional disturbance who is over the age of 18 consistent with section 245.4875,
142.29 subdivision 8, or the child's legal representative, provided the child's service needs can be
142.30 met within the children's service system. Before discontinuing case management services
142.31 under this subdivision for children between the ages of 17 and 21, a transition plan
142.32 must be developed. The transition plan must be developed with the child and, with the
142.33 consent of a child age 18 or over, the child's parent, guardian, or legal representative. The
142.34 transition plan should include plans for health insurance, housing, education, employment,

143.1 and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case
143.2 manager must meet the requirements in section 245.4871, subdivision 4.

143.3 (b) Except as permitted by law and the commissioner under demonstration projects,
143.4 case management services provided to children with severe emotional disturbance eligible
143.5 for medical assistance must be billed to the medical assistance program under sections
143.6 256B.02, subdivision 8, and 256B.0625.

143.7 (c) Case management services are eligible for reimbursement under the medical
143.8 assistance program. Costs of mentoring, supervision, and continuing education may be
143.9 included in the reimbursement rate methodology used for case management services under
143.10 the medical assistance program.

143.11 Sec. 8. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:

143.12 Subd. 8. **State-operated services account.** (a) The state-operated services account is
143.13 established in the special revenue fund. Revenue generated by new state-operated services
143.14 listed under this section established after July 1, 2010, that are not enterprise activities must
143.15 be deposited into the state-operated services account, unless otherwise specified in law:

- 143.16 (1) intensive residential treatment services;
143.17 (2) foster care services; and
143.18 (3) psychiatric extensive recovery treatment services.

143.19 (b) Funds deposited in the state-operated services account are available to the
143.20 commissioner of human services for the purposes of:

143.21 (1) providing services needed to transition individuals from institutional settings
143.22 within state-operated services to the community when those services have no other
143.23 adequate funding source;

143.24 (2) grants to providers participating in mental health specialty treatment services
143.25 under section 245.4661; and

143.26 (3) to fund the operation of the Intensive Residential Treatment Service program in
143.27 Willmar.

143.28 Sec. 9. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision
143.29 to read:

143.30 Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds
143.31 to the account in subdivision 8 for noncovered allowable costs of a provider certified and
143.32 licensed under section 256B.0622 and operating under section 246.014.

144.1 Sec. 10. Minnesota Statutes 2012, section 246.54, is amended to read:

144.2 **246.54 LIABILITY OF COUNTY; REIMBURSEMENT.**

144.3 Subdivision 1. **County portion for cost of care.** (a) Except for chemical
 144.4 dependency services provided under sections 254B.01 to 254B.09, the client's county
 144.5 shall pay to the state of Minnesota a portion of the cost of care provided in a regional
 144.6 treatment center or a state nursing facility to a client legally settled in that county. A
 144.7 county's payment shall be made from the county's own sources of revenue and payments
 144.8 shall equal a percentage of the cost of care, as determined by the commissioner, for each
 144.9 day, or the portion thereof, that the client spends at a regional treatment center or a state
 144.10 nursing facility according to the following schedule:

- 144.11 (1) zero percent for the first 30 days;
 144.12 (2) 20 percent for days 31 to 60; and
 144.13 (3) ~~50~~ 75 percent for any days over 60.

144.14 (b) The increase in the county portion for cost of care under paragraph (a), clause
 144.15 (3), shall be imposed when the treatment facility has determined that it is clinically
 144.16 appropriate for the client to be discharged.

144.17 (c) If payments received by the state under sections 246.50 to 246.53 exceed 80
 144.18 percent of the cost of care for days 31 to 60, or ~~50~~ 25 percent for days over 60, the county
 144.19 shall be responsible for paying the state only the remaining amount. The county shall
 144.20 not be entitled to reimbursement from the client, the client's estate, or from the client's
 144.21 relatives, except as provided in section 246.53.

144.22 Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the
 144.23 Minnesota Security Hospital ~~or the Minnesota extended treatment options program~~. For
 144.24 services at ~~these facilities~~ the Minnesota Security Hospital, a county's payment shall be
 144.25 made from the county's own sources of revenue and payments ~~shall be paid as follows:~~
 144.26 Excluding the state-operated forensic transition service, payments to the state from the
 144.27 county shall equal ten percent of the cost of care, as determined by the commissioner, for
 144.28 each day, or the portion thereof, that the client spends at the facility. For the state-operated
 144.29 forensic transition service, payments to the state from the county shall equal 50 percent of
 144.30 the cost of care, as determined by the commissioner, for each day, or the portion thereof,
 144.31 that the client spends in the program. If payments received by the state under sections
 144.32 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the
 144.33 state-operated forensic transition service, exceed 90 percent of the cost of care, the county
 144.34 shall be responsible for paying the state only the remaining amount. If payments received
 144.35 by the state under sections 246.50 to 246.53 for the state-operated forensic transition service
 144.36 exceed 50 percent of the cost of care, the county shall be responsible for paying the state

145.1 only the remaining amount. The county shall not be entitled to reimbursement from the
 145.2 client, the client's estate, or from the client's relatives, except as provided in section 246.53.

145.3 (b) Regardless of the facility to which the client is committed, subdivision 1 does
 145.4 not apply to the following individuals:

145.5 ~~(1) clients who are committed as mentally ill and dangerous under section 253B.02,~~
 145.6 ~~subdivision 17;~~

145.7 ~~(2) (1) clients who are committed as sexual psychopathic personalities under section~~
 145.8 ~~253B.02, subdivision 18b; and~~

145.9 ~~(3) (2) clients who are committed as sexually dangerous persons under section~~
 145.10 ~~253B.02, subdivision 18c.~~

145.11 ~~For each of the individuals in clauses (1) to (3), the payment by the county to the state~~
 145.12 ~~shall equal ten percent of the cost of care for each day as determined by the commissioner.~~

145.13 Sec. 11. Minnesota Statutes 2012, section 253B.10, subdivision 1, is amended to read:

145.14 Subdivision 1. **Administrative requirements.** (a) When a person is committed,
 145.15 the court shall issue a warrant or an order committing the patient to the custody of the
 145.16 head of the treatment facility. The warrant or order shall state that the patient meets the
 145.17 statutory criteria for civil commitment.

145.18 (b) The commissioner shall prioritize patients being admitted from jail or a
 145.19 correctional institution who are:

145.20 (1) ordered confined in a state hospital for an examination under Minnesota Rules of
 145.21 Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

145.22 (2) under civil commitment for competency treatment and continuing supervision
 145.23 under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

145.24 (3) found not guilty by reason of mental illness under Minnesota Rules of Criminal
 145.25 Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be
 145.26 detained in a state hospital or other facility pending completion of the civil commitment
 145.27 proceedings; or

145.28 (4) committed under this chapter to the commissioner after dismissal of the patient's
 145.29 criminal charges.

145.30 Patients described in this paragraph must be admitted to a service operated by the
 145.31 commissioner within 48 hours. The commitment must be ordered by the court as provided
 145.32 in section 253B.09, subdivision 1, paragraph (c).

145.33 (c) Upon the arrival of a patient at the designated treatment facility, the head of the
 145.34 facility shall retain the duplicate of the warrant and endorse receipt upon the original
 145.35 warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment

146.1 must be filed in the court of commitment. After arrival, the patient shall be under the
146.2 control and custody of the head of the treatment facility.

146.3 (d) Copies of the petition for commitment, the court's findings of fact and
146.4 conclusions of law, the court order committing the patient, the report of the examiners,
146.5 and the prepetition report shall be provided promptly to the treatment facility.

146.6 Sec. 12. Minnesota Statutes 2012, section 254B.13, is amended to read:

146.7 **254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.**

146.8 Subdivision 1. **Authorization for navigator pilot projects.** The commissioner may
146.9 approve and implement navigator pilot projects developed under the planning process
146.10 required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and
146.11 enhance coordination of the delivery of chemical health services required under section
146.12 254B.03.

146.13 Subd. 2. **Program design and implementation.** (a) The commissioner and
146.14 counties participating in the navigator pilot projects shall continue to work in partnership
146.15 to refine and implement the navigator pilot projects initiated under Laws 2009, chapter
146.16 79, article 7, section 26.

146.17 (b) The commissioner and counties participating in the navigator pilot projects shall
146.18 complete the planning phase ~~by June 30, 2010~~, and, if approved by the commissioner for
146.19 implementation, enter into agreements governing the operation of the navigator pilot
146.20 projects with implementation scheduled no earlier than July 1, 2010.

146.21 Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for
146.22 participation in a navigator pilot program, an individual must:

146.23 (1) be a resident of a county with an approved navigator program;

146.24 (2) be eligible for consolidated chemical dependency treatment fund services;

146.25 (3) be a voluntary participant in the navigator program;

146.26 (4) satisfy one of the following items:

146.27 (i) have at least one severity rating of three or above in dimension four, five, or six in
146.28 a comprehensive assessment under Minnesota Rules, part 9530.6422; or

146.29 (ii) have at least one severity rating of two or above in dimension four, five, or six in
146.30 a comprehensive assessment under Minnesota Rules, part 9530.6422, and be currently
146.31 participating in a Rule 31 treatment program under Minnesota Rules, parts 9530.6405 to
146.32 9530.6505, or be within 60 days following discharge after participation in a Rule 31
146.33 treatment program; and

146.34 (5) have had at least two treatment episodes in the past two years, not limited
146.35 to episodes reimbursed by the consolidated chemical dependency treatment funds. An

147.1 admission to an emergency room, a detoxification program, or a hospital may be substituted
147.2 for one treatment episode if it resulted from the individual's substance use disorder.

147.3 (b) New eligibility criteria may be added as mutually agreed upon by the
147.4 commissioner and participating navigator programs.

147.5 Subd. 3. **Program evaluation.** The commissioner shall evaluate navigator pilot
147.6 projects under this section and report the results of the evaluation to the chairs and
147.7 ranking minority members of the legislative committees with jurisdiction over chemical
147.8 health issues by January 15, 2014. Evaluation of the navigator pilot projects must be
147.9 based on outcome evaluation criteria negotiated with the navigator pilot projects prior
147.10 to implementation.

147.11 Subd. 4. **Notice of navigator pilot project discontinuation.** Each county's
147.12 participation in the navigator pilot project may be discontinued for any reason by the county
147.13 or the commissioner of human services after 30 days' written notice to the other party.
147.14 ~~Any unspent funds held for the exiting county's pro rata share in the special revenue fund~~
147.15 ~~under the authority in subdivision 5, paragraph (d), shall be transferred to the consolidated~~
147.16 ~~chemical dependency treatment fund following discontinuation of the pilot project.~~

147.17 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in
147.18 this chapter, the commissioner may authorize navigator pilot projects to use chemical
147.19 dependency treatment funds to pay for nontreatment navigator pilot services:

147.20 (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph
147.21 (a); and

147.22 (2) by vendors in addition to those authorized under section 254B.05 when not
147.23 providing chemical dependency treatment services.

147.24 (b) For purposes of this section, "nontreatment navigator pilot services" include
147.25 navigator services, peer support, family engagement and support, housing support, rent
147.26 subsidies, supported employment, and independent living skills.

147.27 (c) State expenditures for chemical dependency services and nontreatment navigator
147.28 pilot services provided by or through the navigator pilot projects must not be greater than
147.29 the chemical dependency treatment fund expected share of forecasted expenditures in the
147.30 absence of the navigator pilot projects. The commissioner may restructure the schedule of
147.31 payments between the state and participating counties under the local agency share and
147.32 division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to
147.33 facilitate the operation of the navigator pilot projects.

147.34 ~~(d) To the extent that state fiscal year expenditures within a pilot project are less~~
147.35 ~~than the expected share of forecasted expenditures in the absence of the pilot projects,~~
147.36 ~~the commissioner shall deposit the unexpended funds in a separate account within the~~

148.1 ~~consolidated chemical dependency treatment fund, and make these funds available for~~
148.2 ~~expenditure by the pilot projects the following year. To the extent that treatment and~~
148.3 ~~nontreatment pilot services expenditures within the pilot project exceed the amount~~
148.4 ~~expected in the absence of the pilot projects, the pilot project county or counties are~~
148.5 ~~responsible for the portion of nontreatment pilot services expenditures in excess of the~~
148.6 ~~otherwise expected share of forecasted expenditures.~~

148.7 (e) (d) The commissioner may waive administrative rule requirements that are
148.8 incompatible with the implementation of the navigator pilot project, except that any
148.9 chemical dependency treatment funded under this section must continue to be provided
148.10 by a licensed treatment provider.

148.11 (f) (e) The commissioner shall not approve or enter into any agreement related to
148.12 navigator pilot projects authorized under this section that puts current or future federal
148.13 funding at risk.

148.14 (f) The commissioner shall provide participating navigator pilot projects with
148.15 transactional data, reports, provider data, and other data generated by county activity to
148.16 assess and measure outcomes. This information must be transmitted or made available in
148.17 an acceptable form to participating navigator pilot projects at least once every six months
148.18 or within a reasonable time following the commissioner's receipt of information from the
148.19 counties needed to comply with this paragraph.

148.20 Subd. 6. **Duties of county board.** The county board, or other county entity that
148.21 is approved to administer a navigator pilot project, shall:

148.22 (1) administer the navigator pilot project in a manner consistent with the objectives
148.23 described in subdivision 2 and the planning process in subdivision 5;

148.24 (2) ensure that no one is denied chemical dependency treatment services for which
148.25 they would otherwise be eligible under section 254A.03, subdivision 3; and

148.26 (3) provide the commissioner with timely and pertinent information as negotiated in
148.27 agreements governing operation of the navigator pilot projects.

148.28 Subd. 7. **Managed care.** An individual who is eligible for the navigator pilot
148.29 program under subdivision 2a is excluded from mandatory enrollment in managed care
148.30 until these services are included in the health plan's benefit set.

148.31 Subd. 8. **Authorization for continuation of navigator pilots.** The navigator pilot
148.32 projects implemented pursuant to subdivision 1 are authorized to continue operation after
148.33 July 1, 2013, under existing agreements governing operation of the pilot projects.

148.34 **EFFECTIVE DATE.** The amendments to subdivisions 1 to 6 and 8 are effective
148.35 August 1, 2013. Subdivision 7 is effective July 1, 2013.

149.1 Sec. 13. [254B.14] CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL
149.2 HEALTH CARE.

149.3 Subdivision 1. Authorization for continuum of care pilot projects. The
149.4 commissioner shall establish chemical dependency continuum of care pilot projects to
149.5 begin implementing the measures developed with stakeholder input and identified in the
149.6 report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot
149.7 projects are intended to improve the effectiveness and efficiency of the service continuum
149.8 for chemically dependent individuals in Minnesota while reducing duplication of efforts
149.9 and promoting scientifically supported practices.

149.10 Subd. 2. Program implementation. (a) The commissioner, in coordination with
149.11 representatives of the Minnesota Association of County Social Service Administrators
149.12 and the Minnesota Inter-County Association, shall develop a process for identifying and
149.13 selecting interested counties and providers for participation in the continuum of care pilot
149.14 projects. There shall be three pilot projects; one representing the northern region, one for
149.15 the metro region, and one for the southern region. The selection process of counties and
149.16 providers must include consideration of population size, geographic distribution, cultural
149.17 and racial demographics, and provider accessibility. The commissioner shall identify
149.18 counties and providers that are selected for participation in the continuum of care pilot
149.19 projects no later than September 30, 2013.

149.20 (b) The commissioner and entities participating in the continuum of care pilot
149.21 projects shall enter into agreements governing the operation of the continuum of care pilot
149.22 projects. The agreements shall identify pilot project outcomes and include timelines for
149.23 implementation and beginning operation of the pilot projects.

149.24 (c) Entities that are currently participating in the navigator pilot project are
149.25 eligible to participate in the continuum of care pilot project subsequent to or instead of
149.26 participating in the navigator pilot project.

149.27 (d) The commissioner may waive administrative rule requirements that are
149.28 incompatible with implementation of the continuum of care pilot projects.

149.29 (e) Notwithstanding section 254A.19, the commissioner may designate noncounty
149.30 entities to complete chemical use assessments and placement authorizations required
149.31 under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section
149.32 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the
149.33 discretion of the commissioner.

149.34 Subd. 3. Program design. (a) The operation of the pilot projects shall include:

- 149.35 (1) new services that are responsive to the chronic nature of substance use disorder;
149.36 (2) telehealth services, when appropriate to address barriers to services;

150.1 (3) services that assure integration with the mental health delivery system when
150.2 appropriate;

150.3 (4) services that address the needs of diverse populations; and

150.4 (5) an assessment and access process that permits clients to present directly to a
150.5 service provider for a substance use disorder assessment and authorization of services.

150.6 (b) Prior to implementation of the continuum of care pilot projects, a utilization
150.7 review process must be developed and agreed to by the commissioner, participating
150.8 counties, and providers. The utilization review process shall be described in the
150.9 agreements governing operation of the continuum of care pilot projects.

150.10 Subd. 4. **Notice of project discontinuation.** Each entity's participation in the
150.11 continuum of care pilot project may be discontinued for any reason by the county or the
150.12 commissioner after 30 days' written notice to the entity.

150.13 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this
150.14 chapter, the commissioner may authorize chemical dependency treatment funds to pay for
150.15 nontreatment services arranged by continuum of care pilot projects. Individuals who are
150.16 currently accessing Rule 31 treatment services are eligible for concurrent participation in
150.17 the continuum of care pilot projects.

150.18 (b) County expenditures for continuum of care pilot project services shall not
150.19 be greater than their expected share of forecasted expenditures in the absence of the
150.20 continuum of care pilot projects.

150.21 Subd. 6. **Managed care.** An individual who is eligible for the continuum of care
150.22 pilot project is excluded from mandatory enrollment in managed care unless these services
150.23 are included in the health plan's benefit set.

150.24 **EFFECTIVE DATE.** This section is effective August 1, 2013.

150.25 Sec. 14. **[256.478] HOME AND COMMUNITY-BASED SERVICES**
150.26 **TRANSITIONS GRANTS.**

150.27 (a) The commissioner shall make available home and community-based services
150.28 transition grants to serve individuals who do not meet eligibility criteria for the medical
150.29 assistance program under section 256B.056 or 256B.057, but who otherwise meet the
150.30 criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

150.31 (b) For the purposes of this section, the commissioner has the authority to transfer
150.32 funds between the medical assistance account and the home and community-based
150.33 services transitions grants account.

150.34 **EFFECTIVE DATE.** This section is effective July 1, 2013.

151.1 Sec. 15. **[256B.0616] MENTAL HEALTH CERTIFIED FAMILY PEER**
151.2 **SPECIALIST.**

151.3 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer
151.4 specialists services, as established in subdivision 2, subject to federal approval, if provided
151.5 to recipients who have an emotional disturbance or severe emotional disturbance under
151.6 chapter 245, and are provided by a certified family peer specialist who has completed the
151.7 training under subdivision 5. A family peer specialist cannot provide services to the
151.8 peer specialist's family.

151.9 Subd. 2. **Establishment.** The commissioner of human services shall establish a
151.10 certified family peer specialists program model which:

151.11 (1) provides nonclinical family peer support counseling, building on the strengths
151.12 of families and helping them achieve desired outcomes;

151.13 (2) collaborates with others providing care or support to the family;

151.14 (3) provides nonadversarial advocacy;

151.15 (4) promotes the individual family culture in the treatment milieu;

151.16 (5) links parents to other parents in the community;

151.17 (6) offers support and encouragement;

151.18 (7) assists parents in developing coping mechanisms and problem-solving skills;

151.19 (8) promotes resiliency, self-advocacy, development of natural supports, and
151.20 maintenance of skills learned in other support services;

151.21 (9) establishes and provides peer led parent support groups; and

151.22 (10) increases the child's ability to function better within the child's home, school,
151.23 and community by educating parents on community resources, assisting with problem
151.24 solving, and educating parents on mental illnesses.

151.25 Subd. 3. **Eligibility.** Family peer support services may be located in inpatient
151.26 hospitalization, partial hospitalization, residential treatment, treatment foster care, day
151.27 treatment, children's therapeutic services and supports, or crisis services.

151.28 Subd. 4. **Peer support specialist program providers.** The commissioner shall
151.29 develop a process to certify family peer support specialist programs, in accordance with
151.30 the federal guidelines, in order for the program to bill for reimbursable services. Family
151.31 peer support programs must operate within an existing mental health community provider
151.32 or center.

151.33 Subd. 5. **Certified family peer specialist training and certification.** The
151.34 commissioner shall develop a training and certification process for certified family peer
151.35 specialists who must be at least 21 years of age and have a high school diploma or its
151.36 equivalent. The candidates must have raised or are currently raising a child with a mental

152.1 illness, have had experience navigating the children's mental health system, and must
152.2 demonstrate leadership and advocacy skills and a strong dedication to family-driven and
152.3 family-focused services. The training curriculum must teach participating family peer
152.4 specialists specific skills relevant to providing peer support to other parents. In addition
152.5 to initial training and certification, the commissioner shall develop ongoing continuing
152.6 educational workshops on pertinent issues related to family peer support counseling.

152.7 Sec. 16. Minnesota Statutes 2012, section 256B.0623, subdivision 2, is amended to read:

152.8 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
152.9 meanings given them.

152.10 (a) "Adult rehabilitative mental health services" means mental health services
152.11 which are rehabilitative and enable the recipient to develop and enhance psychiatric
152.12 stability, social competencies, personal and emotional adjustment, ~~and~~ independent living,²
152.13 parenting skills, and community skills, when these abilities are impaired by the symptoms
152.14 of mental illness. Adult rehabilitative mental health services are also appropriate when
152.15 provided to enable a recipient to retain stability and functioning, if the recipient would
152.16 be at risk of significant functional decompensation or more restrictive service settings
152.17 without these services.

152.18 (1) Adult rehabilitative mental health services instruct, assist, and support the
152.19 recipient in areas such as: interpersonal communication skills, community resource
152.20 utilization and integration skills, crisis assistance, relapse prevention skills, health care
152.21 directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking
152.22 and nutrition skills, transportation skills, medication education and monitoring, mental
152.23 illness symptom management skills, household management skills, employment-related
152.24 skills, parenting skills, and transition to community living services.

152.25 (2) These services shall be provided to the recipient on a one-to-one basis in the
152.26 recipient's home or another community setting or in groups.

152.27 (b) "Medication education services" means services provided individually or in
152.28 groups which focus on educating the recipient about mental illness and symptoms; the role
152.29 and effects of medications in treating symptoms of mental illness; and the side effects of
152.30 medications. Medication education is coordinated with medication management services
152.31 and does not duplicate it. Medication education services are provided by physicians,
152.32 pharmacists, physician's assistants, or registered nurses.

152.33 (c) "Transition to community living services" means services which maintain
152.34 continuity of contact between the rehabilitation services provider and the recipient and
152.35 which facilitate discharge from a hospital, residential treatment program under Minnesota

153.1 Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community
153.2 living services are not intended to provide other areas of adult rehabilitative mental health
153.3 services.

153.4 Sec. 17. Minnesota Statutes 2012, section 256B.0625, subdivision 48, is amended to
153.5 read:

153.6 Subd. 48. **Psychiatric consultation to primary care practitioners.** Effective
153.7 ~~January 1, 2006~~, Medical assistance covers consultation provided by a psychiatrist, a
153.8 psychologist, or an advanced practice registered nurse certified in psychiatric mental
153.9 health via telephone, e-mail, facsimile, or other means of communication to primary care
153.10 practitioners, including pediatricians. The need for consultation and the receipt of the
153.11 consultation must be documented in the patient record maintained by the primary care
153.12 practitioner. If the patient consents, and subject to federal limitations and data privacy
153.13 provisions, the consultation may be provided without the patient present.

153.14 Sec. 18. Minnesota Statutes 2012, section 256B.0625, subdivision 56, is amended to
153.15 read:

153.16 Subd. 56. **Medical service coordination.** (a)(1) Medical assistance covers in-reach
153.17 community-based service coordination that is performed through a hospital emergency
153.18 department as an eligible procedure under a state healthcare program for a frequent user.
153.19 A frequent user is defined as an individual who has frequented the hospital emergency
153.20 department for services three or more times in the previous four consecutive months.
153.21 In-reach community-based service coordination includes navigating services to address a
153.22 client's mental health, chemical health, social, economic, and housing needs, or any other
153.23 activity targeted at reducing the incidence of emergency room and other nonmedically
153.24 necessary health care utilization.

153.25 (2) Medical assistance covers in-reach community-based service coordination that
153.26 is performed through a hospital emergency department or inpatient psychiatric unit
153.27 for a child or young adult up to age 21 with a serious emotional disturbance who has
153.28 frequented the hospital emergency room two or more times in the previous consecutive
153.29 three months or been admitted to an inpatient psychiatric unit two or more times in the
153.30 previous consecutive four months, or is being discharged to a shelter.

153.31 (b) Reimbursement must be made in 15-minute increments and allowed for up to 60
153.32 days posthospital discharge based upon the specific identified emergency department visit
153.33 or inpatient admitting event. In-reach community-based service coordination shall seek to
153.34 connect frequent users with existing covered services available to them, including, but not

154.1 limited to, targeted case management, waiver case management, or care coordination in a
154.2 health care home. For children and young adults with a serious emotional disturbance,
154.3 in-reach community-based service coordination includes navigating and arranging for
154.4 community-based services prior to discharge to address a client's mental health, chemical
154.5 health, social, educational, family support and housing needs, or any other activity targeted
154.6 at reducing multiple incidents of emergency room use, inpatient readmissions, and other
154.7 nonmedically necessary health care utilization. In-reach services shall seek to connect
154.8 them with existing covered services, including targeted case management, waiver case
154.9 management, care coordination in a health care home, children's therapeutic services and
154.10 supports, crisis services, and respite care. Eligible in-reach service coordinators must hold
154.11 a minimum of a bachelor's degree in social work, public health, corrections, or a related
154.12 field. The commissioner shall submit any necessary application for waivers to the Centers
154.13 for Medicare and Medicaid Services to implement this subdivision.

154.14 (c)(1) For the purposes of this subdivision, "in-reach community-based service
154.15 coordination" means the practice of a community-based worker with training, knowledge,
154.16 skills, and ability to access a continuum of services, including housing, transportation,
154.17 chemical and mental health treatment, employment, education, and peer support services,
154.18 by working with an organization's staff to transition an individual back into the individual's
154.19 living environment. In-reach community-based service coordination includes working
154.20 with the individual during their discharge and for up to a defined amount of time in the
154.21 individual's living environment, reducing the individual's need for readmittance.

154.22 (2) Hospitals utilizing in-reach service coordinators shall report annually to the
154.23 commissioner on the number of adults, children, and adolescents served; the postdischarge
154.24 services which they accessed; and emergency department/psychiatric hospitalization
154.25 readmissions. The commissioner shall ensure that services and payments provided under
154.26 in-reach care coordination do not duplicate services or payments provided under section
154.27 256B.0753, 256B.0755, or 256B.0625, subdivision 20.

154.28 Sec. 19. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
154.29 subdivision to read:

154.30 Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon
154.31 federal approval, whichever is later, medical assistance covers family psychoeducation
154.32 services provided to a child up to age 21 with a diagnosed mental health condition when
154.33 identified in the child's individual treatment plan and provided by a licensed mental health
154.34 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a
154.35 clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who

155.1 has determined it medically necessary to involve family members in the child's care. For
155.2 the purposes of this subdivision, "family psychoeducation services" means information
155.3 or demonstration provided to an individual or family as part of an individual, family,
155.4 multifamily group, or peer group session to explain, educate, and support the child and
155.5 family in understanding a child's symptoms of mental illness, the impact on the child's
155.6 development, and needed components of treatment and skill development so that the
155.7 individual, family, or group can help the child to prevent relapse, prevent the acquisition
155.8 of comorbid disorders, and achieve optimal mental health and long-term resilience.

155.9 Sec. 20. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
155.10 subdivision to read:

155.11 Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon
155.12 federal approval, whichever is later, medical assistance covers clinical care consultation
155.13 for a person up to age 21 who is diagnosed with a complex mental health condition or a
155.14 mental health condition that co-occurs with other complex and chronic conditions, when
155.15 described in the person's individual treatment plan and provided by a licensed mental health
155.16 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical
155.17 trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes
155.18 of this subdivision, "clinical care consultation" means communication from a treating
155.19 mental health professional to other providers or educators not under the clinical supervision
155.20 of the treating mental health professional who are working with the same client to inform,
155.21 inquire, and instruct regarding the client's symptoms; strategies for effective engagement,
155.22 care, and intervention needs; and treatment expectations across service settings; and to
155.23 direct and coordinate clinical service components provided to the client and family.

155.24 Sec. 21. Minnesota Statutes 2012, section 256B.092, is amended by adding a
155.25 subdivision to read:

155.26 Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner
155.27 shall make available additional waiver allocations and additional necessary resources
155.28 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
155.29 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:
155.30 (1) are otherwise eligible for the developmental disabilities waiver under this section;
155.31 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
155.32 the Minnesota Security Hospital;
155.33 (3) whose discharge would be significantly delayed without the available waiver
155.34 allocation; and

156.1 (4) who have met treatment objectives and no longer meet hospital level of care.

156.2 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
156.3 requirements of the federal approved waiver plan.

156.4 (c) Any corporate foster care home developed under this subdivision must be
156.5 considered an exception under section 245A.03, subdivision 7, paragraph (a).

156.6 **EFFECTIVE DATE.** This section is effective July 1, 2013.

156.7 Sec. 22. Minnesota Statutes 2012, section 256B.0943, subdivision 1, is amended to read:

156.8 Subdivision 1. **Definitions.** For purposes of this section, the following terms have
156.9 the meanings given them.

156.10 (a) "Children's therapeutic services and supports" means the flexible package of
156.11 mental health services for children who require varying therapeutic and rehabilitative
156.12 levels of intervention. The services are time-limited interventions that are delivered using
156.13 various treatment modalities and combinations of services designed to reach treatment
156.14 outcomes identified in the individual treatment plan.

156.15 (b) "Clinical supervision" means the overall responsibility of the mental health
156.16 professional for the control and direction of individualized treatment planning, service
156.17 delivery, and treatment review for each client. A mental health professional who is an
156.18 enrolled Minnesota health care program provider accepts full professional responsibility
156.19 for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,
156.20 and oversees or directs the supervisee's work.

156.21 (c) "County board" means the county board of commissioners or board established
156.22 under sections 402.01 to 402.10 or 471.59.

156.23 (d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

156.24 (e) "Culturally competent provider" means a provider who understands and can
156.25 utilize to a client's benefit the client's culture when providing services to the client. A
156.26 provider may be culturally competent because the provider is of the same cultural or
156.27 ethnic group as the client or the provider has developed the knowledge and skills through
156.28 training and experience to provide services to culturally diverse clients.

156.29 (f) "Day treatment program" for children means a site-based structured program
156.30 consisting of group psychotherapy for more than three individuals and other intensive
156.31 therapeutic services provided by a multidisciplinary team, under the clinical supervision
156.32 of a mental health professional.

156.33 (g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision
156.34 11.

157.1 (h) "Direct service time" means the time that a mental health professional, mental
157.2 health practitioner, or mental health behavioral aide spends face-to-face with a client
157.3 and the client's family. Direct service time includes time in which the provider obtains
157.4 a client's history or provides service components of children's therapeutic services and
157.5 supports. Direct service time does not include time doing work before and after providing
157.6 direct services, including scheduling, maintaining clinical records, consulting with others
157.7 about the client's mental health status, preparing reports, receiving clinical supervision,
157.8 and revising the client's individual treatment plan.

157.9 (i) "Direction of mental health behavioral aide" means the activities of a mental
157.10 health professional or mental health practitioner in guiding the mental health behavioral
157.11 aide in providing services to a client. The direction of a mental health behavioral aide
157.12 must be based on the client's individualized treatment plan and meet the requirements in
157.13 subdivision 6, paragraph (b), clause (5).

157.14 (j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
157.15 15. For persons at least age 18 but under age 21, mental illness has the meaning given in
157.16 section 245.462, subdivision 20, paragraph (a).

157.17 (k) "Individual behavioral plan" means a plan of intervention, treatment, and
157.18 services for a child written by a mental health professional or mental health practitioner,
157.19 under the clinical supervision of a mental health professional, to guide the work of the
157.20 mental health behavioral aide.

157.21 (l) "Individual treatment plan" has the meaning given in section 245.4871,
157.22 subdivision 21.

157.23 (m) "Mental health behavioral aide services" means medically necessary one-on-one
157.24 activities performed by a trained paraprofessional to assist a child retain or generalize
157.25 psychosocial skills as taught by a mental health professional or mental health practitioner
157.26 and as described in the child's individual treatment plan and individual behavior plan.
157.27 Activities involve working directly with the child or child's family as provided in
157.28 subdivision 9, paragraph (b), clause (4).

157.29 (n) "Mental health professional" means an individual as defined in section 245.4871,
157.30 subdivision 27, clauses (1) to (6), or tribal vendor as defined in section 256B.02,
157.31 subdivision 7, paragraph (b).

157.32 (o) "Mental health service plan development" includes:

157.33 (1) the development, review, and revision of a child's individual treatment plan,
157.34 as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of
157.35 the client or client's parents, primary caregiver, or other person authorized to consent to

158.1 mental health services for the client, and including arrangement of treatment and support
158.2 activities specified in the individual treatment plan; and

158.3 (2) administering standardized outcome measurement instruments, determined
158.4 and updated by the commissioner, as periodically needed to evaluate the effectiveness
158.5 of treatment for children receiving clinical services and reporting outcome measures,
158.6 as required by the commissioner.

158.7 ~~(o)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules,
158.8 parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and
158.9 supports provider to provide a structured treatment program to a child who is at least 33
158.10 months old but who has not yet attended the first day of kindergarten.

158.11 ~~(p)~~ (q) "Skills training" means individual, family, or group training, delivered
158.12 by or under the direction of a mental health professional, designed to facilitate the
158.13 acquisition of psychosocial skills that are medically necessary to rehabilitate the child
158.14 to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric
158.15 illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits
158.16 or maladaptive skills acquired over the course of a psychiatric illness. Skills training
158.17 is subject to the following requirements:

158.18 (1) a mental health professional or a mental health practitioner must provide skills
158.19 training;

158.20 (2) the child must always be present during skills training; however, a brief absence
158.21 of the child for no more than ten percent of the session unit may be allowed to redirect or
158.22 instruct family members;

158.23 (3) skills training delivered to children or their families must be targeted to the
158.24 specific deficits or maladaptations of the child's mental health disorder and must be
158.25 prescribed in the child's individual treatment plan;

158.26 (4) skills training delivered to the child's family must teach skills needed by parents
158.27 to enhance the child's skill development and to help the child use in daily life the skills
158.28 previously taught by a mental health professional or mental health practitioner and to
158.29 develop or maintain a home environment that supports the child's progressive use skills;

158.30 (5) group skills training may be provided to multiple recipients who, because of the
158.31 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
158.32 interaction in a group setting, which must be staffed as follows:

158.33 (i) one mental health professional or one mental health practitioner under supervision
158.34 of a licensed mental health professional must work with a group of four to eight clients; or

159.1 (ii) two mental health professionals or two mental health practitioners under
159.2 supervision of a licensed mental health professional, or one professional plus one
159.3 practitioner must work with a group of nine to 12 clients.

159.4 Sec. 23. Minnesota Statutes 2012, section 256B.0943, subdivision 2, is amended to read:

159.5 Subd. 2. **Covered service components of children's therapeutic services and**
159.6 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
159.7 children's therapeutic services and supports as defined in this section that an eligible
159.8 provider entity certified under subdivision 4 provides to a client eligible under subdivision
159.9 3.

159.10 (b) The service components of children's therapeutic services and supports are:

159.11 (1) individual, family, and group psychotherapy;

159.12 (2) individual, family, or group skills training provided by a mental health
159.13 professional or mental health practitioner;

159.14 (3) crisis assistance;

159.15 (4) mental health behavioral aide services; ~~and~~

159.16 (5) direction of a mental health behavioral aide; ~~;~~

159.17 (6) mental health service plan development;

159.18 (7) clinical care consultation under section 256B.0625, subdivision 62;

159.19 (8) family psychoeducation under section 256B.0625, subdivision 61; and

159.20 (9) services provided by a family peer specialist under section 256B.0616.

159.21 (c) Service components in paragraph (b) may be combined to constitute therapeutic
159.22 programs, including day treatment programs and therapeutic preschool programs.

159.23 Sec. 24. Minnesota Statutes 2012, section 256B.0943, subdivision 7, is amended to read:

159.24 Subd. 7. **Qualifications of individual and team providers.** (a) An individual
159.25 or team provider working within the scope of the provider's practice or qualifications
159.26 may provide service components of children's therapeutic services and supports that are
159.27 identified as medically necessary in a client's individual treatment plan.

159.28 (b) An individual provider must be qualified as:

159.29 (1) a mental health professional as defined in subdivision 1, paragraph (n); or

159.30 (2) a mental health practitioner as defined in section 245.4871, subdivision 26. The
159.31 mental health practitioner must work under the clinical supervision of a mental health
159.32 professional; or

160.1 (3) a mental health behavioral aide working under the clinical supervision of a
160.2 mental health professional to implement the rehabilitative mental health services identified
160.3 in the client's individual treatment plan and individual behavior plan.

160.4 (A) A level I mental health behavioral aide must:

160.5 (i) be at least 18 years old;

160.6 (ii) have a high school diploma or general equivalency diploma (GED) or two years
160.7 of experience as a primary caregiver to a child with severe emotional disturbance within
160.8 the previous ten years; and

160.9 (iii) meet preservice and continuing education requirements under subdivision 8.

160.10 (B) A level II mental health behavioral aide must:

160.11 (i) be at least 18 years old;

160.12 (ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering
160.13 clinical services in the treatment of mental illness concerning children or adolescents or
160.14 complete a certificate program established under subdivision 8a; and

160.15 (iii) meet preservice and continuing education requirements in subdivision 8.

160.16 (c) A preschool program multidisciplinary team must include at least one mental
160.17 health professional and one or more of the following individuals under the clinical
160.18 supervision of a mental health professional:

160.19 (i) a mental health practitioner; or

160.20 (ii) a program person, including a teacher, assistant teacher, or aide, who meets the
160.21 qualifications and training standards of a level I mental health behavioral aide.

160.22 (d) A day treatment multidisciplinary team must include at least one mental health
160.23 professional and one mental health practitioner.

160.24 Sec. 25. Minnesota Statutes 2012, section 256B.0943, is amended by adding a
160.25 subdivision to read:

160.26 Subd. 8a. **Level II mental health behavioral aide.** The commissioner of human
160.27 services, in collaboration with children's mental health providers and the Board of Trustees
160.28 of the Minnesota State Colleges and Universities, shall develop a certificate program
160.29 for level II mental health behavioral aides.

160.30 Sec. 26. Minnesota Statutes 2012, section 256B.0946, is amended to read:

160.31 **256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.**

160.32 Subdivision 1. **Required covered service components.** (a) Effective ~~July 1, 2006,~~
160.33 upon enactment and subject to federal approval, medical assistance covers medically
160.34 necessary intensive treatment services described under paragraph (b) that are provided

161.1 by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2
161.2 who is placed in a ~~treatment~~ foster home licensed under Minnesota Rules, parts 2960.3000
161.3 to 2960.3340.

161.4 (b) Intensive treatment services to children with severe emotional disturbance mental
161.5 illness residing in treatment foster care family settings must meet the relevant standards
161.6 for mental health services under sections 245.487 to 245.4889. In addition, that comprise
161.7 specific required service components provided in clauses (1) to (5), are reimbursed by
161.8 medical assistance must when they meet the following standards:

161.9 (1) ~~case management service component must meet the standards in Minnesota~~
161.10 ~~Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;~~

161.11 (1) psychotherapy provided by a mental health professional as defined in Minnesota
161.12 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota
161.13 Rules, part 9505.0371, subpart 5, item C;

161.14 (2) ~~psychotherapy, crisis assistance, and skills training components must meet the~~
161.15 ~~provided according to standards for children's therapeutic services and supports in section~~
161.16 ~~256B.0943; and~~

161.17 (3) individual family, and group psychoeducation services under supervision of,
161.18 defined in subdivision 1a, paragraph (q), provided by a mental health professional; or a
161.19 clinical trainee;

161.20 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental
161.21 health professional or a clinical trainee; and

161.22 (5) service delivery payment requirements as provided under subdivision 4.

161.23 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have
161.24 the meanings given them.

161.25 (a) "Clinical care consultation" means communication from a treating clinician to
161.26 other providers working with the same client to inform, inquire, and instruct regarding
161.27 the client's symptoms, strategies for effective engagement, care and intervention needs,
161.28 and treatment expectations across service settings, including but not limited to the client's
161.29 school, social services, day care, probation, home, primary care, medication prescribers,
161.30 disabilities services, and other mental health providers and to direct and coordinate clinical
161.31 service components provided to the client and family.

161.32 (b) "Clinical supervision" means the documented time a clinical supervisor and
161.33 supervisee spend together to discuss the supervisee's work, to review individual client
161.34 cases, and for the supervisee's professional development. It includes the documented
161.35 oversight and supervision responsibility for planning, implementation, and evaluation of
161.36 services for a client's mental health treatment.

162.1 (c) "Clinical supervisor" means the mental health professional who is responsible
162.2 for clinical supervision.

162.3 (d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,
162.4 subpart 5, item C;

162.5 (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a,
162.6 including the development of a plan that addresses prevention and intervention strategies
162.7 to be used in a potential crisis, but does not include actual crisis intervention.

162.8 (f) "Culturally appropriate" means providing mental health services in a manner that
162.9 incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370,
162.10 subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural
162.11 strengths and resources to promote overall wellness.

162.12 (g) "Culture" means the distinct ways of living and understanding the world that
162.13 are used by a group of people and are transmitted from one generation to another or
162.14 adopted by an individual.

162.15 (h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part
162.16 9505.0370, subpart 11.

162.17 (i) "Family" means a person who is identified by the client or the client's parent or
162.18 guardian as being important to the client's mental health treatment. Family may include,
162.19 but is not limited to, parents, foster parents, children, spouse, committed partners, former
162.20 spouses, persons related by blood or adoption, persons who are a part of the client's
162.21 permanency plan, or persons who are presently residing together as a family unit.

162.22 (j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

162.23 (k) "Foster family setting" means the foster home in which the license holder resides.

162.24 (l) "Individual treatment plan" has the meaning given in Minnesota Rules, part
162.25 9505.0370, subpart 15.

162.26 (m) "Mental health practitioner" has the meaning given in Minnesota Rules, part
162.27 9505.0370, subpart 17.

162.28 (n) "Mental health professional" has the meaning given in Minnesota Rules, part
162.29 9505.0370, subpart 18.

162.30 (o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370,
162.31 subpart 20.

162.32 (p) "Parent" has the meaning given in section 260C.007, subdivision 25.

162.33 (q) "Psychoeducation services" means information or demonstration provided to
162.34 an individual, family, or group to explain, educate, and support the individual, family, or
162.35 group in understanding a child's symptoms of mental illness, the impact on the child's
162.36 development, and needed components of treatment and skill development so that the

163.1 individual, family, or group can help the child to prevent relapse, prevent the acquisition
163.2 of comorbid disorders, and achieve optimal mental health and long-term resilience.

163.3 (r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370,
163.4 subpart 27.

163.5 (s) "Team consultation and treatment planning" means the coordination of treatment
163.6 plans and consultation among providers in a group concerning the treatment needs of the
163.7 child, including disseminating the child's treatment service schedule to all members of the
163.8 service team. Team members must include all mental health professionals working with
163.9 the child, a parent, the child unless the team lead or parent deem it clinically inappropriate,
163.10 and at least two of the following: an individualized education program case manager;
163.11 probation agent; children's mental health case manager; child welfare worker, including
163.12 adoption or guardianship worker; primary care provider; foster parent; and any other
163.13 member of the child's service team.

163.14 **Subd. 2. Determination of client eligibility.** ~~A client's eligibility to receive~~
163.15 ~~treatment foster care under this section shall be determined by~~ An eligible recipient is an
163.16 individual, from birth through age 20, who is currently placed in a foster home licensed
163.17 under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic
163.18 assessment; and an evaluation of level of care needed, and development of an individual
163.19 treatment plan, as defined in paragraphs (a) to (e) and (b).

163.20 (a) The diagnostic assessment must:

163.21 (1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be
163.22 conducted by a psychiatrist, licensed psychologist, or licensed independent clinical social
163.23 worker that is mental health professional or a clinical trainee;

163.24 (2) determine whether or not a child meets the criteria for mental illness, as defined
163.25 in Minnesota Rules, part 9505.0370, subpart 20;

163.26 (3) document that intensive treatment services are medically necessary within a
163.27 foster family setting to ameliorate identified symptoms and functional impairments;

163.28 (4) be performed within 180 days prior to before the start of service; and

163.29 (2) include current diagnoses on all five axes of the client's current mental health
163.30 status;

163.31 (3) determine whether or not a child meets the criteria for severe emotional
163.32 disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness
163.33 in section 245.462, subdivision 20; and

163.34 (4) be completed annually until age 18. For individuals between age 18 and 21,
163.35 unless a client's mental health condition has changed markedly since the client's most
163.36 recent diagnostic assessment, annual updating is necessary. For the purpose of this section,

164.1 ~~"updating" means a written summary, including current diagnoses on all five axes, by a~~
 164.2 ~~mental health professional of the client's current mental status and service needs.~~

164.3 (5) be completed as either a standard or extended diagnostic assessment annually to
 164.4 determine continued eligibility for the service.

164.5 (b) The evaluation of level of care must be conducted by the placing county with
 164.6 ~~an instrument, tribe, or case manager in conjunction with the diagnostic assessment as~~
 164.7 described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool
 164.8 approved by the commissioner of human services and not subject to the rulemaking
 164.9 process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which
 164.10 evaluation demonstrates that the child requires intensive intervention without 24-hour
 164.11 medical monitoring. The commissioner shall update the list of approved level of care
 164.12 instruments tools annually and publish on the department's Web site.

164.13 (c) ~~The individual treatment plan must be:~~

164.14 ~~(1) based on the information in the client's diagnostic assessment;~~

164.15 ~~(2) developed through a child-centered, family driven planning process that identifies~~
 164.16 ~~service needs and individualized, planned, and culturally appropriate interventions that~~
 164.17 ~~contain specific measurable treatment goals and objectives for the client and treatment~~
 164.18 ~~strategies for the client's family and foster family;~~

164.19 ~~(3) reviewed at least once every 90 days and revised; and~~

164.20 ~~(4) signed by the client or, if appropriate, by the client's parent or other person~~
 164.21 ~~authorized by statute to consent to mental health services for the client.~~

164.22 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for
 164.23 intensive children's mental health services in a foster family setting must be certified
 164.24 by the state and have a service provision contract with a county board or a reservation
 164.25 tribal council and must be able to demonstrate the ability to provide all of the services
 164.26 required in this section.

164.27 (b) For purposes of this section, a provider agency must have an individual
 164.28 placement agreement for each recipient and must be a licensed child placing agency, under
 164.29 Minnesota Rules, parts 9543.0010 to 9543.0150, and either be:

164.30 (1) a county county-operated entity certified by the state;

164.31 (2) an Indian Health Services facility operated by a tribe or tribal organization under
 164.32 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
 164.33 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

164.34 (3) a noncounty entity under contract with a county board.

164.35 (c) Certified providers that do not meet the service delivery standards required in
 164.36 this section shall be subject to a decertification process.

165.1 (d) For the purposes of this section, all services delivered to a client must be
165.2 provided by a mental health professional or a clinical trainee.

165.3 Subd. 4. ~~Eligible provider responsibilities~~ Service delivery payment
165.4 requirements. (a) To be an eligible provider for payment under this section, a provider
165.5 must develop and practice written policies and procedures for ~~treatment foster care services~~
165.6 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), ~~clauses (1),~~
165.7 (2), and (3) and comply with the following requirements in paragraphs (b) to (n).

165.8 ~~(b) In delivering services under this section, a treatment foster care provider must~~
165.9 ~~ensure that staff caseload size reasonably enables the provider to play an active role in~~
165.10 ~~service planning, monitoring, delivering, and reviewing for discharge planning to meet~~
165.11 ~~the needs of the client, the client's foster family, and the birth family, as specified in each~~
165.12 ~~client's individual treatment plan.~~

165.13 (b) A qualified clinical supervisor, as defined in and performing in compliance with
165.14 Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and
165.15 provision of services described in this section.

165.16 (c) Each client receiving treatment services must receive an extended diagnostic
165.17 assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within
165.18 30 days of enrollment in this service unless the client has a previous extended diagnostic
165.19 assessment that the client, parent, and mental health professional agree still accurately
165.20 describes the client's current mental health functioning.

165.21 (d) Each previous and current mental health, school, and physical health treatment
165.22 provider must be contacted to request documentation of treatment and assessments that
165.23 the eligible client has received. This information must be reviewed and incorporated into
165.24 the diagnostic assessment and team consultation and treatment planning review process.

165.25 (e) Each client receiving treatment must be assessed for a trauma history, and
165.26 the client's treatment plan must document how the results of the assessment will be
165.27 incorporated into treatment.

165.28 (f) Each client receiving treatment services must have an individual treatment plan
165.29 that is reviewed, evaluated, and signed every 90 days using the team consultation and
165.30 treatment planning process, as defined in subdivision 1a, paragraph (s).

165.31 (g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided
165.32 in accordance with the client's individual treatment plan.

165.33 (h) Each client must have a crisis assistance plan within ten days of initiating
165.34 services and must have access to clinical phone support 24 hours per day, seven days per
165.35 week, during the course of treatment. The crisis plan must demonstrate coordination with
165.36 the local or regional mobile crisis intervention team.

166.1 (i) Services must be delivered and documented at least three days per week, equaling
 166.2 at least six hours of treatment per week, unless reduced units of service are specified on
 166.3 the treatment plan as part of transition or on a discharge plan to another service or level of
 166.4 care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

166.5 (j) Location of service delivery must be in the client's home, day care setting,
 166.6 school, or other community-based setting that is specified on the client's individualized
 166.7 treatment plan.

166.8 (k) Treatment must be developmentally and culturally appropriate for the client.

166.9 (l) Services must be delivered in continual collaboration and consultation with the
 166.10 client's medical providers and, in particular, with prescribers of psychotropic medications,
 166.11 including those prescribed on an off-label basis. Members of the service team must be
 166.12 aware of the medication regimen and potential side effects.

166.13 (m) Parents, siblings, foster parents, and members of the child's permanency plan
 166.14 must be involved in treatment and service delivery unless otherwise noted in the treatment
 166.15 plan.

166.16 (n) Transition planning for the child must be conducted starting with the first
 166.17 treatment plan and must be addressed throughout treatment to support the child's
 166.18 permanency plan and postdischarge mental health service needs.

166.19 Subd. 5. **Service authorization.** The commissioner will administer authorizations
 166.20 for services under this section in compliance with section 256B.0625, subdivision 25.

166.21 Subd. 6. **Excluded services.** (a) Services in clauses (1) to ~~(4)~~ (7) are not covered
 166.22 under this section and are not eligible for medical assistance payment as components of
 166.23 intensive treatment in foster care services, but may be billed separately:

166.24 ~~(1) treatment foster care services provided in violation of medical assistance policy~~
 166.25 ~~in Minnesota Rules, part 9505.0220;~~

166.26 ~~(2) service components of children's therapeutic services and supports~~
 166.27 ~~simultaneously provided by more than one treatment foster care provider;~~

166.28 ~~(3) home and community-based waiver services; and~~

166.29 ~~(4) treatment foster care services provided to a child without a level of care~~
 166.30 ~~determination according to section 245.4885, subdivision 1.~~

166.31 (1) inpatient psychiatric hospital treatment;

166.32 (2) mental health targeted case management;

166.33 (3) partial hospitalization;

166.34 (4) medication management;

166.35 (5) children's mental health day treatment services;

166.36 (6) crisis response services under section 256B.0944; and

167.1 (7) transportation.

167.2 (b) Children receiving intensive treatment in foster care services are not eligible for
167.3 medical assistance reimbursement for the following services while receiving intensive
167.4 treatment in foster care:

167.5 ~~(1) mental health case management services under section 256B.0625, subdivision~~
167.6 ~~20; and~~

167.7 ~~(2) (1) psychotherapy and skill skills training components of children's therapeutic~~
167.8 ~~services and supports under section 256B.0625, subdivision 35b.;~~

167.9 (2) mental health behavioral aide services as defined in section 256B.0943,
167.10 subdivision 1, paragraph (m);

167.11 (3) home and community-based waiver services;

167.12 (4) mental health residential treatment; and

167.13 (5) room and board costs as defined in section 256I.03, subdivision 6.

167.14 Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall
167.15 establish a single daily per-client encounter rate for intensive treatment in foster care
167.16 services. The rate must be constructed to cover only eligible services delivered to an
167.17 eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

167.18 Sec. 27. Minnesota Statutes 2012, section 256B.49, is amended by adding a
167.19 subdivision to read:

167.20 Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner
167.21 shall make available additional waiver allocations and additional necessary resources
167.22 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
167.23 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

167.24 (1) are otherwise eligible for the brain injury, community alternatives for disabled
167.25 individuals, or community alternative care waivers under this section;

167.26 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
167.27 the Minnesota Security Hospital;

167.28 (3) whose discharge would be significantly delayed without the available waiver
167.29 allocation; and

167.30 (4) who have met treatment objectives and no longer meet hospital level of care.

167.31 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
167.32 requirements of the federal approved waiver plan.

167.33 (c) Any corporate foster care home developed under this subdivision must be
167.34 considered an exception under section 245A.03, subdivision 7, paragraph (a).

167.35 **EFFECTIVE DATE.** This section is effective July 1, 2013.

168.1 Sec. 28. Minnesota Statutes 2012, section 256B.761, is amended to read:

168.2 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

168.3 (a) Effective for services rendered on or after July 1, 2001, payment for medication
168.4 management provided to psychiatric patients, outpatient mental health services, day
168.5 treatment services, home-based mental health services, and family community support
168.6 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
168.7 50th percentile of 1999 charges.

168.8 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
168.9 services provided by an entity that operates: (1) a Medicare-certified comprehensive
168.10 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
168.11 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
168.12 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
168.13 when those services are provided within the comprehensive outpatient rehabilitation
168.14 facility and provided to residents of nursing facilities owned by the entity.

168.15 (c) The commissioner shall establish three levels of payment for mental health
168.16 diagnostic assessment, based on three levels of complexity. The aggregate payment under
168.17 the tiered rates must not exceed the projected aggregate payments for mental health
168.18 diagnostic assessment under the previous single rate. The new rate structure is effective
168.19 January 1, 2011, or upon federal approval, whichever is later.

168.20 (d) In addition to rate increases otherwise provided, the commissioner may
168.21 restructure coverage policy and rates to improve access to adult rehabilitative mental
168.22 health services under section 256B.0623 and related mental health support services under
168.23 section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and
168.24 2016, the projected state share of increased costs due to this paragraph is transferred
168.25 from adult mental health grants under sections 245.4661 and 256E.12. The transfer for
168.26 fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments
168.27 made to managed care plans and county-based purchasing plans under sections 256B.69,
168.28 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

168.29 Sec. 29. **CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICES.**

168.30 The commissioner of human services shall, in consultation with children's mental
168.31 health community providers, hospitals providing care to children, children's mental health
168.32 advocates, and other interested parties, develop recommendations and legislation, if
168.33 necessary, for the state-operated child and adolescent behavioral health services facility
168.34 to ensure that:

169.1 (1) the facility and the services provided meet the needs of children with serious
169.2 emotional disturbances, autism spectrum disorders, reactive attachment disorder, PTSD,
169.3 serious emotional disturbance co-occurring with a developmental disability, borderline
169.4 personality disorder, schizophrenia, fetal alcohol spectrum disorders, brain injuries,
169.5 violent tendencies, and complex medical issues;

169.6 (2) qualified personnel and staff can be recruited who have specific expertise and
169.7 training to treat the children in the facility; and

169.8 (3) the treatment provided at the facility is high-quality, effective treatment.

169.9 **Sec. 30. PILOT PROVIDER INPUT SURVEY OF PEDIATRIC SERVICES AND**
169.10 **CHILDREN'S MENTAL HEALTH SERVICES.**

169.11 (a) To assess the efficiency and other operational issues in the management of the
169.12 health care delivery system, the commissioner of human services shall initiate a provider
169.13 survey. The pilot survey shall consist of an electronic survey of providers of pediatric
169.14 home health care services and children's mental health services to identify and measure
169.15 issues that arise in dealing with the management of medical assistance. To the maximum
169.16 degree possible, existing technology shall be used and interns sought to analyze the results.

169.17 (b) The survey questions must focus on seven key business functions provided
169.18 by medical assistance contractors: provider inquiries; provider outreach and education;
169.19 claims processing; appeals; provider enrollment; medical review; and provider audit and
169.20 reimbursement. The commissioner must consider the results of the survey in evaluating
169.21 and renewing managed care and fee-for-service management contracts.

169.22 (c) The commissioner shall report by January 15, 2014, the results of the survey to
169.23 the chairs of the health and human services policy and finance committees and shall
169.24 make recommendations on the value of implementing an annual survey with a rotating
169.25 list of provider groups as a component of the continuous quality improvement system for
169.26 medical assistance.

169.27 **Sec. 31. MENTALLY ILL AND DANGEROUS COMMITMENTS**
169.28 **STAKEHOLDERS GROUP.**

169.29 (a) The commissioner of human services, in consultation with the state court
169.30 administrator, shall convene a stakeholder group to develop recommendations for the
169.31 legislature that address issues raised in the February 2013 Office of the Legislative
169.32 Auditor report on State-Operated Services for persons committed to the commissioner as
169.33 mentally ill and dangerous under Minnesota Statutes, section 253B.18. Stakeholders must
169.34 include representatives from the Department of Human Services, county human services,

170.1 county attorneys, commitment defense attorneys, the ombudsman for mental health and
170.2 developmental disabilities, the federal protection and advocacy system, and consumers
170.3 and advocates for persons with mental illnesses.

170.4 (b) The stakeholder group shall provide recommendations in the following areas:

170.5 (1) the role of the special review board, including the scope of authority of the
170.6 special review board and the authority of the commissioner to accept or reject special
170.7 review board recommendations;

170.8 (2) review of special review board decisions by the district court;

170.9 (3) annual district court review of commitment, scope of court authority, and
170.10 appropriate review criteria;

170.11 (4) options, including annual court hearing and review, as alternatives to
170.12 indeterminate commitment under Minnesota Statutes, section 253B.18; and

170.13 (5) extension of the right to petition the court under Minnesota Statutes,
170.14 section 253B.17, to those committed under Minnesota Statutes, section 253B.18.

170.15 The commissioner of human services and the state court administrator shall provide
170.16 relevant data for the group's consideration in developing these recommendations,
170.17 including numbers of proceedings in each category and costs associated with court and
170.18 administrative proceedings under Minnesota Statutes, section 253B.18.

170.19 (c) By January 15, 2014, the commissioner of human services shall submit the
170.20 recommendations of the stakeholder group to the chairs and ranking minority members
170.21 of the committees of the legislature with jurisdiction over civil commitment and human
170.22 services issues.

170.23 **Sec. 32. STATE ASSISTANCE TO COUNTIES; TRANSITIONS FOR HIGH**
170.24 **NEEDS POPULATIONS.**

170.25 (a) Effective immediately, the commissioner of human services shall work with
170.26 counties that request assistance to assure timely discharge from Anoka Metro Regional
170.27 Treatment Center and the Minnesota Security Hospital for individuals who are ready
170.28 for discharge but for whom the county may not have provider resources or appropriate
170.29 placement available. Special consideration must be given to uninsured individuals who are
170.30 not eligible for medical assistance and who may need continued treatment, and individuals
170.31 with complex needs and other factors that hinder county efforts to place the individual in a
170.32 safe, affordable setting.

170.33 (b) The commissioner shall assure that, given Olmstead court directives and the
170.34 role family and friends play in treatment progress, metropolitan area residents are asked
170.35 whether they wished to be placed in an Intensive Residential Treatment Service program

171.1 at Willmar or Cambridge or to be placed in a location more accessible to family, friends,
171.2 and health providers.

171.3 **ARTICLE 5**

171.4 **DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY**

171.5 Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a
171.6 subdivision to read:

171.7 Subd. 7b. **Child care provider and recipient fraud investigations.** Data related
171.8 to child care fraud and recipient fraud investigations are governed by section 245E.01,
171.9 subdivision 15.

171.10 Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 7, is amended to read:

171.11 Subd. 7. **Use of data.** (a) Except as otherwise provided in subdivision 7a or sections
171.12 244.052 and 299C.093, the data provided under this section is private data on individuals
171.13 under section 13.02, subdivision 12.

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

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

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

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

171.21 Sec. 3. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision
171.22 to read:

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

172.1 a new background study regardless of the length of time the individual was no longer
172.2 affiliated with the agency.

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

172.9 Sec. 4. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:

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

172.13 (1) information related to names of substantiated perpetrators of maltreatment of
172.14 vulnerable adults that has been received by the commissioner as required under section
172.15 626.557, subdivision 9c, paragraph (j);

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

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

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

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

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

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

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

172.33 (b) Notwithstanding expungement by a court, the commissioner may consider
172.34 information obtained under paragraph (a), clauses (3) and (4), unless the commissioner

173.1 received notice of the petition for expungement and the court order for expungement is
 173.2 directed specifically to the commissioner.

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

173.7 **Sec. 5. [245E.01] CHILD CARE PROVIDER AND RECIPIENT FRAUD**
 173.8 **INVESTIGATIONS WITHIN THE CHILD CARE ASSISTANCE PROGRAM.**

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

173.11 (b) "Applicant" has the meaning given in section 119B.011, subdivision 2.

173.12 (c) "Child care assistance program" means any of the assistance programs under
 173.13 chapter 119B.

173.14 (d) "Commissioner" means the commissioner of human services.

173.15 (e) "Controlling individual" has the meaning given in section 245A.02, subdivision
 173.16 5a.

173.17 (f) "County" means a local county child care assistance program staff or
 173.18 subcontracted staff, or a county investigator acting on behalf of the commissioner.

173.19 (g) "Department" means the Department of Human Services.

173.20 (h) "Financial misconduct" or "misconduct" means an entity's or individual's acts or
 173.21 omissions that result in fraud and abuse or error against the Department of Human Services.

173.22 (i) "Identify" means to furnish the full name, current or last known address, phone
 173.23 number, and e-mail address of the individual or business entity.

173.24 (j) "License holder" has the meaning given in section 245A.02, subdivision 9.

173.25 (k) "Mail" means the use of any mail service with proof of delivery and receipt.

173.26 (l) "Provider" means either a provider as defined in section 119B.011, subdivision
 173.27 19, or a legal unlicensed provider as defined in section 119B.011, subdivision 16.

173.28 (m) "Recipient" means a family receiving assistance as defined under section
 173.29 119B.011, subdivision 13.

173.30 (n) "Terminate" means revocation of participation in the child care assistance
 173.31 program.

173.32 Subd. 2. **Investigating provider or recipient financial misconduct.** The
 173.33 department shall investigate alleged or suspected financial misconduct by providers and
 173.34 errors related to payments issued by the child care assistance program under this chapter.
 173.35 Recipients, employees, and staff may be investigated when the evidence shows that their

174.1 conduct is related to the financial misconduct of a provider, license holder, or controlling
174.2 individual.

174.3 Subd. 3. **Scope of investigations.** (a) The department may contact any person,
174.4 agency, organization, or other entity that is necessary to an investigation.

174.5 (b) The department may examine or interview any individual, document, or piece of
174.6 evidence that may lead to information that is relevant to child care assistance program
174.7 benefits, payments, and child care provider authorizations. This includes, but is not
174.8 limited to:

174.9 (1) child care assistance program payments;

174.10 (2) services provided by the program or related to child care assistance program
174.11 recipients;

174.12 (3) services provided to a provider;

174.13 (4) provider financial records of any type;

174.14 (5) daily attendance records of the children receiving services from the provider;

174.15 (6) billings; and

174.16 (7) verification of the credentials of a license holder, controlling individual,
174.17 employee, staff person, contractor, subcontractor, and entities under contract with the
174.18 provider to provide services or maintain service and the provider's financial records
174.19 related to those services.

174.20 Subd. 4. **Determination of investigation.** After completing its investigation, the
174.21 department shall issue one of the following determinations:

174.22 (1) no violation of child care assistance requirements occurred;

174.23 (2) there is insufficient evidence to show that a violation of child care assistance
174.24 requirements occurred;

174.25 (3) a preponderance of evidence shows a violation of child care assistance program
174.26 law, rule, or policy; or

174.27 (4) there exists a credible allegation of fraud.

174.28 Subd. 5. **Actions or administrative sanctions.** (a) After completing the
174.29 determination under subdivision 4, the department may take one or more of the actions
174.30 or sanctions specified in this subdivision.

174.31 (b) The department may take the following actions:

174.32 (1) refer the investigation to law enforcement or a county attorney for possible
174.33 criminal prosecution;

174.34 (2) refer relevant information to the department's licensing division, the child care
174.35 assistance program, the Department of Education, the federal child and adult care food
174.36 program, or appropriate child or adult protection agency;

175.1 (3) enter into a settlement agreement with a provider, license holder, controlling
175.2 individual, or recipient; or

175.3 (4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction
175.4 for possible civil action under the Minnesota False Claims Act, chapter 15C.

175.5 (c) In addition to section 256.98, the department may impose sanctions by:

175.6 (1) pursuing administrative disqualification through hearings or waivers;

175.7 (2) establishing and seeking monetary recovery or recoupment; or

175.8 (3) issuing an order of corrective action that states the practices that are violations of
175.9 child care assistance program policies, laws, or regulations, and that they must be corrected.

175.10 Subd. 6. Duty to provide access. (a) A provider, license holder, controlling
175.11 individual, employee, staff person, or recipient has an affirmative duty to provide access
175.12 upon request to information specified under subdivision 8 or the program facility.

175.13 (b) Failure to provide access may result in denial or termination of authorizations for
175.14 or payments to a recipient, provider, license holder, or controlling individual in the child
175.15 care assistance program.

175.16 (c) When a provider fails to provide access, a 15-day notice of denial or termination
175.17 must be issued to the provider, which prohibits the provider from participating in the child
175.18 care assistance program. Notice must be sent to recipients whose children are under the
175.19 provider's care pursuant to Minnesota Rules, part 3400.0185.

175.20 (d) If the provider continues to fail to provide access at the expiration of the 15-day
175.21 notice period, child care assistance program payments to the provider must be denied
175.22 beginning the 16th day following notice of the initial failure or refusal to provide access.
175.23 The department may rescind the denial based upon good cause if the provider submits in
175.24 writing a good cause basis for having failed or refused to provide access. The writing must
175.25 be postmarked no later than the 15th day following the provider's notice of initial failure
175.26 to provide access. Additionally, the provider, license holder, or controlling individual
175.27 must immediately provide complete, ongoing access to the department. Repeated failures
175.28 to provide access must, after the initial failure or for any subsequent failure, result in
175.29 termination from participation in the child care assistance program.

175.30 (e) The department, at its own expense, may photocopy or otherwise duplicate
175.31 records referenced in subdivision 8. Photocopying must be done on the provider's
175.32 premises on the day of the request or other mutually agreeable time, unless removal of
175.33 records is specifically permitted by the provider. If requested, a provider, license holder,
175.34 or controlling individual, or a designee, must assist the investigator in duplicating any
175.35 record, including a hard copy or electronically stored data, on the day of the request.

176.1 (f) A provider, license holder, controlling individual, employee, or staff person must
176.2 grant the department access during the department's normal business hours, and any hours
176.3 that the program is operated, to examine the provider's program or the records listed in
176.4 subdivision 8. A provider shall make records available at the provider's place of business
176.5 on the day for which access is requested, unless the provider and the department both agree
176.6 otherwise. The department's normal business hours are 8:00 a.m. to 5:00 p.m., Monday
176.7 through Friday, excluding state holidays as defined in section 645.44, subdivision 5.

176.8 Subd. 7. **Honest and truthful statements.** It shall be unlawful for a provider,
176.9 license holder, controlling individual, or recipient to:

176.10 (1) falsify, conceal, or cover up by any trick, scheme, or device a material fact;

176.11 (2) make any materially false, fictitious, or fraudulent statement or representation; or

176.12 (3) make or use any false writing or document knowing the same to contain any

176.13 materially false, fictitious, or fraudulent statement or entry related to any child care

176.14 assistance program services that the provider, license holder, or controlling individual

176.15 supplies or in relation to any child care assistance payments received by a provider, license

176.16 holder, or controlling individual or to any fraud investigator or law enforcement officer

176.17 conducting a financial misconduct investigation.

176.18 Subd. 8. **Record retention.** (a) The following records must be maintained,
176.19 controlled, and made immediately accessible to license holders, providers, and controlling
176.20 individuals. The records must be organized and labeled to correspond to categories that
176.21 make them easy to identify so that they can be made available immediately upon request
176.22 to an investigator acting on behalf of the commissioner at the provider's place of business:

176.23 (1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting
176.24 records;

176.25 (2) daily attendance records required by and that comply with section 119B.125,
176.26 subdivision 6;

176.27 (3) billing transmittal forms requesting payments from the child care assistance
176.28 program and billing adjustments related to child care assistance program payments;

176.29 (4) records identifying all persons, corporations, partnerships, and entities with an
176.30 ownership or controlling interest in the provider's child care business;

176.31 (5) employee records identifying those persons currently employed by the provider's
176.32 child care business or who have been employed by the business at any time within the
176.33 previous five years. The records must include each employee's name, hourly and annual
176.34 salary, qualifications, position description, job title, and dates of employment. In addition,
176.35 employee records that must be made available include the employee's time sheets, current

177.1 home address of the employee or last known address of any former employee, and
177.2 documentation of background studies required under chapter 119B or 245C;

177.3 (6) records related to transportation of children in care, including but not limited to:

177.4 (i) the dates and times that transportation is provided to children for transportation to
177.5 and from the provider's business location for any purpose. For transportation related to
177.6 field trips or locations away from the provider's business location, the names and addresses
177.7 of those field trips and locations must also be provided;

177.8 (ii) the name, business address, phone number, and Web site address, if any, of the
177.9 transportation service utilized; and

177.10 (iii) all billing or transportation records related to the transportation.

177.11 (b) A provider, license holder, or controlling individual must retain all records in
177.12 paragraph (a) for at least six years after the last date of service. Microfilm or electronically
177.13 stored records satisfy the record keeping requirements of this subdivision.

177.14 (c) A provider, license holder, or controlling individual who withdraws or is
177.15 terminated from the child care assistance program must retain the records required under
177.16 this subdivision and make them available to the department on demand.

177.17 (d) If the ownership of a provider changes, the transferor, unless otherwise provided
177.18 by law or by written agreement with the transferee, is responsible for maintaining,
177.19 preserving, and upon request from the department, making available the records related to
177.20 the provider that were generated before the date of the transfer. Any written agreement
177.21 affecting this provision must be held in the possession of the transferor and transferee.
177.22 The written agreement must be provided to the department or county immediately upon
177.23 request, and the written agreement must be retained by the transferor and transferee for six
177.24 years after the agreement is fully executed.

177.25 (e) In the event of an appealed case, the provider must retain all records required in
177.26 this subdivision for the duration of the appeal or six years, whichever is longer.

177.27 (f) A provider's use of electronic record keeping or electronic signatures is governed
177.28 by chapter 325L.

177.29 **Subd. 9. Factors regarding imposition of administrative sanctions.** (a) The
177.30 department shall consider the following factors in determining the administrative sanctions
177.31 to be imposed:

177.32 (1) nature and extent of financial misconduct;

177.33 (2) history of financial misconduct;

177.34 (3) actions taken or recommended by other state agencies, other divisions of the
177.35 department, and court and administrative decisions;

177.36 (4) prior imposition of sanctions;

178.1 (5) size and type of provider;
178.2 (6) information obtained through an investigation from any source;
178.3 (7) convictions or pending criminal charges; and
178.4 (8) any other information relevant to the acts or omissions related to the financial
178.5 misconduct.

178.6 (b) Any single factor under paragraph (a) may be determinative of the department's
178.7 decision of whether and what sanctions are imposed.

178.8 Subd. 10. **Written notice of department sanction.** (a) The department shall give
178.9 notice in writing to a person of an administrative sanction that is to be imposed. The notice
178.10 shall be sent by mail as defined in subdivision 1, paragraph (k).

178.11 (b) The notice shall state:

178.12 (1) the factual basis for the department's determination;

178.13 (2) the sanction the department intends to take;

178.14 (3) the dollar amount of the monetary recovery or recoupment, if any;

178.15 (4) how the dollar amount was computed;

178.16 (5) the right to dispute the department's determination and to provide evidence;

178.17 (6) the right to appeal the department's proposed sanction; and

178.18 (7) the option to meet informally with department staff, and to bring additional
178.19 documentation or information, to resolve the issues.

178.20 (c) In cases of determinations resulting in denial or termination of payments, in
178.21 addition to the requirements of paragraph (b), the notice must state:

178.22 (1) the length of the denial or termination;

178.23 (2) the requirements and procedures for reinstatement; and

178.24 (3) the provider's right to submit documents and written arguments against the
178.25 denial or termination of payments for review by the department before the effective date
178.26 of denial or termination.

178.27 (d) The submission of documents and written argument for review by the department
178.28 under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the
178.29 deadline for filing an appeal.

178.30 (e) Unless timely appealed, the effective date of the proposed sanction shall be 30
178.31 days after the license holder's, provider's, controlling individual's, or recipient's receipt of
178.32 the notice. If a timely appeal is made, the proposed sanction shall be delayed pending
178.33 the final outcome of the appeal. Implementation of a proposed sanction following the
178.34 resolution of a timely appeal may be postponed if, in the opinion of the department, the
178.35 delay of sanction is necessary to protect the health or safety of children in care. The
178.36 department may consider the economic hardship of a person in implementing the proposed

179.1 sanction, but economic hardship shall not be a determinative factor in implementing the
179.2 proposed sanction.

179.3 (f) Requests for an informal meeting to attempt to resolve issues and requests
179.4 for appeals must be sent or delivered to the department's Office of Inspector General,
179.5 Financial Fraud and Abuse Division.

179.6 Subd. 11. **Appeal of department sanction under this section.** (a) If the department
179.7 does not pursue a criminal action against a provider, license holder, controlling individual,
179.8 or recipient for financial misconduct, but the department imposes an administrative
179.9 sanction under subdivision 5, paragraph (c), any individual or entity against whom the
179.10 sanction was imposed may appeal the department's administrative sanction under this
179.11 section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses
179.12 (1) to (4). An appeal must specify:

179.13 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
179.14 amount involved for each disputed item, if appropriate;

179.15 (2) the computation that is believed to be correct, if appropriate;

179.16 (3) the authority in the statute or rule relied upon for each disputed item; and

179.17 (4) the name, address, and phone number of the person at the provider's place of
179.18 business with whom contact may be made regarding the appeal.

179.19 (b) An appeal is considered timely only if postmarked or received by the department's
179.20 Appeals Division within 30 days after receiving a notice of department sanction.

179.21 (c) Before the appeal hearing, the department may deny or terminate authorizations
179.22 or payment to the entity or individual if the department determines that the action is
179.23 necessary to protect the public welfare or the interests of the child care assistance program.

179.24 Subd. 12. **Consolidated hearings with licensing sanction.** If a financial
179.25 misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing
179.26 sanction exists for which there is an appeal hearing right and the sanction is timely
179.27 appealed, and the overpayment recovery action and licensing sanction involve the same
179.28 set of facts, the overpayment recovery action and licensing sanction must be consolidated
179.29 in the contested case hearing related to the licensing sanction.

179.30 Subd. 13. **Grounds for and methods of monetary recovery.** (a) The department
179.31 may obtain monetary recovery from a provider who has been improperly paid by the
179.32 child care assistance program, regardless of whether the error was intentional or county
179.33 error. The department does not need to establish a pattern as a precondition of monetary
179.34 recovery of erroneous or false billing claims, duplicate billing claims, or billing claims
179.35 based on false statements or financial misconduct.

180.1 (b) The department shall obtain monetary recovery from providers by the following
180.2 means:

180.3 (1) permitting voluntary repayment of money, either in lump-sum payment or
180.4 installment payments;

180.5 (2) using any legal collection process;

180.6 (3) deducting or withholding program payments; or

180.7 (4) utilizing the means set forth in chapter 16D.

180.8 Subd. 14. **Reporting of suspected fraudulent activity.** (a) A person who, in
180.9 good faith, makes a report of or testifies in any action or proceeding in which financial
180.10 misconduct is alleged, and who is not involved in, has not participated in, or has not aided
180.11 and abetted, conspired, or colluded in the financial misconduct, shall have immunity from
180.12 any liability, civil or criminal, that results by reason of the person's report or testimony.
180.13 For the purpose of any proceeding, the good faith of any person reporting or testifying
180.14 under this provision shall be presumed.

180.15 (b) If a person that is or has been involved in, participated in, aided and abetted,
180.16 conspired, or colluded in the financial misconduct reports the financial misconduct,
180.17 the department may consider that person's report and assistance in investigating the
180.18 misconduct as a mitigating factor in the department's pursuit of civil, criminal, or
180.19 administrative remedies.

180.20 Subd. 15. **Data privacy.** Data of any kind obtained or created in relation to a provider
180.21 or recipient investigation under this section is defined, classified, and protected the same as
180.22 all other data under section 13.46, and this data has the same classification as licensing data.

180.23 Subd. 16. **Monetary recovery; random sample extrapolation.** The department is
180.24 authorized to calculate the amount of monetary recovery from a provider, license holder, or
180.25 controlling individual based upon extrapolation from a statistical random sample of claims
180.26 submitted by the provider, license holder, or controlling individual and paid by the child
180.27 care assistance program. The department's random sample extrapolation shall constitute a
180.28 rebuttable presumption of the accuracy of the calculation of monetary recovery. If the
180.29 presumption is not rebutted by the provider, license holder, or controlling individual in the
180.30 appeal process, the department shall use the extrapolation as the monetary recovery figure.
180.31 The department may use sampling and extrapolation to calculate the amount of monetary
180.32 recovery if the claims to be reviewed represent services to 50 or more children in care.

180.33 Subd. 17. **Effect of department's monetary penalty determination.** Unless a
180.34 timely and proper appeal is received by the department, the department's administrative
180.35 determination or sanction shall be considered a final department determination.

181.1 Subd. 18. **Office of Inspector General recoveries.** Overpayment recoveries
181.2 resulting from child care provider fraud investigations initiated by the department's Office
181.3 of Inspector General's fraud investigations staff are excluded from the county recovery
181.4 provision in section 119B.11, subdivision 3.

181.5 Sec. 6. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

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

181.11 (b) An enrolled provider that is also licensed by the commissioner under chapter
181.12 245A must designate an individual as the entity's compliance officer. The compliance
181.13 officer must:

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

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

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

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

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

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

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

181.30 (c) The commissioner may revoke the enrollment of an ordering or rendering
181.31 provider for a period of not more than one year, if the provider fails to maintain and, upon
181.32 request from the commissioner, provide access to documentation relating to written orders
181.33 or requests for payment for durable medical equipment, certifications for home health
181.34 services, or referrals for other items or services written or ordered by such provider, when
181.35 the commissioner has identified a pattern of a lack of documentation. A pattern means a

182.1 failure to maintain documentation or provide access to documentation on more than one
182.2 occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a
182.3 provider under the provisions of section 256B.064.

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

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

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

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

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

183.1 (h) The Department of Human Services may require a provider to purchase a
183.2 performance surety bond as a condition of initial enrollment, reenrollment, reinstatement,
183.3 or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the
183.4 department determines there is significant evidence of or potential for fraud and abuse by
183.5 the provider, or (3) the provider or category of providers is designated high-risk pursuant
183.6 to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The
183.7 performance bond must be in an amount of \$100,000 or ten percent of the provider's
183.8 payments from Medicaid during the immediately preceding 12 months, whichever is
183.9 greater. The performance bond must name the Department of Human Services as an
183.10 obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

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

183.12 Sec. 7. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
183.13 to read:

183.14 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
183.15 required nonrefundable application fees to pay for provider screening activities in
183.16 accordance with Code of Federal Regulations, title 42, section 455, subpart E. The
183.17 enrollment application must be made under the procedures specified by the commissioner,
183.18 in the form specified by the commissioner, and accompanied by an application fee
183.19 described in paragraph (b), or a request for a hardship exception as described in the
183.20 specified procedures. Application fees must be deposited in the provider screening account
183.21 in the special revenue fund. Amounts in the provider screening account are appropriated
183.22 to the commissioner for costs associated with the provider screening activities required
183.23 in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner
183.24 shall conduct screening activities as required by Code of Federal Regulations, title 42,
183.25 section 455, subpart E, and as otherwise provided by law, to include database checks,
183.26 unannounced pre- and postenrollment site visits, fingerprinting, and criminal background
183.27 studies. The commissioner must revalidate all providers under this subdivision at least
183.28 once every five years.

183.29 (b) The application fee under this subdivision is \$532 for the calendar year 2013.
183.30 For calendar year 2014 and subsequent years, the fee:

183.31 (1) is adjusted by the percentage change to the consumer price index for all urban
183.32 consumers, United States city average, for the 12-month period ending with June of the
183.33 previous year. The resulting fee must be announced in the Federal Register;

183.34 (2) is effective from January 1 to December 31 of a calendar year;

184.1 (3) is required on the submission of an initial application, an application to establish
 184.2 a new practice location, an application for re-enrollment when the provider is not enrolled
 184.3 at the time of application of re-enrollment, or at revalidation when required by federal
 184.4 regulation; and

184.5 (4) must be in the amount in effect for the calendar year during which the application
 184.6 for enrollment, new practice location, or re-enrollment is being submitted.

184.7 (c) The application fee under this subdivision cannot be charged to:

184.8 (1) providers who are enrolled in Medicare or who provide documentation of
 184.9 payment of the fee to, and enrollment with, another state, unless the commissioner is
 184.10 required to rescreen the provider;

184.11 (2) providers who are enrolled but are required to submit new applications for
 184.12 purposes of reenrollment;

184.13 (3) a provider who enrolls as an individual; and

184.14 (4) group practices and clinics that bill on behalf of individually enrolled providers
 184.15 within the practice who have reassigned their billing privileges to the group practice
 184.16 or clinic.

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

184.18 Sec. 8. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

184.19 Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may
 184.20 impose sanctions against a vendor of medical care for any of the following: (1) fraud,
 184.21 theft, or abuse in connection with the provision of medical care to recipients of public
 184.22 assistance; (2) a pattern of presentment of false or duplicate claims or claims for services
 184.23 not medically necessary; (3) a pattern of making false statements of material facts for
 184.24 the purpose of obtaining greater compensation than that to which the vendor is legally
 184.25 entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state
 184.26 agency access during regular business hours to examine all records necessary to disclose
 184.27 the extent of services provided to program recipients and appropriateness of claims for
 184.28 payment; (6) failure to repay an overpayment or a fine finally established under this
 184.29 section; and (7) failure to correct errors in the maintenance of health service or financial
 184.30 records for which a fine was imposed or after issuance of a warning by the commissioner;
 184.31 and (8) any reason for which a vendor could be excluded from participation in the
 184.32 Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.
 184.33 The determination of services not medically necessary may be made by the commissioner
 184.34 in consultation with a peer advisory task force appointed by the commissioner on the

185.1 recommendation of appropriate professional organizations. The task force expires as
185.2 provided in section 15.059, subdivision 5.

185.3 Sec. 9. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:

185.4 Subd. 1b. **Sanctions available.** The commissioner may impose the following
185.5 sanctions for the conduct described in subdivision 1a: suspension or withholding of
185.6 payments to a vendor and suspending or terminating participation in the program, or
185.7 imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under
185.8 this section, the commissioner shall consider the nature, chronicity, or severity of the
185.9 conduct and the effect of the conduct on the health and safety of persons served by the
185.10 vendor. Regardless of imposition of sanctions, the commissioner may make a referral
185.11 to the appropriate state licensing board.

185.12 Sec. 10. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:

185.13 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner
185.14 shall determine any monetary amounts to be recovered and sanctions to be imposed upon
185.15 a vendor of medical care under this section. Except as provided in paragraphs (b) and
185.16 (d), neither a monetary recovery nor a sanction will be imposed by the commissioner
185.17 without prior notice and an opportunity for a hearing, according to chapter 14, on the
185.18 commissioner's proposed action, provided that the commissioner may suspend or reduce
185.19 payment to a vendor of medical care, except a nursing home or convalescent care facility,
185.20 after notice and prior to the hearing if in the commissioner's opinion that action is
185.21 necessary to protect the public welfare and the interests of the program.

185.22 (b) Except when the commissioner finds good cause not to suspend payments under
185.23 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall
185.24 withhold or reduce payments to a vendor of medical care without providing advance
185.25 notice of such withholding or reduction if either of the following occurs:

185.26 (1) the vendor is convicted of a crime involving the conduct described in subdivision
185.27 1a; or

185.28 (2) the commissioner determines there is a credible allegation of fraud for which an
185.29 investigation is pending under the program. A credible allegation of fraud is an allegation
185.30 which has been verified by the state, from any source, including but not limited to:

185.31 (i) fraud hotline complaints;

185.32 (ii) claims data mining; and

185.33 (iii) patterns identified through provider audits, civil false claims cases, and law
185.34 enforcement investigations.

186.1 Allegations are considered to be credible when they have an indicia of reliability
186.2 and the state agency has reviewed all allegations, facts, and evidence carefully and acts
186.3 judiciously on a case-by-case basis.

186.4 (c) The commissioner must send notice of the withholding or reduction of payments
186.5 under paragraph (b) within five days of taking such action unless requested in writing by a
186.6 law enforcement agency to temporarily withhold the notice. The notice must:

186.7 (1) state that payments are being withheld according to paragraph (b);

186.8 (2) set forth the general allegations as to the nature of the withholding action, but
186.9 need not disclose any specific information concerning an ongoing investigation;

186.10 (3) except in the case of a conviction for conduct described in subdivision 1a, state
186.11 that the withholding is for a temporary period and cite the circumstances under which
186.12 withholding will be terminated;

186.13 (4) identify the types of claims to which the withholding applies; and

186.14 (5) inform the vendor of the right to submit written evidence for consideration by
186.15 the commissioner.

186.16 The withholding or reduction of payments will not continue after the commissioner
186.17 determines there is insufficient evidence of fraud by the vendor, or after legal proceedings
186.18 relating to the alleged fraud are completed, unless the commissioner has sent notice of
186.19 intention to impose monetary recovery or sanctions under paragraph (a).

186.20 (d) The commissioner shall suspend or terminate a vendor's participation in the
186.21 program without providing advance notice and an opportunity for a hearing when the
186.22 suspension or termination is required because of the vendor's exclusion from participation
186.23 in Medicare. Within five days of taking such action, the commissioner must send notice of
186.24 the suspension or termination. The notice must:

186.25 (1) state that suspension or termination is the result of the vendor's exclusion from
186.26 Medicare;

186.27 (2) identify the effective date of the suspension or termination; and

186.28 (3) inform the vendor of the need to be reinstated to Medicare before reapplying
186.29 for participation in the program.

186.30 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or
186.31 sanction is to be imposed, a vendor may request a contested case, as defined in section
186.32 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The
186.33 appeal request must be received by the commissioner no later than 30 days after the date
186.34 the notification of monetary recovery or sanction was mailed to the vendor. The appeal
186.35 request must specify:

187.1 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
187.2 amount involved for each disputed item;

187.3 (2) the computation that the vendor believes is correct;

187.4 (3) the authority in statute or rule upon which the vendor relies for each disputed item;

187.5 (4) the name and address of the person or entity with whom contacts may be made
187.6 regarding the appeal; and

187.7 (5) other information required by the commissioner.

187.8 (f) The commissioner may order a vendor to forfeit a fine for failure to fully document
187.9 services according to standards in this chapter and Minnesota Rules, chapter 9505. The
187.10 commissioner may assess fines if specific required components of documentation are
187.11 missing. The fine for incomplete documentation shall equal 20 percent of the amount paid
187.12 on the claims for reimbursement submitted by the vendor, or up to \$5,000, whichever is less.

187.13 (g) The vendor shall pay the fine assessed on or before the payment date specified. If
187.14 the vendor fails to pay the fine, the commissioner may withhold or reduce payments and
187.15 recover the amount of the fine. A timely appeal shall stay payment of the fine until the
187.16 commissioner issues a final order.

187.17 Sec. 11. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to
187.18 read:

187.19 Subd. 21. **Requirements for initial provider enrollment of personal care**
187.20 **assistance provider agencies.** (a) All personal care assistance provider agencies must
187.21 provide, at the time of enrollment, reenrollment, and revalidation as a personal care
187.22 assistance provider agency in a format determined by the commissioner, information and
187.23 documentation that includes, but is not limited to, the following:

187.24 (1) the personal care assistance provider agency's current contact information
187.25 including address, telephone number, and e-mail address;

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

187.28 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's
187.29 Medicaid revenue in the previous calendar year is up to and including \$300,000,
187.30 the provider agency must purchase a performance bond of \$50,000. If the Medicaid
187.31 revenue in the previous year is over \$300,000, the provider agency must purchase a
187.32 performance bond of \$100,000. The performance bond must be in a form approved by the
187.33 commissioner, must be renewed annually, and must allow for recovery of costs and fees
187.34 in pursuing a claim on the bond;

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

- 188.1 (4) proof of workers' compensation insurance coverage;
- 188.2 (5) proof of liability insurance;
- 188.3 (6) a description of the personal care assistance provider agency's organization
- 188.4 identifying the names of all owners, managing employees, staff, board of directors, and
- 188.5 the affiliations of the directors, owners, or staff to other service providers;
- 188.6 (7) a copy of the personal care assistance provider agency's written policies and
- 188.7 procedures including: hiring of employees; training requirements; service delivery;
- 188.8 and employee and consumer safety including process for notification and resolution
- 188.9 of consumer grievances, identification and prevention of communicable diseases, and
- 188.10 employee misconduct;
- 188.11 (8) copies of all other forms the personal care assistance provider agency uses in
- 188.12 the course of daily business including, but not limited to:
- 188.13 (i) a copy of the personal care assistance provider agency's time sheet if the time
- 188.14 sheet varies from the standard time sheet for personal care assistance services approved
- 188.15 by the commissioner, and a letter requesting approval of the personal care assistance
- 188.16 provider agency's nonstandard time sheet;
- 188.17 (ii) the personal care assistance provider agency's template for the personal care
- 188.18 assistance care plan; and
- 188.19 (iii) the personal care assistance provider agency's template for the written
- 188.20 agreement in subdivision 20 for recipients using the personal care assistance choice
- 188.21 option, if applicable;
- 188.22 (9) a list of all training and classes that the personal care assistance provider agency
- 188.23 requires of its staff providing personal care assistance services;
- 188.24 (10) documentation that the personal care assistance provider agency and staff have
- 188.25 successfully completed all the training required by this section;
- 188.26 (11) documentation of the agency's marketing practices;
- 188.27 (12) disclosure of ownership, leasing, or management of all residential properties
- 188.28 that is used or could be used for providing home care services;
- 188.29 (13) documentation that the agency will use the following percentages of revenue
- 188.30 generated from the medical assistance rate paid for personal care assistance services
- 188.31 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
- 188.32 personal care assistance choice option and 72.5 percent of revenue from other personal
- 188.33 care assistance providers. The revenue generated by the qualified professional and the
- 188.34 reasonable costs associated with the qualified professional shall not be used in making
- 188.35 this calculation; and

189.1 (14) effective May 15, 2010, documentation that the agency does not burden
189.2 recipients' free exercise of their right to choose service providers by requiring personal
189.3 care assistants to sign an agreement not to work with any particular personal care
189.4 assistance recipient or for another personal care assistance provider agency after leaving
189.5 the agency and that the agency is not taking action on any such agreements or requirements
189.6 regardless of the date signed.

189.7 (b) Personal care assistance provider agencies shall provide the information specified
189.8 in paragraph (a) to the commissioner at the time the personal care assistance provider
189.9 agency enrolls as a vendor or upon request from the commissioner. The commissioner
189.10 shall collect the information specified in paragraph (a) from all personal care assistance
189.11 providers beginning July 1, 2009.

189.12 (c) All personal care assistance provider agencies shall require all employees in
189.13 management and supervisory positions and owners of the agency who are active in the
189.14 day-to-day management and operations of the agency to complete mandatory training
189.15 as determined by the commissioner before enrollment of the agency as a provider.
189.16 Employees in management and supervisory positions and owners who are active in
189.17 the day-to-day operations of an agency who have completed the required training as
189.18 an employee with a personal care assistance provider agency do not need to repeat
189.19 the required training if they are hired by another agency, if they have completed the
189.20 training within the past three years. By September 1, 2010, the required training must
189.21 be available with meaningful access according to title VI of the Civil Rights Act and
189.22 federal regulations adopted under that law or any guidance from the United States Health
189.23 and Human Services Department. The required training must be available online or by
189.24 electronic remote connection. The required training must provide for competency testing.
189.25 Personal care assistance provider agency billing staff shall complete training about
189.26 personal care assistance program financial management. This training is effective July 1,
189.27 2009. Any personal care assistance provider agency enrolled before that date shall, if it
189.28 has not already, complete the provider training within 18 months of July 1, 2009. Any new
189.29 owners or employees in management and supervisory positions involved in the day-to-day
189.30 operations are required to complete mandatory training as a requisite of working for the
189.31 agency. Personal care assistance provider agencies certified for participation in Medicare
189.32 as home health agencies are exempt from the training required in this subdivision. When
189.33 available, Medicare-certified home health agency owners, supervisors, or managers must
189.34 successfully complete the competency test.

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

190.1 Sec. 12. Minnesota Statutes 2012, section 299C.093, is amended to read:

190.2 **299C.093 DATABASE OF REGISTERED PREDATORY OFFENDERS.**

190.3 The superintendent of the Bureau of Criminal Apprehension shall maintain a
190.4 computerized data system relating to individuals required to register as predatory offenders
190.5 under section 243.166. To the degree feasible, the system must include the data required
190.6 to be provided under section 243.166, subdivisions 4 and 4a, and indicate the time period
190.7 that the person is required to register. The superintendent shall maintain this data in a
190.8 manner that ensures that it is readily available to law enforcement agencies. This data is
190.9 private data on individuals under section 13.02, subdivision 12, but may be used for law
190.10 enforcement and corrections purposes. The commissioner of human services has access
190.11 to the data for state-operated services, as defined in section 246.014, ~~are also authorized~~
190.12 ~~to have access to the data~~ for the purposes described in section 246.13, subdivision 2,
190.13 paragraph (b), and for purposes of conducting background studies under chapter 245C.

190.14 Sec. 13. Minnesota Statutes 2012, section 402A.10, is amended to read:

190.15 **402A.10 DEFINITIONS.**

190.16 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined
190.17 in this section have the meanings given.

190.18 Subd. 1a. **Balanced set of program measures.** A "balanced set of program
190.19 measures" is a set of measures that, together, adequately quantify achievement toward a
190.20 particular program's outcome. As directed by section 402A.16, the Human Services
190.21 Performance Council must recommend to the commissioner when a particular program
190.22 has a balanced set of program measures.

190.23 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
190.24 services.

190.25 Subd. 3. **Council.** "Council" means the State-County Results, Accountability, and
190.26 Service Delivery Redesign Council established in section 402A.20.

190.27 Subd. 4. **Essential human services or essential services.** "Essential human
190.28 services" or "essential services" means assistance and services to recipients or potential
190.29 recipients of public welfare and other services delivered by counties or tribes that are
190.30 mandated in federal and state law that are to be available in all counties of the state.

190.31 Subd. 4a. **Essential human services program.** An "essential human services
190.32 program" for the purposes of remedies under section 402A.18 means the following
190.33 programs:

190.34 (1) child welfare, including protection, truancy, minor parent, guardianship, and
190.35 adoption;

- 191.1 (2) children's mental health;
191.2 (3) children's disability services;
191.3 (4) public assistance eligibility, including measures related to processing timelines
191.4 across information services programs;
191.5 (5) MFIP;
191.6 (6) child support;
191.7 (7) chemical dependency;
191.8 (8) adult disability;
191.9 (9) adult mental health;
191.10 (10) adult services such as long-term care; and
191.11 (11) adult protection.

191.12 Subd. 4b. **Measure.** A "measure" means a quantitative indicator of a performance
191.13 outcome.

191.14 Subd. 4c. **Performance improvement plan.** A "performance improvement plan"
191.15 means a plan developed by a county or service delivery authority that describes steps the
191.16 county or service delivery authority must take to improve performance on a specific
191.17 measure or set of measures. The performance improvement plan must be negotiated
191.18 with and approved by the commissioner. The performance improvement plan must
191.19 require a specific numerical improvement in the measure or measures on which the plan
191.20 is based and may include specific programmatic best practices or specific performance
191.21 management practices that the county must implement.

191.22 Subd. 4d. **Performance management system for human services.** A "performance
191.23 management system for human services" means a process by which performance data for
191.24 essential human services is collected from counties or service delivery authorities and used
191.25 to inform a variety of stakeholders and to improve performance over time.

191.26 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single
191.27 county, or consortium of counties operating by execution of a joint powers agreement
191.28 under section 471.59 or other contractual agreement, that has voluntarily chosen by
191.29 resolution of the county board of commissioners to participate in the redesign under this
191.30 chapter or has been assigned by the commissioner pursuant to section 402A.18. A service
191.31 delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen
191.32 by resolution of tribal government to participate in redesign under this chapter.

191.33 Subd. 6. **Steering committee.** "Steering committee" means the Steering Committee
191.34 on Performance and Outcome Reforms.

192.1 Sec. 14. **[402A.12] ESTABLISHMENT OF A PERFORMANCE MANAGEMENT**
192.2 **SYSTEM FOR HUMAN SERVICES.**

192.3 By January 1, 2014, the commissioner shall implement a performance management
192.4 system for essential human services as described in sections 402A.15 to 402A.18 that
192.5 includes initial performance measures and standards consistent with the recommendations
192.6 of the Steering Committee on Performance and Outcome Reforms in the December 2012
192.7 report to the legislature.

192.8 Sec. 15. **[402A.16] HUMAN SERVICES PERFORMANCE COUNCIL.**

192.9 Subdivision 1. **Establishment.** By October 1, 2013, the commissioner shall convene
192.10 a Human Services Performance Council to advise the commissioner on the implementation
192.11 and operation of the performance management system for human services.

192.12 Subd. 2. **Duties.** The Human Services Performance Council shall:

192.13 (1) hold meetings at least quarterly that are in compliance with Minnesota's Open
192.14 Meeting Law under chapter 13D;

192.15 (2) annually review the annual performance data submitted by counties or service
192.16 delivery authorities;

192.17 (3) review and advise the commissioner on department procedures related to the
192.18 implementation of the performance management system and system process requirements
192.19 and on barriers to process improvement in human services delivery;

192.20 (4) advise the commissioner on the training and technical assistance needs of county
192.21 or service delivery authority and department personnel;

192.22 (5) review instances in which a county or service delivery authority has not made
192.23 adequate progress on a performance improvement plan and make recommendations to
192.24 the commissioner under section 402A.18;

192.25 (6) consider appeals from counties or service delivery authorities that are in the
192.26 remedies process and make recommendations to the commissioner on resolving the issue;

192.27 (7) convene working groups to update and develop outcomes, measures, and
192.28 performance standards for the performance management system and, on an annual basis,
192.29 present these recommendations to the commissioner, including recommendations on when
192.30 a particular essential human service program has a balanced set of program measures
192.31 in place;

192.32 (8) make recommendations on human services administrative rules or statutes that
192.33 could be repealed in order to improve service delivery;

192.34 (9) provide information to stakeholders on the council's role and regularly collect
192.35 stakeholder input on performance management system performance; and

193.1 (10) submit an annual report to the legislature and the commissioner, which
193.2 includes a comprehensive report on the performance of individual counties or service
193.3 delivery authorities as it relates to system measures; a list of counties or service delivery
193.4 authorities that have been required to create performance improvement plans and the areas
193.5 identified for improvement as part of the remedies process; a summary of performance
193.6 improvement training and technical assistance activities offered to the county personnel
193.7 by the department; recommendations on administrative rules or state statutes that could be
193.8 repealed in order to improve service delivery; recommendations for system improvements,
193.9 including updates to system outcomes, measures, and standards; and a response from
193.10 the commissioner.

193.11 Subd. 3. **Membership.** (a) Human Services Performance Council membership shall
193.12 be equally balanced among the following five stakeholder groups: the Association of
193.13 Minnesota Counties, the Minnesota Association of County Social Service Administrators,
193.14 the Department of Human Services, tribes and communities of color, and service providers
193.15 and advocates for persons receiving human services. The Association of Minnesota
193.16 Counties and the Minnesota Association of County Social Service Administrators shall
193.17 appoint their own respective representatives. The commissioner of human services shall
193.18 appoint representatives of the Department of Human Services, tribes and communities of
193.19 color, and social services providers and advocates. Minimum council membership shall
193.20 be 15 members, with at least three representatives from each stakeholder group, and
193.21 maximum council membership shall be 20 members, with four representatives from
193.22 each stakeholder group.

193.23 (b) Notwithstanding section 15.059, Human Services Performance Council members
193.24 shall be appointed for a minimum of two years, but may serve longer terms at the
193.25 discretion of their appointing authority.

193.26 (c) Notwithstanding section 15.059, members of the council shall receive no
193.27 compensation for their services.

193.28 (d) A commissioner's representative and a county representative from either the
193.29 Association of Minnesota Counties or the Minnesota Association of County Social Service
193.30 Administrators shall serve as Human Services Performance Council cochairs.

193.31 Subd. 4. **Commissioner duties.** The commissioner shall:

193.32 (1) implement and maintain the performance management system for human services;

193.33 (2) establish and regularly update the system's outcomes, measures, and standards,
193.34 including the minimum performance standard for each performance measure;

193.35 (3) determine when a particular program has a balanced set of measures;

194.1 (4) receive reports from counties or service delivery authorities at least annually on
 194.2 their performance against system measures, provide counties with data needed to assess
 194.3 performance and monitor progress, and provide timely feedback to counties or service
 194.4 delivery authorities on their performance;

194.5 (5) implement and monitor the remedies process in section 402A.18;

194.6 (6) report to the Human Services Performance Council on county or service delivery
 194.7 authority performance on a semiannual basis;

194.8 (7) provide general training and technical assistance to counties or service delivery
 194.9 authorities on topics related to performance measurement and performance improvement;

194.10 (8) provide targeted training and technical assistance to counties or service delivery
 194.11 authorities that supports their performance improvement plans; and

194.12 (9) provide staff support for the Human Services Performance Council.

194.13 Subd. 5. County or service delivery authority duties. The counties or service
 194.14 delivery authorities shall:

194.15 (1) report performance data to meet performance management system requirements;

194.16 and

194.17 (2) provide training to personnel on basic principles of performance measurement
 194.18 and improvement and participate in training provided by the department.

194.19 Sec. 16. Minnesota Statutes 2012, section 402A.18, is amended to read:

194.20 **402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET**
 194.21 **PERFORMANCE OUTCOMES.**

194.22 Subdivision 1. **Underperforming county; specific service.** If the commissioner
 194.23 determines that a county or service delivery authority is deficient in achieving minimum
 194.24 performance ~~outcomes~~ standards for a specific essential ~~service~~ human services program,
 194.25 the commissioner may impose the following remedies and adjust state and federal
 194.26 program allocations accordingly:

194.27 (1) voluntary incorporation of the administration and operation of the specific
 194.28 essential ~~service~~ human services program with an existing service delivery authority or
 194.29 another county. A service delivery authority or county incorporating an underperforming
 194.30 county shall not be financially liable for the costs associated with remedying performance
 194.31 outcome deficiencies;

194.32 (2) mandatory incorporation of the administration and operation of the specific
 194.33 essential ~~service~~ human services program with an existing service delivery authority or
 194.34 another county. A service delivery authority or county incorporating an underperforming

195.1 county shall not be financially liable for the costs associated with remedying performance
195.2 outcome deficiencies; or

195.3 (3) transfer of authority for program administration and operation of the specific
195.4 essential ~~service~~ human services program to the commissioner.

195.5 Subd. 2. **Underperforming county; more than one-half of services.** If the
195.6 commissioner determines that a county or service delivery authority is deficient in
195.7 achieving minimum performance ~~outcomes~~ standards for more than one-half of the defined
195.8 essential human services programs, the commissioner may impose the following remedies:

195.9 (1) voluntary incorporation of the administration and operation of essential human
195.10 services programs with an existing service delivery authority or another county. A
195.11 service delivery authority or county incorporating an underperforming county shall
195.12 not be financially liable for the costs associated with remedying performance outcome
195.13 deficiencies;

195.14 (2) mandatory incorporation of the administration and operation of essential human
195.15 services programs with an existing service delivery authority or another county. A
195.16 service delivery authority or county incorporating an underperforming county shall
195.17 not be financially liable for the costs associated with remedying performance outcome
195.18 deficiencies; or

195.19 (3) transfer of authority for ~~program~~ administration and operation of essential human
195.20 services programs to the commissioner.

195.21 Subd. 2a. **Financial responsibility of underperforming county.** A county subject
195.22 to remedies under subdivision 1 or 2 shall provide to the entity assuming administration
195.23 of the ~~essential service~~ or essential human services program or programs the amount of
195.24 nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

195.25 Subd. 3. **Conditions prior to imposing remedies.** ~~Before the commissioner may~~
195.26 ~~impose the remedies authorized under this section, the following conditions must be met:~~

195.27 (1) ~~the county or service delivery authority determined by the commissioner~~
195.28 ~~to be deficient in achieving minimum performance outcomes has the opportunity, in~~
195.29 ~~coordination with the council, to develop a program outcome improvement plan. The~~
195.30 ~~program outcome improvement plan must be developed no later than six months from the~~
195.31 ~~date of the deficiency determination; and~~

195.32 (2) ~~the council has conducted an assessment of the program outcome improvement~~
195.33 ~~plan to determine if the county or service delivery authority has made satisfactory progress~~
195.34 ~~toward performance outcomes and has made a recommendation about remedies to the~~
195.35 ~~commissioner. The assessment and recommendation must be made to the commissioner~~
195.36 ~~within 12 months from the date of the deficiency determination. (a) The commissioner~~

196.1 shall notify a county or service delivery authority that it must submit a performance
196.2 improvement plan if:

196.3 (1) the county or service delivery authority does not meet the minimum performance
196.4 standard for a measure; or

196.5 (2) the county or service delivery authority does not meet the minimum performance
196.6 standard for one or more racial or ethnic subgroup for which there is a statistically valid
196.7 population size for three or more measures, even if the county or service delivery authority
196.8 met the standard for the overall population.

196.9 The commissioner must approve the performance improvement plan. The county or
196.10 service delivery authority may negotiate the terms of the performance improvement plan
196.11 with the commissioner.

196.12 (b) When the department determines that a county or service delivery authority does
196.13 not meet the minimum performance standard for a given measure, the commissioner
196.14 must advise the county or service delivery authority that fiscal penalties may result if the
196.15 performance does not improve. The department must offer technical assistance to the
196.16 county or service delivery authority. Within 30 days of the initial advisement from the
196.17 department, the county or service delivery authority may claim and the department may
196.18 approve an extenuating circumstance that relieves the county or service delivery authority
196.19 of any further remedy. If a county or service delivery authority has a small number of
196.20 participants in an essential human services program such that reliable measurement is
196.21 not possible, the commissioner may approve extenuating circumstances or may average
196.22 performance over three years.

196.23 (c) If there are no extenuating circumstances, the county or service delivery authority
196.24 must submit a performance improvement plan to the commissioner within 60 days of the
196.25 initial advisement from the department. The term of the performance improvement plan
196.26 must be two years, starting with the date the plan is approved by the commissioner. This
196.27 plan must include a target level for improvement for each measure that did not meet
196.28 the minimum performance standard. The commissioner must approve the performance
196.29 improvement plan within 60 days of submittal.

196.30 (d) The department must monitor the performance improvement plan for two
196.31 years. After two years, if the county or service delivery authority meets the minimum
196.32 performance standard, there is no further remedy. If the county or service delivery
196.33 authority fails to meet the minimum performance standard, but meets the improvement
196.34 target in the performance improvement plan, the county or service delivery authority shall
196.35 modify the performance improvement plan for further improvement and the department
196.36 shall continue to monitor the plan.

197.1 (e) If, after two years of monitoring, the county or service delivery authority fails to
197.2 meet both the minimum performance standard and the improvement target identified in
197.3 the performance improvement plan, the next step of the remedies process shall be invoked
197.4 by the commissioner. This phase of the remedies process may include:

197.5 (1) fiscal penalties for the county or service delivery authority that do not exceed
197.6 one percent of the county's human services expenditures and that are negotiated in the
197.7 performance improvement plan, based on what is needed to improve outcomes. Counties
197.8 or service delivery authorities must reinvest the amount of the fiscal penalty into the
197.9 essential human services program that was underperforming. A county or service delivery
197.10 authority shall not be required to pay more than three fiscal penalties in a year; and

197.11 (2) the department's provision of technical assistance to the county or service
197.12 delivery authority that is targeted to address the specific performance issues.

197.13 The commissioner shall continue monitoring the performance improvement plan for a
197.14 third year.

197.15 (f) If, after the third year of monitoring, the county or service delivery authority
197.16 meets the minimum performance standard, there is no further remedy. If the county or
197.17 service delivery authority fails to meet the minimum performance standard, but meets the
197.18 improvement target for the performance improvement plan, the county or service delivery
197.19 authority shall modify the performance improvement plan for further improvement and
197.20 the department shall continue to monitor the plan.

197.21 (g) If, after the third year of monitoring, the county or service delivery authority fails
197.22 to meet the minimum performance standard and the improvement target identified in the
197.23 performance improvement plan, the Human Services Performance Council shall review
197.24 the situation and recommend a course of action to the commissioner.

197.25 (h) If the commissioner has determined that a program has a balanced set of program
197.26 measures and a county or service delivery authority is subject to fiscal penalties for more
197.27 than one-half of the measures for that program, the commissioner may apply further
197.28 remedies as described in subdivisions 1 and 2.

197.29 **Sec. 17. INSTRUCTIONS TO THE COMMISSIONER.**

197.30 In collaboration with labor organizations, the commissioner of human services shall
197.31 develop clear and consistent standards for state-operated services programs to:

197.32 (1) address direct service staffing shortages;

197.33 (2) identify and help resolve workplace safety issues; and

197.34 (3) elevate the use and visibility of performance measures and objectives related to
197.35 overtime use.

198.1 **ARTICLE 6**198.2 **HEALTH CARE**

198.3 Section 1. Minnesota Statutes 2012, section 245.03, subdivision 1, is amended to read:

198.4 Subdivision 1. **Establishment.** There is created a Department of Human Services.

198.5 A commissioner of human services shall be appointed by the governor under the

198.6 provisions of section 15.06. The commissioner shall be selected on the basis of ability and

198.7 experience in welfare and without regard to political affiliations. The commissioner shall

198.8 may appoint a up to two deputy commissioner commissioners.

198.9 Sec. 2. Minnesota Statutes 2012, section 256.9657, subdivision 3, is amended to read:

198.10 Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a)

198.11 Effective October 1, 1992, each health maintenance organization with a certificate of

198.12 authority issued by the commissioner of health under chapter 62D and each community

198.13 integrated service network licensed by the commissioner under chapter 62N shall pay to

198.14 the commissioner of human services a surcharge equal to six-tenths of one percent of the

198.15 total premium revenues of the health maintenance organization or community integrated

198.16 service network as reported to the commissioner of health according to the schedule in

198.17 subdivision 4.

198.18 (b) For purposes of this subdivision, total premium revenue means:

198.19 (1) premium revenue recognized on a prepaid basis from individuals and groups

198.20 for provision of a specified range of health services over a defined period of time which

198.21 is normally one month, excluding premiums paid to a health maintenance organization

198.22 or community integrated service network from the Federal Employees Health Benefit

198.23 Program;

198.24 (2) premiums from Medicare wraparound subscribers for health benefits which

198.25 supplement Medicare coverage;

198.26 (3) Medicare revenue, as a result of an arrangement between a health maintenance

198.27 organization or a community integrated service network and the Centers for Medicare

198.28 and Medicaid Services of the federal Department of Health and Human Services, for

198.29 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited

198.30 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social

198.31 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and

198.32 1395w-24, respectively, as they may be amended from time to time; and

199.1 (4) medical assistance revenue, as a result of an arrangement between a health
199.2 maintenance organization or community integrated service network and a Medicaid state
199.3 agency, for services to a medical assistance beneficiary.

199.4 If advance payments are made under clause (1) or (2) to the health maintenance
199.5 organization or community integrated service network for more than one reporting period,
199.6 the portion of the payment that has not yet been earned must be treated as a liability.

199.7 (c) When a health maintenance organization or community integrated service
199.8 network merges or consolidates with or is acquired by another health maintenance
199.9 organization or community integrated service network, the surviving corporation or the
199.10 new corporation shall be responsible for the annual surcharge originally imposed on
199.11 each of the entities or corporations subject to the merger, consolidation, or acquisition,
199.12 regardless of whether one of the entities or corporations does not retain a certificate of
199.13 authority under chapter 62D or a license under chapter 62N.

199.14 (d) Effective ~~July 1~~ June 15 of each year, the surviving corporation's or the new
199.15 corporation's surcharge shall be based on the revenues earned in the ~~second~~ previous
199.16 calendar year by all of the entities or corporations subject to the merger, consolidation,
199.17 or acquisition regardless of whether one of the entities or corporations does not retain a
199.18 certificate of authority under chapter 62D or a license under chapter 62N until the total
199.19 premium revenues of the surviving corporation include the total premium revenues of all
199.20 the merged entities as reported to the commissioner of health.

199.21 (e) When a health maintenance organization or community integrated service
199.22 network, which is subject to liability for the surcharge under this chapter, transfers,
199.23 assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability
199.24 for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer
199.25 of the health maintenance organization or community integrated service network.

199.26 (f) In the event a health maintenance organization or community integrated service
199.27 network converts its licensure to a different type of entity subject to liability for the
199.28 surcharge under this chapter, but survives in the same or substantially similar form, the
199.29 surviving entity remains liable for the surcharge regardless of whether one of the entities
199.30 or corporations does not retain a certificate of authority under chapter 62D or a license
199.31 under chapter 62N.

199.32 (g) The surcharge assessed to a health maintenance organization or community
199.33 integrated service network ends when the entity ceases providing services for premiums
199.34 and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

199.35 Sec. 3. Minnesota Statutes 2012, section 256.9657, subdivision 4, is amended to read:

200.1 Subd. 4. **Payments into the account.** (a) Payments to the commissioner under
 200.2 ~~subdivisions~~ subdivision 1 to 3 must be paid in monthly installments due on the 15th of
 200.3 the month beginning October 15, 1992. The monthly payment must be equal to the annual
 200.4 surcharge divided by 12. ~~Payments to the commissioner under subdivisions 2 and 3 for~~
 200.5 ~~fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each~~
 200.6 ~~year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues~~
 200.7 ~~earned in the second previous calendar year.~~

200.8 (b) Effective October 15, 2014, payment to the commissioner under subdivision 2
 200.9 must be paid in nine monthly installments due on the 15th of the month beginning October
 200.10 15, 2014, through June 15 of the following year. The monthly payment must be equal
 200.11 to the annual surcharge divided by nine.

200.12 ~~(b)~~ (c) Effective October 1, ~~1995~~ 2014, and each October 1 thereafter, the payments
 200.13 in ~~subdivisions~~ subdivision 2 and 3 must be based on revenues earned in the previous
 200.14 calendar year.

200.15 ~~(e)~~ (d) If the commissioner of health does not provide by August 15 of any year data
 200.16 needed to update the base year for the hospital ~~and~~ or April 15 of any year data needed to
 200.17 update the base year for the health maintenance organization surcharges, the commissioner
 200.18 of human services may estimate base year revenue and use that estimate for the purposes
 200.19 of this section until actual data is provided by the commissioner of health.

200.20 ~~(d)~~ (e) Payments to the commissioner under subdivision 3a must be paid in monthly
 200.21 installments due on the 15th of the month beginning July 15, 2003. The monthly payment
 200.22 must be equal to the annual surcharge divided by 12.

200.23 (f) Payments due in July through September 2014 under subdivision 3 for revenue
 200.24 earned in calendar year 2012 shall be paid in a lump sum on June 15, 2014. On June
 200.25 15, 2014, each health maintenance organization and community-integrated service
 200.26 network shall pay all payments under subdivision 3 in a lump sum for revenue earned in
 200.27 calendar year 2013. Effective June 15, 2015, and each June 15 thereafter, the payments in
 200.28 subdivision 3 shall be based on revenues earned in the previous calendar year and paid
 200.29 in a lump sum on June 15 of each year.

200.30 Sec. 4. Minnesota Statutes 2012, section 256.969, subdivision 29, is amended to read:

200.31 Subd. 29. **Reimbursement for the fee increase for the early hearing detection**
 200.32 **and intervention program.** (a) For admissions occurring on or after July 1, 2010,
 200.33 payment rates shall be adjusted to include the increase to the fee that is effective on July 1,
 200.34 2010, for the early hearing detection and intervention program recipients under section
 200.35 144.125, subdivision 1, that is paid by the hospital for public program recipients. This

201.1 payment increase shall be in effect until the increase is fully recognized in the base year
201.2 cost under subdivision 2b. This payment shall be included in payments to contracted
201.3 managed care organizations.

201.4 (b) For admissions occurring on or after July 1, 2013, payment rates shall be adjusted
201.5 to include the increase to the fee that is effective July 1, 2013, for the early hearing
201.6 detection and intervention program under section 144.125, subdivision 1, paragraph (d),
201.7 that is paid by the hospital for medical assistance and MinnesotaCare program enrollees.
201.8 This payment increase shall be in effect until the increase is fully recognized in the
201.9 base-year cost under subdivision 2b. This payment shall be included in payments to
201.10 managed care plans and county-based purchasing plans.

201.11 Sec. 5. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
201.12 to read:

201.13 Subd. 22. **Medical assistance costs for certain inmates.** The commissioner shall
201.14 execute an interagency agreement with the commissioner of corrections to recover the
201.15 state cost attributable to medical assistance eligibility for inmates of public institutions
201.16 admitted to a medical institution on an inpatient basis. The annual amount to be transferred
201.17 from the Department of Corrections under the agreement must include all eligible state
201.18 medical assistance costs, including administrative costs incurred by the Department of
201.19 Human Services, attributable to inmates under state and county jurisdiction admitted to
201.20 medical institutions on an inpatient basis that are related to the implementation of section
201.21 256B.055, subdivision 14, paragraph (c).

201.22 Sec. 6. Minnesota Statutes 2012, section 256B.055, subdivision 14, is amended to read:

201.23 **Subd. 14. Persons detained by law.** (a) Medical assistance may be paid for an
201.24 inmate of a correctional facility who is conditionally released as authorized under section
201.25 241.26, 244.065, or 631.425, if the individual does not require the security of a public
201.26 detention facility and is housed in a halfway house or community correction center, or
201.27 under house arrest and monitored by electronic surveillance in a residence approved
201.28 by the commissioner of corrections, and if the individual meets the other eligibility
201.29 requirements of this chapter.

201.30 (b) An individual who is enrolled in medical assistance, and who is charged with a
201.31 crime and incarcerated for less than 12 months shall be suspended from eligibility at the
201.32 time of incarceration until the individual is released. Upon release, medical assistance
201.33 eligibility is reinstated without reapplication using a reinstatement process and form, if the
201.34 individual is otherwise eligible.

202.1 (c) An individual, regardless of age, who is considered an inmate of a public
202.2 institution as defined in Code of Federal Regulations, title 42, section 435.1010, and
202.3 who meets the eligibility requirements in section 256B.056, is not eligible for medical
202.4 assistance, except for covered services received while an inpatient in a medical institution
202.5 as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues,
202.6 including costs, related to the inpatient treatment of an inmate are the responsibility of the
202.7 entity with jurisdiction over the inmate.

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

202.9 Sec. 7. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

203.3 (c) All qualified noncitizens who were residing in the United States before August
203.4 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
203.5 medical assistance with federal financial participation.

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

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

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

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

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

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

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

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

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

203.34 (g) For purposes of this subdivision, the term "emergency medical condition" means
203.35 a medical condition that meets the requirements of United States Code, title 42, section
203.36 1396b(v).

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

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

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

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

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

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

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

204.15 (iii) services for routine prenatal care;

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

204.18 (v) elective surgery;

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

204.21 (vii) preventative health care and family planning services;

204.22 ~~(viii) dialysis;~~

204.23 ~~(ix) chemotherapy or therapeutic radiation services;~~

204.24 ~~(x) (viii) rehabilitation services;~~

204.25 ~~(xi) (ix) physical, occupational, or speech therapy;~~

204.26 ~~(xii) (x) transportation services;~~

204.27 ~~(xiii) (xi) case management;~~

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

204.29 ~~(xv) (xiii) dental services;~~

204.30 ~~(xvi) (xiv) hospice care;~~

204.31 ~~(xvii) (xv) audiology services and hearing aids;~~

204.32 ~~(xviii) (xvi) podiatry services;~~

204.33 ~~(xix) (xvii) chiropractic services;~~

204.34 ~~(xx) (xviii) immunizations;~~

204.35 ~~(xxi) (xix) vision services and eyeglasses;~~

204.36 ~~(xxii) (xx) waiver services;~~

205.1 ~~(xxiii)~~ (xxi) individualized education programs; or

205.2 ~~(xxiv)~~ (xxii) chemical dependency treatment.

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

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

205.17 (k) Notwithstanding paragraph (h), clause (2), the following services are covered as
205.18 emergency medical conditions under paragraph (f) except where coverage is prohibited
205.19 under federal law:

205.20 (1) dialysis services provided in a hospital or freestanding dialysis facility; and

205.21 (2) surgery and the administration of chemotherapy, radiation, and related services
205.22 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission
205.23 and requires surgery, chemotherapy, or radiation treatment.

205.24 (l) Effective July 1, 2013, recipients of emergency medical assistance under this
205.25 subdivision are eligible for coverage of the elderly waiver services provided under section
205.26 256B.0915, and coverage of rehabilitative services provided in a nursing facility. The
205.27 age limit for elderly waiver services does not apply. In order to qualify for coverage, a
205.28 recipient of emergency medical assistance is subject to the assessment and reassessment
205.29 requirements of section 256B.0911. Initial and continued enrollment under this paragraph
205.30 is subject to the limits of available funding.

205.31 **EFFECTIVE DATE.** This section is effective July 1, 2013.

205.32 Sec. 8. Minnesota Statutes 2012, section 256B.0625, subdivision 9, is amended to read:

205.33 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

205.34 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
205.35 following services:

- 206.1 (1) comprehensive exams, limited to once every five years;
- 206.2 (2) periodic exams, limited to one per year;
- 206.3 (3) limited exams;
- 206.4 (4) bitewing x-rays, limited to one per year;
- 206.5 (5) periapical x-rays;
- 206.6 (6) panoramic x-rays, limited to one every five years except (1) when medically
- 206.7 necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma
- 206.8 or (2) once every two years for patients who cannot cooperate for intraoral film due to
- 206.9 a developmental disability or medical condition that does not allow for intraoral film
- 206.10 placement;
- 206.11 (7) prophylaxis, limited to one per year;
- 206.12 (8) application of fluoride varnish, limited to one per year;
- 206.13 (9) posterior fillings, all at the amalgam rate;
- 206.14 (10) anterior fillings;
- 206.15 (11) endodontics, limited to root canals on the anterior and premolars only;
- 206.16 (12) removable prostheses, each dental arch limited to one every six years;
- 206.17 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of
- 206.18 abscesses;
- 206.19 (14) palliative treatment and sedative fillings for relief of pain; and
- 206.20 (15) full-mouth debridement, limited to one every five years.
- 206.21 (c) In addition to the services specified in paragraph (b), medical assistance
- 206.22 covers the following services for adults, if provided in an outpatient hospital setting or
- 206.23 freestanding ambulatory surgical center as part of outpatient dental surgery:
- 206.24 (1) periodontics, limited to periodontal scaling and root planing once every two years;
- 206.25 (2) general anesthesia; and
- 206.26 (3) full-mouth survey once every five years.
- 206.27 (d) Medical assistance covers medically necessary dental services for children and
- 206.28 pregnant women. The following guidelines apply:
- 206.29 (1) posterior fillings are paid at the amalgam rate;
- 206.30 (2) application of sealants are covered once every five years per permanent molar for
- 206.31 children only;
- 206.32 (3) application of fluoride varnish is covered once every six months; and
- 206.33 (4) orthodontia is eligible for coverage for children only.
- 206.34 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance
- 206.35 covers the following services for adults:
- 206.36 (1) house calls or extended care facility calls for on-site delivery of covered services;

207.1 (2) behavioral management when additional staff time is required to accommodate
207.2 behavioral challenges and sedation is not used;

207.3 (3) oral or IV sedation, if the covered dental service cannot be performed safely
207.4 without it or would otherwise require the service to be performed under general anesthesia
207.5 in a hospital or surgical center; and

207.6 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
207.7 no more than four times per year.

207.8 Sec. 9. Minnesota Statutes 2012, section 256B.0625, subdivision 13, is amended to read:

207.9 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs
207.10 when specifically used to enhance fertility, if prescribed by a licensed practitioner and
207.11 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance
207.12 program as a dispensing physician, or by a physician, physician assistant, or a nurse
207.13 practitioner employed by or under contract with a community health board as defined in
207.14 section 145A.02, subdivision 5, for the purposes of communicable disease control.

207.15 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
207.16 unless authorized by the commissioner.

207.17 (c) For the purpose of this subdivision and subdivision 13d, an "active
207.18 pharmaceutical ingredient" is defined as a substance that is represented for use in a drug
207.19 and when used in the manufacturing, processing, or packaging of a drug becomes an
207.20 active ingredient of the drug product. An "excipient" is defined as an inert substance
207.21 used as a diluent or vehicle for a drug. The commissioner shall establish a list of active
207.22 pharmaceutical ingredients and excipients which are included in the medical assistance
207.23 formulary. Medical assistance covers selected active pharmaceutical ingredients and
207.24 excipients used in compounded prescriptions when the compounded combination is
207.25 specifically approved by the commissioner or when a commercially available product:

207.26 (1) is not a therapeutic option for the patient;

207.27 (2) does not exist in the same combination of active ingredients in the same strengths
207.28 as the compounded prescription; and

207.29 (3) cannot be used in place of the active pharmaceutical ingredient in the
207.30 compounded prescription.

207.31 (d) Medical assistance covers the following over-the-counter drugs when prescribed
207.32 by a licensed practitioner or by a licensed pharmacist who meets standards established by
207.33 the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen,
207.34 family planning products, aspirin, insulin, products for the treatment of lice, vitamins for
207.35 adults with documented vitamin deficiencies, vitamins for children under the age of seven

208.1 and pregnant or nursing women, and any other over-the-counter drug identified by the
208.2 commissioner, in consultation with the formulary committee, as necessary, appropriate,
208.3 and cost-effective for the treatment of certain specified chronic diseases, conditions,
208.4 or disorders, and this determination shall not be subject to the requirements of chapter
208.5 14. A pharmacist may prescribe over-the-counter medications as provided under this
208.6 paragraph for purposes of receiving reimbursement under Medicaid. When prescribing
208.7 over-the-counter drugs under this paragraph, licensed pharmacists must consult with
208.8 the recipient to determine necessity, provide drug counseling, review drug therapy
208.9 for potential adverse interactions, and make referrals as needed to other health care
208.10 professionals. Over-the-counter medications must be dispensed in a quantity that is the
208.11 lower of: (1) the number of dosage units contained in the manufacturer's original package;
208.12 and (2) the number of dosage units required to complete the patient's course of therapy.

208.13 (e) Effective January 1, 2006, medical assistance shall not cover drugs that
208.14 are coverable under Medicare Part D as defined in the Medicare Prescription Drug,
208.15 Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e),
208.16 for individuals eligible for drug coverage as defined in the Medicare Prescription
208.17 Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section
208.18 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the
208.19 drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this
208.20 subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code,
208.21 title 42, section 1396r-8(d)(2)(E), shall not be covered.

208.22 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
208.23 Program and dispensed by 340B covered entities and ambulatory pharmacies under
208.24 common ownership of the 340B covered entity. Medical assistance does not cover drugs
208.25 acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract
208.26 pharmacies.

208.27 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to
208.28 read:

208.29 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
208.30 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable
208.31 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
208.32 charged to the public. The amount of payment basis must be reduced to reflect all discount
208.33 amounts applied to the charge by any provider/insurer agreement or contract for submitted
208.34 charges to medical assistance programs. The net submitted charge may not be greater
208.35 than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65,

209.1 except that the dispensing fee for intravenous solutions which must be compounded by
209.2 the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and
209.3 \$30 per bag for total parenteral nutritional products dispensed in one liter quantities,
209.4 or \$44 per bag for total parenteral nutritional products dispensed in quantities greater
209.5 than one liter. Actual acquisition cost includes quantity and other special discounts
209.6 except time and cash discounts. The actual acquisition cost of a drug shall be estimated
209.7 by the commissioner at wholesale acquisition cost plus four percent for independently
209.8 owned pharmacies located in a designated rural area within Minnesota, and at wholesale
209.9 acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently
209.10 owned" if it is one of four or fewer pharmacies under the same ownership nationally. A
209.11 "designated rural area" means an area defined as a small rural area or isolated rural area
209.12 according to the four-category classification of the Rural Urban Commuting Area system
209.13 developed for the United States Health Resources and Services Administration. Effective
209.14 January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B
209.15 Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition
209.16 cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list
209.17 price for a drug or biological to wholesalers or direct purchasers in the United States, not
209.18 including prompt pay or other discounts, rebates, or reductions in price, for the most
209.19 recent month for which information is available, as reported in wholesale price guides or
209.20 other publications of drug or biological pricing data. The maximum allowable cost of a
209.21 multisource drug may be set by the commissioner and it shall be comparable to, but no
209.22 higher than, the maximum amount paid by other third-party payors in this state who have
209.23 maximum allowable cost programs. Establishment of the amount of payment for drugs
209.24 shall not be subject to the requirements of the Administrative Procedure Act.

209.25 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
209.26 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
209.27 facilities when a unit dose blister card system, approved by the department, is used. Under
209.28 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The
209.29 National Drug Code (NDC) from the drug container used to fill the blister card must be
209.30 identified on the claim to the department. The unit dose blister card containing the drug
209.31 must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that
209.32 govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will
209.33 be required to credit the department for the actual acquisition cost of all unused drugs that
209.34 are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in
209.35 a quantity that is less than a 30-day supply.

210.1 (c) Whenever a maximum allowable cost has been set for a multisource drug,
210.2 payment shall be the lower of the usual and customary price charged to the public or the
210.3 maximum allowable cost established by the commissioner unless prior authorization
210.4 for the brand name product has been granted according to the criteria established by
210.5 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the
210.6 prescriber has indicated "dispense as written" on the prescription in a manner consistent
210.7 with section 151.21, subdivision 2.

210.8 (d) The basis for determining the amount of payment for drugs administered in an
210.9 outpatient setting shall be the lower of the usual and customary cost submitted by the
210.10 provider or, 106 percent of the average sales price as determined by the United States
210.11 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
210.12 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
210.13 set by the commissioner. If average sales price is unavailable, the amount of payment
210.14 must be lower of the usual and customary cost submitted by the provider or, the wholesale
210.15 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the
210.16 commissioner. Effective January 1, 2014, the commissioner shall discount the payment
210.17 rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The
210.18 payment for drugs administered in an outpatient setting shall be made to the administering
210.19 facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration
210.20 in an outpatient setting is not eligible for direct reimbursement.

210.21 (e) The commissioner may negotiate lower reimbursement rates for specialty
210.22 pharmacy products than the rates specified in paragraph (a). The commissioner may
210.23 require individuals enrolled in the health care programs administered by the department
210.24 to obtain specialty pharmacy products from providers with whom the commissioner has
210.25 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
210.26 used by a small number of recipients or recipients with complex and chronic diseases
210.27 that require expensive and challenging drug regimens. Examples of these conditions
210.28 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
210.29 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
210.30 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
210.31 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
210.32 that require complex care. The commissioner shall consult with the formulary committee
210.33 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
210.34 with the formulary committee in developing this list, the commissioner shall take into
210.35 consideration the population served by specialty pharmacy products, the current delivery

211.1 system and standard of care in the state, and access to care issues. The commissioner shall
211.2 have the discretion to adjust the reimbursement rate to prevent access to care issues.

211.3 (f) Home infusion therapy services provided by home infusion therapy pharmacies
211.4 must be paid at rates according to subdivision 8d.

211.5 **EFFECTIVE DATE.** This section is effective July 1, 2013.

211.6 Sec. 11. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
211.7 subdivision to read:

211.8 **Subd. 28b. Doula services.** Medical assistance covers doula services provided by a
211.9 certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For
211.10 purposes of this section, "doula services" means childbirth education and support services,
211.11 including emotional and physical support provided during pregnancy, labor, birth, and
211.12 postpartum.

211.13 **EFFECTIVE DATE.** This section is effective July 1, 2014, or upon federal
211.14 approval, whichever is later, and applies to services provided on or after the effective date.

211.15 Sec. 12. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to
211.16 read:

211.17 **Subd. 31. Medical supplies and equipment.** (a) Medical assistance covers medical
211.18 supplies and equipment. Separate payment outside of the facility's payment rate shall
211.19 be made for wheelchairs and wheelchair accessories for recipients who are residents
211.20 of intermediate care facilities for the developmentally disabled. Reimbursement for
211.21 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same
211.22 conditions and limitations as coverage for recipients who do not reside in institutions. A
211.23 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
211.24 The commissioner may set reimbursement rates for specified categories of medical
211.25 supplies at levels below the Medicare payment rate.

211.26 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
211.27 must enroll as a Medicare provider.

211.28 (c) When necessary to ensure access to durable medical equipment, prosthetics,
211.29 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
211.30 enrollment requirement if:

211.31 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
211.32 orthotic, or medical supply;

211.33 (2) the vendor serves ten or fewer medical assistance recipients per year;

212.1 (3) the commissioner finds that other vendors are not available to provide same or
212.2 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

212.3 (4) the vendor complies with all screening requirements in this chapter and Code of
212.4 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
212.5 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
212.6 and Medicaid Services approved national accreditation organization as complying with
212.7 the Medicare program's supplier and quality standards and the vendor serves primarily
212.8 pediatric patients.

212.9 (d) Durable medical equipment means a device or equipment that:

212.10 (1) can withstand repeated use;

212.11 (2) is generally not useful in the absence of an illness, injury, or disability; and

212.12 (3) is provided to correct or accommodate a physiological disorder or physical
212.13 condition or is generally used primarily for a medical purpose.

212.14 (e) Electronic tablets may be considered durable medical equipment if the electronic
212.15 tablet will be used as an augmentative and alternative communication system as defined
212.16 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device
212.17 must be locked in order to prevent use not related to communication.

212.18 Sec. 13. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
212.19 subdivision to read:

212.20 Subd. 31b. Preferred diabetic testing supply program. (a) The commissioner
212.21 shall implement a point-of-sale preferred diabetic testing supply program by January 1,
212.22 2014. Medical assistance coverage for diabetic testing supplies shall conform to the
212.23 limitations established under the program. The commissioner may enter into a contract
212.24 with a vendor for the purpose of participating in a preferred diabetic testing supply list and
212.25 supplemental rebate program. The commissioner shall ensure that any contract meets all
212.26 federal requirements and maximizes federal financial participation. The commissioner
212.27 shall maintain an accurate and up-to-date list on the department's Web site.

212.28 (b) The commissioner may add to, delete from, and otherwise modify the preferred
212.29 diabetic testing supply program drug list after consulting with the Drug Formulary
212.30 Committee and appropriate medical specialists and providing public notice and the
212.31 opportunity for public comment.

212.32 (c) The commissioner shall adopt and administer the preferred diabetic testing
212.33 supply program as part of the administration of the diabetic testing supply rebate program.
212.34 Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply
212.35 list may be subject to prior authorization.

213.1 (d) All claims for diabetic testing supplies in categories on the preferred diabetic
213.2 testing supply list must be submitted by enrolled pharmacy providers using the most
213.3 current National Council of Prescription Drug Plans electronic claims standard.

213.4 (e) For purposes of this subdivision, "preferred diabetic testing supply list" means a
213.5 list of diabetic testing supplies selected by the commissioner, for which prior authorization
213.6 is not required.

213.7 (f) The commissioner shall seek any federal waivers or approvals necessary to
213.8 implement this subdivision.

213.9 Sec. 14. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to
213.10 read:

213.11 Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines
213.12 within the scope of their licensure, and who are enrolled as a medical assistance provider,
213.13 must enroll in the pediatric vaccine administration program established by section 13631
213.14 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an~~
213.15 ~~\$8.50 fee per dose~~ for administration of the vaccine to children eligible for medical
213.16 assistance. Medical assistance does not pay for vaccines that are available at no cost from
213.17 the pediatric vaccine administration program.

213.18 Sec. 15. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to
213.19 read:

213.20 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**
213.21 Medical assistance covers early and periodic screening, diagnosis, and treatment services
213.22 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges
213.23 for vaccines that are available at no cost to the provider and shall not exceed the rate
213.24 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

213.25 Sec. 16. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
213.26 subdivision to read:

213.27 Subd. 61. **Payment for multiple services provided on the same day.** The
213.28 commissioner shall not prohibit payment, including supplemental payments, for mental
213.29 health services or dental services provided to a patient by a clinic or health care
213.30 professional solely because the mental health or dental services were provided on the same
213.31 day as other covered health services furnished by the same provider.

213.32 Sec. 17. Minnesota Statutes 2012, section 256B.0631, subdivision 1, is amended to read:

214.1 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
214.2 assistance benefit plan shall include the following cost-sharing for all recipients, effective
214.3 for services provided on or after September 1, 2011:

214.4 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes
214.5 of this subdivision, a visit means an episode of service which is required because of
214.6 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
214.7 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
214.8 midwife, advanced practice nurse, audiologist, optician, or optometrist;

214.9 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that
214.10 this co-payment shall be increased to \$20 upon federal approval;

214.11 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
214.12 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
214.13 shall apply to antipsychotic drugs when used for the treatment of mental illness;

214.14 (4) effective January 1, 2012, a family deductible equal to the maximum amount
214.15 allowed under Code of Federal Regulations, title 42, part 447.54; and

214.16 (5) for individuals identified by the commissioner with income at or below 100
214.17 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five
214.18 percent of family income. For purposes of this paragraph, family income is the total
214.19 earned and unearned income of the individual and the individual's spouse, if the spouse is
214.20 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

214.21 (b) Recipients of medical assistance are responsible for all co-payments and
214.22 deductibles in this subdivision.

214.23 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
214.24 process under sections 256B.69 and 256B.692, may allow managed care plans and
214.25 county-based purchasing plans to waive the family deductible under paragraph (a),
214.26 clause (4). The value of the family deductible shall not be included in the capitation
214.27 payment to managed care plans and county-based purchasing plans. Managed care plans
214.28 and county-based purchasing plans shall certify annually to the commissioner the dollar
214.29 value of the family deductible.

214.30 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of
214.31 the family deductible described under paragraph (a), clause (4), from individuals and
214.32 allow long-term care and waived service providers to assume responsibility for payment.

214.33 (e) Notwithstanding paragraph (b), the commissioner, through the contracting
214.34 process under section 256B.0756 shall allow the pilot program in Hennepin County to
214.35 waive co-payments. The value of the co-payments shall not be included in the capitation
214.36 payment amount to the integrated health care delivery networks under the pilot program.

215.1 Sec. 18. Minnesota Statutes 2012, section 256B.0756, is amended to read:

215.2 **256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.**

215.3 (a) The commissioner, upon federal approval of a new waiver request or amendment
215.4 of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey
215.5 County, or both, to test alternative and innovative integrated health care delivery networks.

215.6 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
215.7 medical assistance under section 256B.055, ~~subdivision 15~~, and who reside in Hennepin
215.8 County or Ramsey County. The commissioner may identify individuals to be enrolled in
215.9 the Hennepin County pilot program based on zip code in Hennepin County or whether the
215.10 individuals would benefit from an integrated health care delivery network.

215.11 (c) Individuals enrolled in the pilot program shall be enrolled in an integrated
215.12 health care delivery network in their county of residence. The integrated health care
215.13 delivery network in Hennepin County shall be a network, such as an accountable care
215.14 organization or a community-based collaborative care network, created by or including
215.15 Hennepin County Medical Center. The integrated health care delivery network in Ramsey
215.16 County shall be a network, such as an accountable care organization or community-based
215.17 collaborative care network, created by or including Regions Hospital.

215.18 ~~(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for~~
215.19 ~~Hennepin County and 3,500 enrollees for Ramsey County.~~

215.20 ~~(e)~~ (d) In developing a payment system for the pilot programs, the commissioner
215.21 shall establish a total cost of care for the recipients enrolled in the pilot programs that
215.22 equals the cost of care that would otherwise be spent for these enrollees in the prepaid
215.23 medical assistance program.

215.24 ~~(f) Counties may transfer funds necessary to support the nonfederal share of~~
215.25 ~~payments for integrated health care delivery networks in their county. Such transfers per~~
215.26 ~~county shall not exceed 15 percent of the expected expenses for county enrollees.~~

215.27 ~~(g)~~ (e) The commissioner shall apply to the federal government for, or as appropriate,
215.28 cooperate with counties, providers, or other entities that are applying for any applicable
215.29 grant or demonstration under the Patient Protection and Affordable Health Care Act, Public
215.30 Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law
215.31 111-152, that would further the purposes of or assist in the creation of an integrated health
215.32 care delivery network for the purposes of this subdivision, including, but not limited to, a
215.33 global payment demonstration or the community-based collaborative care network grants.

215.34 Sec. 19. Minnesota Statutes 2012, section 256B.196, subdivision 2, is amended to read:

216.1 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and
216.2 subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital
216.3 services upper payment limit for nonstate government hospitals. The commissioner shall
216.4 then determine the amount of a supplemental payment to Hennepin County Medical
216.5 Center and Regions Hospital for these services that would increase medical assistance
216.6 spending in this category to the aggregate upper payment limit for all nonstate government
216.7 hospitals in Minnesota. In making this determination, the commissioner shall allot the
216.8 available increases between Hennepin County Medical Center and Regions Hospital
216.9 based on the ratio of medical assistance fee-for-service outpatient hospital payments to
216.10 the two facilities. The commissioner shall adjust this allotment as necessary based on
216.11 federal approvals, the amount of intergovernmental transfers received from Hennepin and
216.12 Ramsey Counties, and other factors, in order to maximize the additional total payments.
216.13 The commissioner shall inform Hennepin County and Ramsey County of the periodic
216.14 intergovernmental transfers necessary to match federal Medicaid payments available
216.15 under this subdivision in order to make supplementary medical assistance payments to
216.16 Hennepin County Medical Center and Regions Hospital equal to an amount that when
216.17 combined with existing medical assistance payments to nonstate governmental hospitals
216.18 would increase total payments to hospitals in this category for outpatient services to
216.19 the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon
216.20 receipt of these periodic transfers, the commissioner shall make supplementary payments
216.21 to Hennepin County Medical Center and Regions Hospital.

216.22 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
216.23 determine an upper payment limit for physicians and other billing professionals affiliated
216.24 with Hennepin County Medical Center and with Regions Hospital. The upper payment
216.25 limit shall be based on the average commercial rate or be determined using another method
216.26 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
216.27 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers
216.28 necessary to match the federal Medicaid payments available under this subdivision in order
216.29 to make supplementary payments to physicians and other billing professionals affiliated
216.30 with Hennepin County Medical Center and to make supplementary payments to physicians
216.31 and other billing professionals affiliated with Regions Hospital through HealthPartners
216.32 Medical Group equal to the difference between the established medical assistance
216.33 payment for physician and other billing professional services and the upper payment limit.
216.34 Upon receipt of these periodic transfers, the commissioner shall make supplementary
216.35 payments to physicians and other billing professionals affiliated with Hennepin County

217.1 Medical Center and shall make supplementary payments to physicians and other billing
217.2 professionals affiliated with Regions Hospital through HealthPartners Medical Group.

217.3 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make
217.4 monthly voluntary intergovernmental transfers to the commissioner in amounts not to
217.5 exceed \$12,000,000 per year from Hennepin County and \$6,000,000 per year from
217.6 Ramsey County. The commissioner shall increase the medical assistance capitation
217.7 payments to any licensed health plan under contract with the medical assistance program
217.8 that agrees to make enhanced payments to Hennepin County Medical Center or Regions
217.9 Hospital. The increase shall be in an amount equal to the annual value of the monthly
217.10 transfers plus federal financial participation, with each health plan receiving its pro rata
217.11 share of the increase based on the pro rata share of medical assistance admissions to
217.12 Hennepin County Medical Center and Regions Hospital by those plans. Upon the request
217.13 of the commissioner, health plans shall submit individual-level cost data for verification
217.14 purposes. The commissioner may ratably reduce these payments on a pro rata basis in
217.15 order to satisfy federal requirements for actuarial soundness. If payments are reduced,
217.16 transfers shall be reduced accordingly. Any licensed health plan that receives increased
217.17 medical assistance capitation payments under the intergovernmental transfer described in
217.18 this paragraph shall increase its medical assistance payments to Hennepin County Medical
217.19 Center and Regions Hospital by the same amount as the increased payments received in
217.20 the capitation payment described in this paragraph.

217.21 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
217.22 determine an upper payment limit for ambulance services affiliated with Hennepin County
217.23 Medical Center and the city of St. Paul. The upper payment limit shall be based on
217.24 the average commercial rate or be determined using another method acceptable to the
217.25 Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin
217.26 County and the city of St. Paul of the periodic intergovernmental transfers necessary to
217.27 match the federal Medicaid payments available under this subdivision in order to make
217.28 supplementary payments to Hennepin County Medical Center and the city of St. Paul
217.29 equal to the difference between the established medical assistance payment for ambulance
217.30 services and the upper payment limit. Upon receipt of these periodic transfers, the
217.31 commissioner shall make supplementary payments to Hennepin County Medical Center
217.32 and the city of St. Paul.

217.33 (e) The commissioner shall inform the transferring governmental entities on an
217.34 ongoing basis of the need for any changes needed in the intergovernmental transfers in
217.35 order to continue the payments under paragraphs (a) to ~~(e)~~ (d), at their maximum level,

218.1 including increases in upper payment limits, changes in the federal Medicaid match, and
218.2 other factors.

218.3 ~~(e)~~ (f) The payments in paragraphs (a) to ~~(e)~~ (d) shall be implemented independently
218.4 of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

218.5 Sec. 20. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:

218.6 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
218.7 services shall transfer each year to the medical education and research fund established
218.8 under section 62J.692, an amount specified in this subdivision. The commissioner shall
218.9 calculate the following:

218.10 (1) an amount equal to the reduction in the prepaid medical assistance payments as
218.11 specified in this clause. Until January 1, 2002, the county medical assistance capitation
218.12 base rate prior to plan specific adjustments and after the regional rate adjustments under
218.13 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
218.14 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
218.15 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
218.16 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining
218.17 metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing
218.18 facility and elderly waiver payments and demonstration project payments operating
218.19 under subdivision 23 are excluded from this reduction. The amount calculated under
218.20 this clause shall not be adjusted for periods already paid due to subsequent changes to
218.21 the capitation payments;

218.22 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this
218.23 section;

218.24 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates
218.25 paid under this section; and

218.26 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid
218.27 under this section.

218.28 (b) This subdivision shall be effective upon approval of a federal waiver which
218.29 allows federal financial participation in the medical education and research fund. The
218.30 amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount
218.31 transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under
218.32 paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally
218.33 reduce the amount specified under paragraph (a), clause (1).

218.34 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
218.35 shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

219.1 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the
219.2 transfer under paragraph (c), the commissioner shall transfer to the medical education
219.3 research fund \$23,936,000 in fiscal years 2012 and 2013 and ~~\$36,744,000~~ \$49,552,000 in
219.4 fiscal year 2014 and thereafter.

219.5 Sec. 21. Minnesota Statutes 2012, section 256B.69, subdivision 5i, is amended to read:

219.6 Subd. 5i. **Administrative expenses.** (a) Managed care plan and county-based
219.7 purchasing plan administrative costs for a prepaid health plan provided under this section
219.8 or section 256B.692 must not exceed by more than five percent that prepaid health plan's
219.9 or county-based purchasing plan's actual calculated administrative spending for the
219.10 previous calendar year as a percentage of total revenue. The penalty for exceeding this
219.11 limit must be the amount of administrative spending in excess of 105 percent of the actual
219.12 calculated amount. The commissioner may waive this penalty if the excess administrative
219.13 spending is the result of unexpected shifts in enrollment or member needs or new program
219.14 requirements.

219.15 (b) ~~Expenses listed under section 62D.12, subdivision 9a, clause (4), are not~~
219.16 ~~allowable administrative expenses for rate-setting purposes under this section, unless~~
219.17 ~~approved by the commissioner.~~ The following expenses are not allowable administrative
219.18 expenses for rate-setting purposes under this section:

219.19 (1) charitable contributions made by the managed care plan or the county-based
219.20 purchasing plan;

219.21 (2) any portion of an individual's compensation in excess of \$200,000 paid by the
219.22 managed care plan or county-based purchasing plan;

219.23 (3) any penalties or fines assessed against the managed care plan or county-based
219.24 purchasing plan; and

219.25 (4) any indirect marketing or advertising expenses of the managed care plan or
219.26 county-based purchasing plan.

219.27 For the purposes of this subdivision, compensation includes salaries, bonuses and
219.28 incentives, other reportable compensation on an IRS 990 form, retirement and other
219.29 deferred compensation, and nontaxable benefits.

219.30 Sec. 22. Minnesota Statutes 2012, section 256B.69, subdivision 9c, is amended to read:

219.31 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect
219.32 detailed data regarding financials, provider payments, provider rate methodologies, and
219.33 other data as determined by the commissioner ~~and managed care and county-based~~
219.34 ~~purchasing plans that are required to be submitted under this section.~~ The commissioner,

220.1 in consultation with the commissioners of health and commerce, and in consultation
220.2 with managed care plans and county-based purchasing plans, shall set uniform criteria,
220.3 definitions, and standards for the data to be submitted, and shall require managed care and
220.4 county-based purchasing plans to comply with these criteria, definitions, and standards
220.5 when submitting data under this section. In carrying out the responsibilities of this
220.6 subdivision, the commissioner shall ensure that the data collection is implemented in an
220.7 integrated and coordinated manner that avoids unnecessary duplication of effort. To the
220.8 extent possible, the commissioner shall use existing data sources and streamline data
220.9 collection in order to reduce public and private sector administrative costs. Nothing in
220.10 this subdivision shall allow release of information that is nonpublic data pursuant to
220.11 section 13.02.

220.12 (b) Effective January 1, 2014, each managed care and county-based purchasing plan
220.13 must ~~annually~~ quarterly provide to the commissioner the following information on state
220.14 public programs, in the form and manner specified by the commissioner, according to
220.15 guidelines developed by the commissioner in consultation with managed care plans and
220.16 county-based purchasing plans under contract:

220.17 (1) an income statement by program;

220.18 (2) financial statement footnotes;

220.19 (3) quarterly profitability by program and population group;

220.20 (4) a medical liability summary by program and population group;

220.21 (5) received but unpaid claims report by program;

220.22 (6) services versus payment lags by program for hospital services, outpatient
220.23 services, physician services, other medical services, and pharmaceutical benefits;

220.24 (7) utilization reports that summarize utilization and unit cost information by
220.25 program for hospitalization services, outpatient services, physician services, and other
220.26 medical services;

220.27 (8) pharmaceutical statistics by program and population group for measures of price
220.28 and utilization of pharmaceutical services;

220.29 (9) subcapitation expenses by population group;

220.30 (10) third-party payments by program;

220.31 (11) all new, active, and closed subrogation cases by program;

220.32 (12) all new, active, and closed fraud and abuse cases by program;

220.33 (13) medical loss ratios by program;

220.34 ~~(14)~~ (14) administrative expenses by category and subcategory consistent with
220.35 administrative expense reporting by program that reconcile to other state and federal
220.36 regulatory agencies, by program;

221.1 ~~(2)~~ (15) revenues by program, including investment income;
 221.2 ~~(3)~~ (16) nonadministrative service payments, provider payments, and reimbursement
 221.3 rates by provider type or service category, by program, paid by the managed care plan
 221.4 under this section or the county-based purchasing plan under section 256B.692 to
 221.5 providers and vendors for administrative services under contract with the plan, including
 221.6 but not limited to:

221.7 (i) individual-level provider payment and reimbursement rate data;
 221.8 (ii) provider reimbursement rate methodologies by provider type, by program,
 221.9 including a description of alternative payment arrangements and payments outside the
 221.10 claims process;
 221.11 (iii) data on implementation of legislatively mandated provider rate changes; and
 221.12 (iv) individual-level provider payment and reimbursement rate data and plan-specific
 221.13 provider reimbursement rate methodologies by provider type, by program, including
 221.14 alternative payment arrangements and payments outside the claims process, provided to
 221.15 the commissioner under this subdivision are nonpublic data as defined in section 13.02;
 221.16 ~~(4)~~ (17) data on the amount of reinsurance or transfer of risk by program; and
 221.17 ~~(5)~~ (18) contribution to reserve, by program.

221.18 (c) In the event a report is published or released based on data provided under
 221.19 this subdivision, the commissioner shall provide the report to managed care plans and
 221.20 county-based purchasing plans ~~30~~ 15 days prior to the publication or release of the report.
 221.21 Managed care plans and county-based purchasing plans shall have ~~30~~ 15 days to review
 221.22 the report and provide comment to the commissioner.

221.23 The quarterly reports shall be submitted to the commissioner no later than 60 days after the
 221.24 end of the previous quarter, except the fourth-quarter report, which shall be submitted by
 221.25 April 1 of each year. The fourth-quarter report shall include audited financial statements,
 221.26 parent company audited financial statements, an income statement reconciliation report,
 221.27 and any other documentation necessary to reconcile the detailed reports to the audited
 221.28 financial statements.

221.29 Sec. 23. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

221.30 Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner
 221.31 shall reduce payments and limit future rate increases paid to managed care plans and
 221.32 county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved
 221.33 on a statewide aggregate basis by program. The commissioner may use competitive
 221.34 bidding, payment reductions, or other reductions to achieve the reductions and limits
 221.35 in this subdivision.

222.1 (b) Beginning September 1, 2011, the commissioner shall reduce payments to
222.2 managed care plans and county-based purchasing plans as follows:

222.3 (1) 2.0 percent for medical assistance elderly basic care. This shall not apply
222.4 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
222.5 services;

222.6 (2) 2.82 percent for medical assistance families and children;

222.7 (3) 10.1 percent for medical assistance adults without children; and

222.8 (4) 6.0 percent for MinnesotaCare families and children.

222.9 (c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed
222.10 care plans and county-based purchasing plans for calendar year 2012 to a percentage of
222.11 the rates in effect on August 31, 2011, as follows:

222.12 (1) 98 percent for medical assistance elderly basic care. This shall not apply to
222.13 Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
222.14 services;

222.15 (2) 97.18 percent for medical assistance families and children;

222.16 (3) 89.9 percent for medical assistance adults without children; and

222.17 (4) 94 percent for MinnesotaCare families and children.

222.18 (d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit
222.19 the maximum annual trend increases to rates paid to managed care plans and county-based
222.20 purchasing plans as follows:

222.21 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply
222.22 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
222.23 services;

222.24 (2) 5.0 percent for medical assistance special needs basic care;

222.25 (3) 2.0 percent for medical assistance families and children;

222.26 (4) 3.0 percent for medical assistance adults without children;

222.27 (5) 3.0 percent for MinnesotaCare families and children; and

222.28 (6) 3.0 percent for MinnesotaCare adults without children.

222.29 (e) The commissioner may limit trend increases to less than the maximum.

222.30 Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases
222.31 to rates paid to managed care plans and county-based purchasing plans as follows for
222.32 calendar years 2014 and 2015:

222.33 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply
222.34 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
222.35 services;

222.36 (2) 5.0 percent for medical assistance special needs basic care;

- 223.1 (3) 2.0 percent for medical assistance families and children;
223.2 (4) 3.0 percent for medical assistance adults without children;
223.3 (5) 3.0 percent for MinnesotaCare families and children; and
223.4 (6) 4.0 percent for MinnesotaCare adults without children.

223.5 The commissioner may limit trend increases to less than the maximum. For calendar
223.6 year 2014, the commissioner shall reduce the maximum aggregate trend increases by
223.7 \$47,000,000 in state and federal funds to account for the reductions in administrative
223.8 expenses in subdivision 5i.

223.9 Sec. 24. Minnesota Statutes 2012, section 256B.69, is amended by adding a
223.10 subdivision to read:

223.11 Subd. 35. **Supplemental recovery program.** The commissioner shall conduct a
223.12 supplemental recovery program for third-party liabilities not recovered by managed care
223.13 plans and county-based purchasing plans for state public health programs. Any third-party
223.14 liability identified and recovered by the commissioner more than six months after the date
223.15 a managed care plan or county-based purchasing plan receives a health care claim shall
223.16 be retained by the commissioner and deposited in the general fund. The commissioner
223.17 shall establish a mechanism for managed care plans and county-based purchasing plans to
223.18 coordinate third-party liability collections efforts with the commissioner to ensure there
223.19 is no duplication of efforts. The coordination mechanism must be consistent with the
223.20 reporting requirements in subdivision 9c.

223.21 Sec. 25. Minnesota Statutes 2012, section 256B.76, subdivision 1, is amended to read:

223.22 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
223.23 or after October 1, 1992, the commissioner shall make payments for physician services
223.24 as follows:

223.25 (1) payment for level one Centers for Medicare and Medicaid Services' common
223.26 procedural coding system codes titled "office and other outpatient services," "preventive
223.27 medicine new and established patient," "delivery, antepartum, and postpartum care,"
223.28 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
223.29 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
223.30 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
223.31 30, 1992. If the rate on any procedure code within these categories is different than the
223.32 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
223.33 then the larger rate shall be paid;

224.1 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
224.2 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

224.3 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
224.4 percentile of 1989, less the percent in aggregate necessary to equal the above increases
224.5 except that payment rates for home health agency services shall be the rates in effect
224.6 on September 30, 1992.

224.7 (b) Effective for services rendered on or after January 1, 2000, payment rates for
224.8 physician and professional services shall be increased by three percent over the rates
224.9 in effect on December 31, 1999, except for home health agency and family planning
224.10 agency services. The increases in this paragraph shall be implemented January 1, 2000,
224.11 for managed care.

224.12 (c) Effective for services rendered on or after July 1, 2009, payment rates for
224.13 physician and professional services shall be reduced by five percent, except that for the
224.14 period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent
224.15 for the medical assistance and general assistance medical care programs, over the rates in
224.16 effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply
224.17 to office or other outpatient visits, preventive medicine visits and family planning visits
224.18 billed by physicians, advanced practice nurses, or physician assistants in a family planning
224.19 agency or in one of the following primary care practices: general practice, general internal
224.20 medicine, general pediatrics, general geriatrics, and family medicine. This reduction
224.21 and the reductions in paragraph (d) do not apply to federally qualified health centers,
224.22 rural health centers, and Indian health services. Effective October 1, 2009, payments
224.23 made to managed care plans and county-based purchasing plans under sections 256B.69,
224.24 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

224.25 (d) Effective for services rendered on or after July 1, 2010, payment rates for
224.26 physician and professional services shall be reduced an additional seven percent over
224.27 the five percent reduction in rates described in paragraph (c). This additional reduction
224.28 does not apply to physical therapy services, occupational therapy services, and speech
224.29 pathology and related services provided on or after July 1, 2010. This additional reduction
224.30 does not apply to physician services billed by a psychiatrist or an advanced practice nurse
224.31 with a specialty in mental health. Effective October 1, 2010, payments made to managed
224.32 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
224.33 256L.12 shall reflect the payment reduction described in this paragraph.

224.34 (e) Effective for services rendered on or after September 1, 2011, through June 30,
224.35 2013, payment rates for physician and professional services shall be reduced three percent

225.1 from the rates in effect on August 31, 2011. This reduction does not apply to physical
225.2 therapy services, occupational therapy services, and speech pathology and related services.

225.3 (f) Effective for services rendered on or after September 1, 2014, payment rates for
225.4 physician and professional services, including physical therapy, occupational therapy,
225.5 speech pathology, and mental health services shall be increased by five percent from the
225.6 rates in effect on August 31, 2014. In calculating this rate increase, the commissioner
225.7 shall not include in the base rate for August 31, 2014, the rate increase provided under
225.8 section 256B.76, subdivision 7. This increase does not apply to federally qualified health
225.9 centers, rural health centers, and Indian health services. Payments made to managed
225.10 care plans and county-based purchasing plans shall not be adjusted to reflect payments
225.11 under this paragraph.

225.12 Sec. 26. Minnesota Statutes 2012, section 256B.76, subdivision 2, is amended to read:

225.13 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after
225.14 October 1, 1992, the commissioner shall make payments for dental services as follows:

225.15 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
225.16 percent above the rate in effect on June 30, 1992; and

225.17 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
225.18 percentile of 1989, less the percent in aggregate necessary to equal the above increases.

225.19 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
225.20 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

225.21 (c) Effective for services rendered on or after January 1, 2000, payment rates for
225.22 dental services shall be increased by three percent over the rates in effect on December
225.23 31, 1999.

225.24 (d) Effective for services provided on or after January 1, 2002, payment for
225.25 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
225.26 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

225.27 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
225.28 2000, for managed care.

225.29 (f) Effective for dental services rendered on or after October 1, 2010, by a
225.30 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
225.31 on the Medicare principles of reimbursement. This payment shall be effective for services
225.32 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
225.33 county-based purchasing plans.

225.34 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
225.35 in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal

226.1 year, a supplemental state payment equal to the difference between the total payments
226.2 in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated
226.3 services for the operation of the dental clinics.

226.4 (h) If the cost-based payment system for state-operated dental clinics described in
226.5 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
226.6 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
226.7 receive the critical access dental reimbursement rate as described under subdivision 4,
226.8 paragraph (a).

226.9 (i) Effective for services rendered on or after September 1, 2011, through June 30,
226.10 2013, payment rates for dental services shall be reduced by three percent. This reduction
226.11 does not apply to state-operated dental clinics in paragraph (f).

226.12 (j) Effective for services rendered on or after January 1, 2014, payment rates for
226.13 dental services shall be increased by five percent from the rates in effect on December
226.14 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
226.15 federally qualified health centers, rural health centers, and Indian health services. Effective
226.16 January 1, 2014, payments made to managed care plans and county-based purchasing
226.17 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
226.18 described in this paragraph.

226.19 Sec. 27. Minnesota Statutes 2012, section 256B.76, subdivision 4, is amended to read:

226.20 Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered
226.21 on or after January 1, 2002, the commissioner shall increase reimbursements to dentists
226.22 and dental clinics deemed by the commissioner to be critical access dental providers.
226.23 For dental services rendered on or after July 1, 2007, the commissioner shall increase
226.24 reimbursement by ~~30~~35 percent above the reimbursement rate that would otherwise be
226.25 paid to the critical access dental provider. The commissioner shall pay the managed
226.26 care plans and county-based purchasing plans in amounts sufficient to reflect increased
226.27 reimbursements to critical access dental providers as approved by the commissioner.

226.28 (b) The commissioner shall designate the following dentists and dental clinics as
226.29 critical access dental providers:

226.30 (1) nonprofit community clinics that:

226.31 (i) have nonprofit status in accordance with chapter 317A;

226.32 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
226.33 501(c)(3);

226.34 (iii) are established to provide oral health services to patients who are low income,
226.35 uninsured, have special needs, and are underserved;

- 227.1 (iv) have professional staff familiar with the cultural background of the clinic's
227.2 patients;
- 227.3 (v) charge for services on a sliding fee scale designed to provide assistance to
227.4 low-income patients based on current poverty income guidelines and family size;
- 227.5 (vi) do not restrict access or services because of a patient's financial limitations
227.6 or public assistance status; and
- 227.7 (vii) have free care available as needed;
- 227.8 (2) federally qualified health centers, rural health clinics, and public health clinics;
- 227.9 (3) city or county owned and operated hospital-based dental clinics;
- 227.10 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
227.11 accordance with chapter 317A with more than 10,000 patient encounters per year with
227.12 patients who are uninsured or covered by medical assistance, ~~general assistance medical~~
227.13 ~~care~~, or MinnesotaCare; ~~and~~
- 227.14 (5) a dental clinic owned and operated by the University of Minnesota or the
227.15 Minnesota State Colleges and Universities system; and
- 227.16 (6) private practicing dentists if:
- 227.17 (i) the dentist's office is located within a health professional shortage area as defined
227.18 under Code of Federal Regulations, title 42, part 5, and United States Code, title 42,
227.19 section 254E;
- 227.20 (ii) more than 50 percent of the dentist's patient encounters per year are with patients
227.21 who are uninsured or covered by medical assistance or MinnesotaCare;
- 227.22 (iii) the dentist does not restrict access or services because of a patient's financial
227.23 limitations or public assistance status; and
- 227.24 (iv) the level of service provided by the dentist is critical to maintaining adequate
227.25 levels of patient access within the service area in which the dentist operates.
- 227.26 ~~(e) The commissioner may designate a dentist or dental clinic as a critical access~~
227.27 ~~dental provider if the dentist or dental clinic is willing to provide care to patients covered~~
227.28 ~~by medical assistance, general assistance medical care, or MinnesotaCare at a level which~~
227.29 ~~significantly increases access to dental care in the service area.~~
- 227.30 ~~(d)~~ (c) A designated critical access clinic shall receive the reimbursement rate
227.31 specified in paragraph (a) for dental services provided off site at a private dental office if
227.32 the following requirements are met:
- 227.33 (1) the designated critical access dental clinic is located within a health professional
227.34 shortage area as defined under Code of Federal Regulations, title 42, part 5, and United
227.35 States Code, title 42, section 254E, and is located outside the seven-county metropolitan
227.36 area;

228.1 (2) the designated critical access dental clinic is not able to provide the service
228.2 and refers the patient to the off-site dentist;

228.3 (3) the service, if provided at the critical access dental clinic, would be reimbursed
228.4 at the critical access reimbursement rate;

228.5 (4) the dentist and allied dental professionals providing the services off site are
228.6 licensed and in good standing under chapter 150A;

228.7 (5) the dentist providing the services is enrolled as a medical assistance provider;

228.8 (6) the critical access dental clinic submits the claim for services provided off site
228.9 and receives the payment for the services; and

228.10 (7) the critical access dental clinic maintains dental records for each claim submitted
228.11 under this paragraph, including the name of the dentist, the off-site location, and the
228.12 license number of the dentist and allied dental professionals providing the services.

228.13 Sec. 28. Minnesota Statutes 2012, section 256B.76, is amended by adding a
228.14 subdivision to read:

228.15 **Subd. 7. Payment for certain primary care services and immunization**
228.16 **administration.** Payment for certain primary care services and immunization
228.17 administration services rendered on or after January 1, 2013, through December 31, 2014,
228.18 shall be made in accordance with section 1902(a)(13) of the Social Security Act.

228.19 Sec. 29. Minnesota Statutes 2012, section 256B.764, is amended to read:

228.20 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

228.21 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
228.22 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,
228.23 when these services are provided by a community clinic as defined in section 145.9268,
228.24 subdivision 1.

228.25 (b) Effective for services rendered on or after July 1, 2013, payment rates for
228.26 family planning services shall be increased by 20 percent over the rates in effect June
228.27 30, 2013, when these services are provided by a community clinic as defined in section
228.28 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care
228.29 and county-based purchasing plans to reflect this increase, and shall require plans to pass
228.30 on the full amount of the rate increase to eligible community clinics, in the form of higher
228.31 payment rates for family planning services.

228.32 Sec. 30. Minnesota Statutes 2012, section 256B.766, is amended to read:

228.33 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

229.1 (a) Effective for services provided on or after July 1, 2009, total payments for basic
229.2 care services, shall be reduced by three percent, except that for the period July 1, 2009,
229.3 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
229.4 assistance and general assistance medical care programs, prior to third-party liability and
229.5 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
229.6 therapy services, occupational therapy services, and speech-language pathology and
229.7 related services as basic care services. The reduction in this paragraph shall apply to
229.8 physical therapy services, occupational therapy services, and speech-language pathology
229.9 and related services provided on or after July 1, 2010.

229.10 (b) Payments made to managed care plans and county-based purchasing plans shall
229.11 be reduced for services provided on or after October 1, 2009, to reflect the reduction
229.12 effective July 1, 2009, and payments made to the plans shall be reduced effective October
229.13 1, 2010, to reflect the reduction effective July 1, 2010.

229.14 (c) Effective for services provided on or after September 1, 2011, through June 30,
229.15 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
229.16 from the rates in effect on August 31, 2011.

229.17 (d) Effective for services provided on or after September 1, 2011, through June
229.18 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
229.19 and durable medical equipment not subject to a volume purchase contract, prosthetics
229.20 and orthotics, renal dialysis services, laboratory services, public health nursing services,
229.21 physical therapy services, occupational therapy services, speech therapy services,
229.22 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
229.23 purchase contract, and anesthesia services, and hospice services shall be reduced by three
229.24 percent from the rates in effect on August 31, 2011.

229.25 (e) Effective for services provided on or after September 1, 2014, payments for
229.26 ambulatory surgery centers facility fees, medical supplies and durable medical equipment
229.27 not subject to a volume purchase contract, prosthetics and orthotics, hospice services, renal
229.28 dialysis services, laboratory services, public health nursing services, eyeglasses not subject
229.29 to a volume purchase contract, and hearing aids not subject to a volume purchase contract
229.30 shall be increased by three percent and payments for outpatient hospital facility fees shall
229.31 be increased by three percent. Payments made to managed care plans and county-based
229.32 purchasing plans shall not be adjusted to reflect payments under this paragraph.

229.33 (e) (f) This section does not apply to physician and professional services, inpatient
229.34 hospital services, family planning services, mental health services, dental services,
229.35 prescription drugs, medical transportation, federally qualified health centers, rural health
229.36 centers, Indian health services, and Medicare cost-sharing.

230.1 Sec. 31. Minnesota Statutes 2012, section 256B.767, is amended to read:

230.2 **256B.767 MEDICARE PAYMENT LIMIT.**

230.3 (a) Effective for services rendered on or after July 1, 2010, fee-for-service payment
230.4 rates for physician and professional services under section 256B.76, subdivision 1, and
230.5 basic care services subject to the rate reduction specified in section 256B.766, shall not
230.6 exceed the Medicare payment rate for the applicable service, as adjusted for any changes
230.7 in Medicare payment rates after July 1, 2010. The commissioner shall implement this
230.8 section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates
230.9 under this section by first reducing or eliminating provider rate add-ons.

230.10 (b) This section does not apply to services provided by advanced practice certified
230.11 nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter
230.12 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates
230.13 for advanced practice certified nurse midwives and licensed traditional midwives shall
230.14 equal and shall not exceed the medical assistance payment rate to physicians for the
230.15 applicable service.

230.16 (c) This section does not apply to mental health services or physician services billed
230.17 by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

230.18 (d) Effective for durable medical equipment, prosthetics, orthotics, or supplies
230.19 provided on or after July 1, 2013, through June 30, 2014, the payment rate for items
230.20 that are subject to the rates established under Medicare's National Competitive Bidding
230.21 Program shall be equal to the rate that applies to the same item when not subject to the
230.22 rate established under Medicare's National Competitive Bidding Program. This paragraph
230.23 does not apply to mail order diabetic supplies and does not apply to items provided to
230.24 dually eligible recipients when Medicare is the primary payer of the item.

230.25 Sec. 32. Laws 2013, chapter 1, section 6, is amended to read:

230.26 Sec. 6. **TRANSFER.**

230.27 (a) The commissioner of management and budget shall transfer from the health care
230.28 access fund to the general fund up to \$21,319,000 in fiscal year 2014; up to \$42,314,000
230.29 in fiscal year 2015; up to \$56,147,000 in fiscal year 2016; and up to \$64,683,000 in fiscal
230.30 year 2017.

230.31 (b) The commissioner of human services shall determine the difference between the
230.32 actual or forecasted cost to the medical assistance program of adding 19- and 20-year-olds
230.33 and parents and relative caretaker populations with income between 100 and 138 percent of
230.34 the federal poverty guidelines and the cost of adding those populations that was estimated
230.35 during the 2013 legislative session based on the data from the February 2013 forecast.

231.1 (c) For each fiscal year from 2014 to 2017, the commissioner of human services
231.2 shall certify and report to the commissioner of management and budget the actual
231.3 or forecasted cost difference of adding 19- and 20-year-olds and parents and relative
231.4 caretaker populations with income between 100 and 138 percent of the federal poverty
231.5 guidelines, as determined under paragraph (b), to the commissioner of management and
231.6 budget at least four weeks prior to the release of a forecast under Minnesota Statutes,
231.7 section 16A.103, of each fiscal year.

231.8 (d) No later than three weeks before the release of the forecast under Minnesota
231.9 Statutes, section 16A.103, the commissioner of management and budget shall reduce the
231.10 health care access fund transfer in paragraph (a), by the cumulative differences in costs
231.11 reported by the commissioner of human services under paragraph (c). If, for any fiscal
231.12 year, the amount of the cumulative cost differences determined under paragraph (b) is
231.13 positive, no change is made to the appropriation. If, for any fiscal year, the amount of the
231.14 cumulative cost differences determined under paragraph (b) is less than the amount of the
231.15 original appropriation, the appropriation for that year must be zero.

231.16 **Sec. 33. REQUEST FOR INFORMATION; EMERGENCY MEDICAL**
231.17 **ASSISTANCE AND THE UNINSURED STUDY.**

231.18 (a) The commissioner of human services, in consultation with safety net hospitals,
231.19 nonprofit health care coverage programs, nonprofit community clinics, counties, and other
231.20 interested parties, shall identify alternatives and make recommendations for providing
231.21 coordinated and cost-effective health care and coverage to individuals who:

231.22 (1) meet eligibility standards for emergency medical assistance; or

231.23 (2) are uninsured and ineligible for other state public health care programs, have
231.24 incomes below 400 percent of the federal poverty level, and are ineligible for premium
231.25 credits through the Minnesota Insurance Marketplace as defined under Minnesota Statutes,
231.26 section 62V.02.

231.27 (b) The commissioner of human services shall issue a request for information
231.28 to help identify options for coverage of medically necessary services not eligible for
231.29 federal financial participation for emergency medical assistance recipients and medically
231.30 necessary services for individuals who are uninsured and ineligible for other state public
231.31 health care programs or coverage through the Minnesota Insurance Marketplace. The
231.32 request for information shall provide:

231.33 (1) the identification of services, including community-based medical, dental, and
231.34 behavioral health services, necessary to reduce emergency department and inpatient
231.35 hospital utilization for these recipients;

232.1 (2) delivery system options, including for each option how the system would be
232.2 organized to promote care coordination and cost-effectiveness, and how the system would
232.3 be available statewide;

232.4 (3) funding options and payment mechanisms to encourage providers to manage
232.5 the delivery of care to these populations at a lower cost of care and with better patient
232.6 outcomes than the current system;

232.7 (4) how the funding and delivery of services will be coordinated with the services
232.8 covered under emergency medical assistance;

232.9 (5) options for administration of eligibility determination and service delivery; and

232.10 (6) evaluation methods to measure cost-effectiveness and health outcomes that take
232.11 into consideration the social determinants of health care for recipients participating in
232.12 this alternative coverage option.

232.13 (c) The commissioner shall issue a request for information by August 1, 2013, and
232.14 respondents to the request must submit information to the commissioner by October
232.15 1, 2013.

232.16 (d) The commissioner shall incorporate the information obtained through the request
232.17 for information described in paragraph (b) and information collected by the commissioner
232.18 of health and other relevant sources related to the uninsured in this state when developing
232.19 recommendations.

232.20 (e) The commissioner shall submit recommendations to the chairs and ranking
232.21 minority members of the legislative committees and divisions with jurisdiction over health
232.22 and human services and finance by January 15, 2014.

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

232.24 Sec. 34. **REQUEST FOR INFORMATION; EMERGENCY MEDICAL**
232.25 **ASSISTANCE.**

232.26 (a) The commissioner of human services shall issue a request for information (RFI)
232.27 to identify and develop options for a program to provide emergency medical assistance
232.28 recipients with coverage for medically necessary services not eligible for federal financial
232.29 participation. The RFI must focus on providing coverage for nonemergent services
232.30 for recipients who have two or more chronic conditions and have had two or more
232.31 hospitalizations covered by emergency medical assistance in a one-year period.

232.32 (b) The RFI must be issued by August 1, 2013, and require respondents to submit
232.33 information to the commissioner by November 1, 2013. The RFI must request information
232.34 on:

233.1 (1) services necessary to reduce emergency department and inpatient hospital use for
233.2 emergency medical assistance recipients;

233.3 (2) methods of service delivery that promote efficiency and cost-effectiveness, and
233.4 provide statewide access;

233.5 (3) funding options for the services to be covered under the program;

233.6 (4) coordination of service delivery and funding with services covered under
233.7 emergency medical assistance;

233.8 (5) options for program administration; and

233.9 (6) methods to evaluate the program, including evaluation of cost-effectiveness and
233.10 health outcomes for those emergency medical assistance recipients eligible for coverage
233.11 of additional services under the program.

233.12 (c) The commissioner shall make information submitted in response to the RFI
233.13 available on the agency Web site. The commissioner, based on the responses to the RFI,
233.14 shall submit recommendations on providing emergency medical assistance recipients
233.15 with coverage for nonemergent services, as described in paragraph (a), to the chairs and
233.16 ranking minority members of the legislative committees with jurisdiction over health and
233.17 human services policy and finance by January 15, 2014.

233.18 **Sec. 35. DENTAL ACCESS AND REIMBURSEMENT REPORT.**

233.19 **Subdivision 1. Study.** (a) The commissioner of human services shall study
233.20 the current oral health and dental services delivery system for state public health
233.21 care programs to improve access and ensure cost-effective delivery of services. The
233.22 commissioner shall make recommendations on modifying the delivery of services and
233.23 reimbursement methods, including modifications to the critical access dental provider
233.24 payments under Minnesota Statutes, section 256B.76, subdivision 4.

233.25 (b) The commissioner shall consult with dental providers enrolled in Minnesota
233.26 health care programs, including providers who serve substantial numbers of low-income
233.27 and uninsured patients and are currently receiving enhanced critical access dental provider
233.28 payments.

233.29 **Subd. 2. Service delivery and reimbursement methods.** The recommendations
233.30 must address:

233.31 (1) targeting state funding and critical access dental payments to improve access
233.32 to oral health services for individuals enrolled in Minnesota health care programs who
233.33 are not receiving timely and appropriate dental services;

234.1 (2) encouraging the use of cost-effective service delivery methods, workforce
234.2 innovations, and the delivery of preventive services, including, but not limited to, dental
234.3 sealants that will reduce dental disease and future costs of treatment;

234.4 (3) improving access in all geographic areas of the state;

234.5 (4) encouraging the use of tele-dentistry and mobile dental equipment to serve
234.6 underserved patients and communities;

234.7 (5) evaluating the use of a single administrator delivery model;

234.8 (6) compensating providers for the added costs to providers of serving low-income
234.9 and underserved patients and populations who experience the greatest oral health
234.10 disparities in terms of incidence of oral health disease and access to and utilization of
234.11 needed oral health services;

234.12 (7) encouraging coordination of oral health care with other health care services;

234.13 (8) preventing overtreatment, fraud, and abuse; and

234.14 (9) reducing administrative costs for the state and for dental providers.

234.15 Subd. 3. **Report.** The commissioner shall submit a report on the recommendations to
234.16 the chairs and ranking minority members of the of the legislative committees and divisions
234.17 with jurisdiction over health and human services policy and finance by December 15, 2013.

234.18 **ARTICLE 7**

234.19 **CONTINUING CARE**

234.20 Section 1. Minnesota Statutes 2012, section 144.0724, subdivision 6, is amended to read:

234.21 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete
234.22 or submit an assessment for a RUG-III or RUG-IV classification within seven days of the
234.23 time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident.
234.24 The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on
234.25 the day of admission for new admission assessments or on the day that the assessment
234.26 was due for all other assessments and continues in effect until the first day of the month
234.27 following the date of submission of the resident's assessment.

234.28 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
234.29 are equal to or greater than 1.0 percent of the total operating costs on the facility's most
234.30 recent annual statistical and cost report, a facility may apply to the commissioner of
234.31 human services for a reduction in the total penalty amount. The commissioner of human
234.32 services, in consultation with the commissioner of health, may, at the sole discretion of
234.33 the commissioner of human services, limit the penalty for residents covered by medical
234.34 assistance to 15 days.

235.1 Sec. 2. Minnesota Statutes 2012, section 144A.071, subdivision 4b, is amended to read:

235.2 Subd. 4b. **Licensed beds on layaway status.** A licensed and certified nursing
235.3 facility may lay away, upon prior written notice to the commissioner of health, licensed
235.4 and certified beds. A nursing facility may not discharge a resident in order to lay away
235.5 a bed. Notice to the commissioner shall be given 60 days prior to the effective date of
235.6 the layaway. Beds on layaway shall have the same status as voluntarily delicensed and
235.7 decertified beds and shall not be subject to license fees and license surcharge fees. In
235.8 addition, beds on layaway may be removed from layaway at any time on or after ~~one-year~~
235.9 six months after the effective date of layaway in the facility of origin, with a 60-day notice
235.10 to the commissioner. A nursing facility that removes beds from layaway may not place
235.11 beds on layaway status for ~~one-year~~ six months after the effective date of the removal from
235.12 layaway. The commissioner may approve the immediate removal of beds from layaway if
235.13 necessary to provide access to those nursing home beds to residents relocated from other
235.14 nursing homes due to emergency situations or closure. In the event approval is granted,
235.15 the ~~one-year~~ six-month restriction on placing beds on layaway after a removal of beds
235.16 from layaway shall not apply. Beds may remain on layaway for up to ten years. The
235.17 commissioner may approve placing and removing beds on layaway at any time during
235.18 renovation or construction related to a moratorium project approved under this section
235.19 or section 144A.073. Nursing facilities are not required to comply with any licensure or
235.20 certification requirements for beds on layaway status.

235.21 Sec. 3. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

235.22 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
235.23 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
235.24 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
235.25 9555.6265, under this chapter for a physical location that will not be the primary residence
235.26 of the license holder for the entire period of licensure. If a license is issued during this
235.27 moratorium, and the license holder changes the license holder's primary residence away
235.28 from the physical location of the foster care license, the commissioner shall revoke the
235.29 license according to section 245A.07. Exceptions to the moratorium include:

- 235.30 (1) foster care settings that are required to be registered under chapter 144D;
- 235.31 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
235.32 and determined to be needed by the commissioner under paragraph (b);
- 235.33 (3) new foster care licenses determined to be needed by the commissioner under
235.34 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center;
235.35 or restructuring of state-operated services that limits the capacity of state-operated

236.1 facilities; or, allowing movement to the community for people who no longer require the
236.2 level of care provided in state-operated facilities as provided under section 256B.092,
236.3 subdivision 13, or 256B.49, subdivision 24;

236.4 (4) new foster care licenses determined to be needed by the commissioner under
236.5 paragraph (b) for persons requiring hospital level care; or

236.6 (5) new foster care licenses determined to be needed by the commissioner for the
236.7 transition of people from personal care assistance to the home and community-based
236.8 services.

236.9 (b) The commissioner shall determine the need for newly licensed foster care homes
236.10 as defined under this subdivision. As part of the determination, the commissioner shall
236.11 consider the availability of foster care capacity in the area in which the licensee seeks to
236.12 operate, and the recommendation of the local county board. The determination by the
236.13 commissioner must be final. A determination of need is not required for a change in
236.14 ownership at the same address.

236.15 ~~(e) The commissioner shall study the effects of the license moratorium under this~~
236.16 ~~subdivision and shall report back to the legislature by January 15, 2011. This study shall~~
236.17 ~~include, but is not limited to the following:~~

236.18 ~~(1) the overall capacity and utilization of foster care beds where the physical location~~
236.19 ~~is not the primary residence of the license holder prior to and after implementation~~
236.20 ~~of the moratorium;~~

236.21 ~~(2) the overall capacity and utilization of foster care beds where the physical~~
236.22 ~~location is the primary residence of the license holder prior to and after implementation~~
236.23 ~~of the moratorium; and~~

236.24 ~~(3) the number of licensed and occupied ICF/MR beds prior to and after~~
236.25 ~~implementation of the moratorium.~~

236.26 ~~(d)~~ (c) When a foster care recipient moves out of a foster home that is not the primary
236.27 residence of the license holder according to section 256B.49, subdivision 15, paragraph
236.28 (f), the county shall immediately inform the Department of Human Services Licensing
236.29 Division. The department shall decrease the statewide licensed capacity for foster care
236.30 settings where the physical location is not the primary residence of the license holder, if
236.31 the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the savings
236.32 required by reductions in licensed bed capacity under Laws 2011, First Special Session
236.33 chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term
236.34 care residential services capacity within budgetary limits. Implementation of the statewide
236.35 licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense
236.36 up to 128 beds by June 30, 2014, using the needs determination process. Under this

237.1 paragraph, the commissioner has the authority to reduce unused licensed capacity of a
237.2 current foster care program to accomplish the consolidation or closure of settings. Under
237.3 this paragraph, the commissioner has the authority to manage statewide capacity, including
237.4 adjusting the capacity available to each county and adjusting statewide available capacity,
237.5 to meet the statewide needs identified through the process in paragraph (e). A decreased
237.6 licensed capacity according to this paragraph is not subject to appeal under this chapter.

237.7 (e) ~~(d)~~ Residential settings that would otherwise be subject to the decreased license
237.8 capacity established in paragraph ~~(d)~~ (c) shall be exempt under the following circumstances:

237.9 (1) until August 1, 2013, the license holder's beds occupied by residents whose
237.10 primary diagnosis is mental illness and the license holder is:

237.11 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
237.12 health services (ARMHS) as defined in section 256B.0623;

237.13 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
237.14 9520.0870;

237.15 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
237.16 9520.0870; or

237.17 (iv) a provider of intensive residential treatment services (IRTS) licensed under
237.18 Minnesota Rules, parts 9520.0500 to 9520.0670; or

237.19 (2) the license holder's beds occupied by residents whose primary diagnosis is
237.20 mental illness and the license holder is certified under the requirements in subdivision 6a.

237.21 ~~(f)~~ (e) A resource need determination process, managed at the state level, using the
237.22 available reports required by section 144A.351, and other data and information shall
237.23 be used to determine where the reduced capacity required under paragraph ~~(d)~~ (c) will
237.24 be implemented. The commissioner shall consult with the stakeholders described in
237.25 section 144A.351, and employ a variety of methods to improve the state's capacity to
237.26 meet long-term care service needs within budgetary limits, including seeking proposals
237.27 from service providers or lead agencies to change service type, capacity, or location to
237.28 improve services, increase the independence of residents, and better meet needs identified
237.29 by the long-term care services reports and statewide data and information. By February
237.30 ~~1 of each, 2013, and August 1, 2014, and each following~~ year, the commissioner shall
237.31 provide information and data on the overall capacity of licensed long-term care services,
237.32 actions taken under this subdivision to manage statewide long-term care services and
237.33 supports resources, and any recommendations for change to the legislative committees
237.34 with jurisdiction over health and human services budget.

237.35 ~~(g)~~ (f) At the time of application and reapplication for licensure, the applicant and the
237.36 license holder that are subject to the moratorium or an exclusion established in paragraph

238.1 (a) are required to inform the commissioner whether the physical location where the foster
238.2 care will be provided is or will be the primary residence of the license holder for the entire
238.3 period of licensure. If the primary residence of the applicant or license holder changes, the
238.4 applicant or license holder must notify the commissioner immediately. The commissioner
238.5 shall print on the foster care license certificate whether or not the physical location is the
238.6 primary residence of the license holder.

238.7 ~~(h)~~ (g) License holders of foster care homes identified under paragraph ~~(g)~~ (f) that
238.8 are not the primary residence of the license holder and that also provide services in the
238.9 foster care home that are covered by a federally approved home and community-based
238.10 services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must
238.11 inform the human services licensing division that the license holder provides or intends to
238.12 provide these waiver-funded services. These license holders must be considered registered
238.13 under section 256B.092, subdivision 11, paragraph (c), and this registration status must
238.14 be identified on their license certificates.

238.15 Sec. 4. Minnesota Statutes 2012, section 252.291, is amended by adding a subdivision
238.16 to read:

238.17 Subd. 2b. Nicollet County facility project. The commissioner of health shall
238.18 certify one additional bed in an intermediate care facility for persons with developmental
238.19 disabilities in Nicollet County.

238.20 Sec. 5. Minnesota Statutes 2012, section 256.9657, subdivision 3a, is amended to read:

238.21 Subd. 3a. ~~ICF/MR~~ ICF/DD license surcharge. (a) Effective July 1, 2003, each
238.22 non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay
238.23 to the commissioner an annual surcharge according to the schedule in subdivision 4,
238.24 paragraph (d). The annual surcharge shall be \$1,040 per licensed bed. If the number of
238.25 licensed beds is reduced, the surcharge shall be based on the number of remaining licensed
238.26 beds the second month following the receipt of timely notice by the commissioner of
238.27 human services that beds have been delicensed. The facility must notify the commissioner
238.28 of health in writing when beds are delicensed. The commissioner of health must notify
238.29 the commissioner of human services within ten working days after receiving written
238.30 notification. If the notification is received by the commissioner of human services by
238.31 the 15th of the month, the invoice for the second following month must be reduced to
238.32 recognize the delicensing of beds. The commissioner may reduce, and may subsequently
238.33 restore, the surcharge under this subdivision based on the commissioner's determination of
238.34 a permissible surcharge.

239.1 (b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to \$3,679
239.2 per licensed bed.

239.3 **EFFECTIVE DATE.** This section is effective July 1, 2013.

239.4 Sec. 6. Minnesota Statutes 2012, section 256B.0915, subdivision 3a, is amended to read:

239.5 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
239.6 waived services to an individual elderly waiver client except for individuals described in
239.7 ~~paragraph~~ paragraphs (b) and (d) shall be the weighted average monthly nursing facility
239.8 rate of the case mix resident class to which the elderly waiver client would be assigned
239.9 under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance
239.10 needs allowance as described in subdivision 1d, paragraph (a), until the first day of the
239.11 state fiscal year in which the resident assessment system as described in section 256B.438
239.12 for nursing home rate determination is implemented. Effective on the first day of the state
239.13 fiscal year in which the resident assessment system as described in section 256B.438 for
239.14 nursing home rate determination is implemented and the first day of each subsequent state
239.15 fiscal year, the monthly limit for the cost of waived services to an individual elderly
239.16 waiver client shall be the rate of the case mix resident class to which the waiver client
239.17 would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on
239.18 the last day of the previous state fiscal year, adjusted by any legislatively adopted home
239.19 and community-based services percentage rate adjustment.

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

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

239.23 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating
239.24 when the dependency score in eating is three or greater as determined by an assessment
239.25 performed under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011,
239.26 for all new participants enrolled in the program on or after July 1, 2011. This monthly
239.27 limit shall be applied to all other participants who meet this criteria at reassessment. This
239.28 monthly limit shall be increased annually as described in paragraph (a).

239.29 (c) If extended medical supplies and equipment or environmental modifications are
239.30 or will be purchased for an elderly waiver client, the costs may be prorated for up to
239.31 12 consecutive months beginning with the month of purchase. If the monthly cost of a
239.32 recipient's waived services exceeds the monthly limit established in paragraph (a) or
239.33 (b), the annual cost of all waived services shall be determined. In this event, the annual
239.34 cost of all waived services shall not exceed 12 times the monthly limit of waived
239.35 services as described in paragraph (a) or (b).

240.1 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
240.2 any necessary home care services described in section 256B.0651, subdivision 2, for
240.3 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
240.4 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
240.5 amount established for home care services as described in section 256B.0652, subdivision
240.6 7, and the annual average contracted amount established by the commissioner for nursing
240.7 facility services for ventilator-dependent individuals. This monthly limit shall be increased
240.8 annually as described in paragraph (a).

240.9 Sec. 7. Minnesota Statutes 2012, section 256B.0915, is amended by adding a
240.10 subdivision to read:

240.11 Subd. 3j. **Individual community living support.** Upon federal approval, there
240.12 is established a new service called individual community living support (ICLS) that is
240.13 available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor
240.14 have any interest in the recipient's housing. ICLS must be delivered in a single-family
240.15 home or apartment where the service recipient or their family owns or rents, as
240.16 demonstrated by a lease agreement, and maintains control over the individual unit. Case
240.17 managers or care coordinators must develop individual ICLS plans in consultation with
240.18 the client using a tool developed by the commissioner. The commissioner shall establish
240.19 payment rates and mechanisms to align payments with the type and amount of service
240.20 provided, assure statewide uniformity for payment rates, and assure cost-effectiveness.
240.21 Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and
240.22 Human Services to avoid conflict with provider regulatory standards pursuant to section
240.23 144A.43 and chapter 245D.

240.24 Sec. 8. Minnesota Statutes 2012, section 256B.0916, is amended by adding a
240.25 subdivision to read:

240.26 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending
240.27 in excess of the allocation made by the commissioner. In the event a county or tribal
240.28 agency spends in excess of the allocation made by the commissioner for a given allocation
240.29 period, they must submit a corrective action plan to the commissioner. The plan must state
240.30 the actions the agency will take to correct their overspending for the year following the
240.31 period when the overspending occurred. Failure to correct overspending shall result in
240.32 recoupment of spending in excess of the allocation. Nothing in this subdivision shall be
240.33 construed as reducing the county's responsibility to offer and make available feasible

241.1 home and community-based options to eligible waiver recipients within the resources
241.2 allocated to them for that purpose.

241.3 Sec. 9. Minnesota Statutes 2012, section 256B.092, subdivision 7, is amended to read:

241.4 Subd. 7. **Screening teams.** (a) For persons with developmental disabilities, screening
241.5 teams shall be established which shall evaluate the need for the level of care provided
241.6 by residential-based habilitation services, residential services, training and habilitation
241.7 services, and nursing facility services. The evaluation shall address whether home and
241.8 community-based services are appropriate for persons who are at risk of placement in an
241.9 intermediate care facility for persons with developmental disabilities, or for whom there is
241.10 reasonable indication that they might require this level of care. The screening team shall
241.11 make an evaluation of need within 60 working days of a request for service by a person
241.12 with a developmental disability, and within five working days of an emergency admission
241.13 of a person to an intermediate care facility for persons with developmental disabilities.

241.14 (b) The screening team shall consist of the case manager for persons with
241.15 developmental disabilities, the person, the person's legal guardian or conservator, or the
241.16 parent if the person is a minor, and a qualified developmental disability professional, as
241.17 defined in Code of Federal Regulations, title 42, section 483.430, as amended through
241.18 June 3, 1988. The case manager may also act as the qualified developmental disability
241.19 professional if the case manager meets the federal definition.

241.20 (c) County social service agencies may contract with a public or private agency
241.21 or individual who is not a service provider for the person for the public guardianship
241.22 representation required by the screening or individual service planning process. The
241.23 contract shall be limited to public guardianship representation for the screening and
241.24 individual service planning activities. The contract shall require compliance with the
241.25 commissioner's instructions and may be for paid or voluntary services.

241.26 (d) For persons determined to have overriding health care needs and are
241.27 seeking admission to a nursing facility or an ICF/MR, or seeking access to home and
241.28 community-based waived services, a registered nurse must be designated as either the
241.29 case manager or the qualified developmental disability professional.

241.30 (e) For persons under the jurisdiction of a correctional agency, the case manager
241.31 must consult with the corrections administrator regarding additional health, safety, and
241.32 supervision needs.

241.33 (f) The case manager, with the concurrence of the person, the person's legal guardian
241.34 or conservator, or the parent if the person is a minor, may invite other individuals to
241.35 attend meetings of the screening team. With the permission of the person being screened

242.1 or the person's designated legal representative, the person's current provider of services
242.2 may submit a written report outlining their recommendations regarding the person's care
242.3 needs prepared by a direct service employee with at least 20 hours of service to that client.
242.4 The screening team must notify the provider of the date by which this information is to
242.5 be submitted. This information must be provided to the screening team and the person
242.6 or the person's legal representative and must be considered prior to the finalization of
242.7 the screening.

242.8 (g) Upon federal approval, if during an assessment or reassessment the recipient
242.9 is determined to be able to have the recipient's needs met through alternative services
242.10 in a less restrictive setting, the case manager shall help the recipient develop a plan to
242.11 transition to an appropriate less restrictive setting.

242.12 ~~(g)~~ (h) No member of the screening team shall have any direct or indirect service
242.13 provider interest in the case.

242.14 ~~(h)~~ (i) Nothing in this section shall be construed as requiring the screening team
242.15 meeting to be separate from the service planning meeting.

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

242.17 Sec. 10. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

242.18 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
242.19 established a new service called residential support that is available on the community
242.20 alternative care, community alternatives for disabled individuals, developmental
242.21 disabilities, and brain injury waivers. Existing waiver service descriptions must be
242.22 modified to the extent necessary to ensure there is no duplication between other services.
242.23 Residential support services must be provided by vendors licensed as a community
242.24 residential setting as defined in section 245A.11, subdivision 8.

242.25 (b) Residential support services must meet the following criteria:

242.26 (1) providers of residential support services must own or control the residential site;

242.27 (2) the residential site must not be the primary residence of the license holder;

242.28 (3) the residential site must have a designated program supervisor responsible for
242.29 program oversight, development, and implementation of policies and procedures;

242.30 (4) the provider of residential support services must provide supervision, training,
242.31 and assistance as described in the person's coordinated service and support plan; and

242.32 (5) the provider of residential support services must meet the requirements of
242.33 licensure and additional requirements of the person's coordinated service and support plan.

242.34 (c) Providers of residential support services that meet the definition in paragraph

242.35 (a) must be registered using a process determined by the commissioner beginning July

243.1 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts
243.2 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts
243.3 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision
243.4 7, paragraph ~~(g)~~ (f), are considered registered under this section.

243.5 Sec. 11. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:

243.6 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall
243.7 establish statewide priorities for individuals on the waiting list for developmental
243.8 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must
243.9 include, but are not limited to, individuals who continue to have a need for waiver services
243.10 after they have maximized the use of state plan services and other funding resources,
243.11 including natural supports, prior to accessing waiver services, and who meet at least one
243.12 of the following criteria:

243.13 (1) no longer require the intensity of services provided where they are currently
243.14 living; or

243.15 (2) make a request to move from an institutional setting.

243.16 (b) After the priorities in paragraph (a) are met, priority must also be given to
243.17 individuals who meet at least one of the following criteria:

243.18 (1) have unstable living situations due to the age, incapacity, or sudden loss of
243.19 the primary caregivers;

243.20 (2) are moving from an institution due to bed closures;

243.21 (3) experience a sudden closure of their current living arrangement;

243.22 (4) require protection from confirmed abuse, neglect, or exploitation;

243.23 (5) experience a sudden change in need that can no longer be met through state plan
243.24 services or other funding resources alone; or

243.25 (6) meet other priorities established by the department.

243.26 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
243.27 consideration the number of individuals waiting who meet statewide priorities and the
243.28 lead agencies' current use of waiver funds and existing service options. The commissioner
243.29 has the authority to transfer funds between counties, groups of counties, and tribes to
243.30 accommodate statewide priorities and resource needs while accounting for a necessary
243.31 base level reserve amount for each county, group of counties, and tribe.

243.32 ~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and~~
243.33 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
243.34 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
243.35 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

244.1 Sec. 12. Minnesota Statutes 2012, section 256B.092, is amended by adding a
244.2 subdivision to read:

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

244.11 (1) conduct a functional assessment of the crisis incident as defined in section
244.12 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
244.13 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
244.14 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

244.26 Sec. 13. **[256B.0922] ESSENTIAL COMMUNITY SUPPORTS.**

244.27 Subdivision 1. **Essential community supports.** (a) The purpose of the essential
244.28 community supports program is to provide targeted services to persons age 65 and older
244.29 who need essential community support, but whose needs do not meet the level of care
244.30 required for nursing facility placement under section 144.0724, subdivision 11.

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

244.34 (1) is age 65 or older;

244.35 (2) is not eligible for medical assistance;

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

245.3 (4) meets the financial eligibility criteria for the alternative care program under
245.4 section 256B.0913, subdivision 4;

245.5 (5) has a community support plan; and

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

245.10 (i) caregiver support;

245.11 (ii) homemaker support;

245.12 (iii) chores;

245.13 (iv) a personal emergency response device or system;

245.14 (v) home-delivered meals; or

245.15 (vi) community living assistance as defined by the commissioner.

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

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

245.22 (e) The commissioner is authorized to use federal matching funds for essential
245.23 community supports as necessary and to meet demand for essential community supports
245.24 as outlined in subdivision 2, and that amount of federal funds is appropriated to the
245.25 commissioner for this purpose.

245.26 Subd. 2. Essential community supports for people in transition. (a) Essential
245.27 community supports under subdivision 1 are also available to an individual who:

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

245.32 (2) meets one of the following criteria:

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

246.1 after the effective date of the revised nursing facility level of care criteria under section
246.2 144.0724, subdivision 11; or

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

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

246.10 (4) has an assessed need for one or more of the supportive services offered under
246.11 essential community supports under subdivision 1, paragraph (b), clause (6).

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

246.15 (b) Additional onetime case management is available for participants under
246.16 paragraph (a), not to exceed \$600 per person to be used within one authorization period
246.17 not to exceed 12 months. This service is provided in addition to the essential community
246.18 supports benefit described under subdivision 1, paragraph (b).

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

246.20 Sec. 14. **[256B.0949] AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**

246.21 Subdivision 1. **Purpose.** This section creates a new benefit to provide early
246.22 intensive intervention to a child with an autism spectrum disorder diagnosis. This benefit
246.23 must provide coverage for diagnosis, multidisciplinary assessment, ongoing progress
246.24 evaluation, and medically necessary treatment of autism spectrum disorder.

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

246.27 (b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the
246.28 current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

246.29 (c) "Child" means a person under the age of 18.

246.30 (d) "Commissioner" means the commissioner of human services, unless otherwise
246.31 specified.

246.32 (e) "Early intensive intervention benefit" means autism treatment options based in
246.33 behavioral and developmental science, which may include modalities such as applied
246.34 behavior analysis, developmental treatment approaches, and naturalistic and parent
246.35 training models.

247.1 (f) "Generalizable goals" means results or gains that are observed during a variety
247.2 of activities with different people, such as providers, family members, other adults, and
247.3 children, and in different environments including, but not limited to, clinics, homes,
247.4 schools, and the community.

247.5 (g) "Mental health professional" has the meaning given in section 245.4871,
247.6 subdivision 27, clauses (1) to (6).

247.7 Subd. 3. **Initial eligibility.** This benefit is available to a child enrolled in medical
247.8 assistance who:

247.9 (1) has an autism spectrum disorder diagnosis;

247.10 (2) has had a diagnostic assessment described in subdivision 5, which recommends
247.11 early intensive intervention services; and

247.12 (3) meets the criteria for medically necessary autism early intensive intervention
247.13 services.

247.14 Subd. 4. **Diagnosis.** (a) A diagnosis must:

247.15 (1) be based upon current DSM criteria including direct observations of the child
247.16 and reports from parents or primary caregivers; and

247.17 (2) be completed by both a licensed physician or advanced practice registered nurse
247.18 and a mental health professional.

247.19 (b) Additional diagnostic assessment information may be considered including from
247.20 special education evaluations and licensed school personnel, and from professionals
247.21 licensed in the fields of medicine, speech and language, psychology, occupational therapy,
247.22 and physical therapy.

247.23 (c) If the commissioner determines there are access problems or delays in diagnosis
247.24 for a geographic area due to the lack of qualified professionals, the commissioner shall
247.25 waive the requirement in paragraph (a), clause (2), for two professionals and allow a
247.26 diagnosis to be made by one professional for that geographic area. This exception must be
247.27 limited to a specific period of time until, with stakeholder input as described in subdivision
247.28 8, there is a determination of an adequate number of professionals available to require two
247.29 professionals for each diagnosis.

247.30 Subd. 5. **Diagnostic assessment.** The following information and assessments must
247.31 be performed, reviewed, and relied upon for the eligibility determination, treatment and
247.32 services recommendations, and treatment plan development for the child:

247.33 (1) an assessment of the child's developmental skills, functional behavior, needs, and
247.34 capacities based on direct observation of the child which must be administered by a licensed
247.35 mental health professional and may also include observations from family members,
247.36 school personnel, child care providers, or other caregivers, as well as any medical or

248.1 assessment information from other licensed professionals such as the child's physician,
248.2 rehabilitation therapists, licensed school personnel, or mental health professionals; and

248.3 (2) an assessment of parental or caregiver capacity to participate in therapy including
248.4 the type and level of parental or caregiver involvement and training recommended.

248.5 Subd. 6. **Treatment plan.** (a) Each child's treatment plan must be:

248.6 (1) based on the diagnostic assessment information specified in subdivisions 4 and 5;

248.7 (2) coordinated with medically necessary occupational, physical, and speech and
248.8 language therapies, special education, and other services the child and family are receiving;

248.9 (3) family-centered;

248.10 (4) culturally sensitive; and

248.11 (5) individualized based on the child's developmental status and the child's and
248.12 family's identified needs.

248.13 (b) The treatment plan must specify the:

248.14 (1) child's goals which are developmentally appropriate, functional, and
248.15 generalizable;

248.16 (2) treatment modality;

248.17 (3) treatment intensity;

248.18 (4) setting; and

248.19 (5) level and type of parental or caregiver involvement.

248.20 (c) The treatment must be supervised by a professional with expertise and training in
248.21 autism and child development who is a licensed physician, advanced practice registered
248.22 nurse, or mental health professional.

248.23 (d) The treatment plan must be submitted to the commissioner for approval in a
248.24 manner determined by the commissioner for this purpose.

248.25 (e) Services authorized must be consistent with the child's approved treatment plan.

248.26 Services included in the treatment plan must meet all applicable requirements for
248.27 medical necessity and coverage.

248.28 Subd. 7. **Ongoing eligibility.** (a) An independent progress evaluation conducted
248.29 by a licensed mental health professional with expertise and training in autism spectrum
248.30 disorder and child development must be completed after each six months of treatment,
248.31 or more frequently as determined by the commissioner, to determine if progress is being
248.32 made toward achieving generalizable goals and meeting functional goals contained in
248.33 the treatment plan.

248.34 (b) The progress evaluation must include:

248.35 (1) the treating provider's report;

248.36 (2) parental or caregiver input;

249.1 (3) an independent observation of the child which can be performed by the child's
249.2 licensed special education staff;

249.3 (4) any treatment plan modifications; and

249.4 (5) recommendations for continued treatment services.

249.5 (c) Progress evaluations must be submitted to the commissioner in a manner
249.6 determined by the commissioner for this purpose.

249.7 (d) A child who continues to achieve generalizable goals and treatment goals as
249.8 specified in the treatment plan is eligible to continue receiving this benefit.

249.9 (e) A child's treatment shall continue during the progress evaluation using the
249.10 process determined under subdivision 8, clause (8). Treatment may continue during an
249.11 appeal pursuant to section 256.045.

249.12 Subd. 8. Refining the benefit with stakeholders. The commissioner must develop
249.13 the implementation details of the benefit in consultation with stakeholders and consider
249.14 recommendations from the Health Services Advisory Council, the Department of Human
249.15 Services Autism Spectrum Disorder Advisory Council, the Legislative Autism Spectrum
249.16 Disorder Task Force, and the Interagency Task Force of the Departments of Health,
249.17 Education, and Human Services. The commissioner must release these details for a 30-day
249.18 public comment period prior to submission to the federal government for approval. The
249.19 implementation details must include, but are not limited to, the following components:

249.20 (1) a definition of the qualifications, standards, and roles of the treatment team,
249.21 including recommendations after stakeholder consultation on whether board-certified
249.22 behavior analysts and other types of professionals trained in autism spectrum disorder and
249.23 child development should be added as mental health or other professionals for treatment
249.24 supervision or other functions under medical assistance;

249.25 (2) development of initial, uniform parameters for comprehensive multidisciplinary
249.26 diagnostic assessment information and progress evaluation standards;

249.27 (3) the design of an effective and consistent process for assessing parent and
249.28 caregiver capacity to participate in the child's early intervention treatment and methods of
249.29 involving the parents and caregivers in the treatment of the child;

249.30 (4) formulation of a collaborative process in which professionals have opportunities
249.31 to collectively inform a comprehensive, multidisciplinary diagnostic assessment and
249.32 progress evaluation processes and standards to support quality improvement of early
249.33 intensive intervention services;

249.34 (5) coordination of this benefit and its interaction with other services provided by the
249.35 Departments of Human Services, Health, and Education;

250.1 (6) evaluation, on an ongoing basis, of research regarding the program and treatment
250.2 modalities provided to children under this benefit;

250.3 (7) determination of the availability of licensed physicians, nurse practitioners,
250.4 and mental health professionals with expertise and training in autism spectrum disorder
250.5 throughout the state to assess whether there are sufficient professionals to require
250.6 involvement of both a physician or nurse practitioner and a mental health professional to
250.7 provide access and prevent delay in the diagnosis and treatment of young children, so as to
250.8 implement subdivision 4, and to ensure treatment is effective, timely, and accessible; and

250.9 (8) development of the process for the progress evaluation that will be used to
250.10 determine the ongoing eligibility, including necessary documentation, timelines, and
250.11 responsibilities of all parties.

250.12 Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered
250.13 treatment options as needed based on outcome data and other evidence.

250.14 (b) Before the changes become effective, the commissioner must provide public
250.15 notice of the changes, the reasons for the change, and a 30-day public comment period
250.16 to those who request notice through an electronic list accessible to the public on the
250.17 department's Web site.

250.18 Subd. 10. **Coordination between agencies.** The commissioners of human services
250.19 and education must develop the capacity to coordinate services and information including
250.20 diagnostic, functional, developmental, medical, and educational assessments; service
250.21 delivery; and progress evaluations across health and education sectors.

250.22 Subd. 11. **Federal approval of the autism benefit.** The provisions of subdivision 9
250.23 shall apply to state plan services under Title XIX of the Social Security Act when federal
250.24 approval is granted under a 1915(i) waiver or other authority which allows children
250.25 eligible for medical assistance through the TEFRA option under section 256B.055,
250.26 subdivision 12, to qualify and includes children eligible for medical assistance in families
250.27 over 150 percent of the federal poverty guidelines.

250.28 **EFFECTIVE DATE.** Subdivisions 1 to 7 and 9, are effective upon federal approval
250.29 consistent with subdivision 11, but no earlier than March 1, 2014. Subdivisions 8, 10,
250.30 and 11 are effective July 1, 2013.

250.31 Sec. 15. Minnesota Statutes 2012, section 256B.095, is amended to read:

250.32 **256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.**

250.33 (a) Effective July 1, 1998, a quality assurance system for persons with developmental
250.34 disabilities, which includes an alternative quality assurance licensing system for programs,

251.1 is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice,
251.2 Steele, Wabasha, and Winona Counties for the purpose of improving the quality of
251.3 services provided to persons with developmental disabilities. A county, at its option, may
251.4 choose to have all programs for persons with developmental disabilities located within
251.5 the county licensed under chapter 245A using standards determined under the alternative
251.6 quality assurance licensing system or may continue regulation of these programs under the
251.7 licensing system operated by the commissioner. ~~The project expires on June 30, 2014.~~

251.8 (b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to
251.9 participate in the quality assurance system established under paragraph (a). The
251.10 commission established under section 256B.0951 may, at its option, allow additional
251.11 counties to participate in the system.

251.12 (c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a)
251.13 may establish a quality assurance system under this section. A new system established
251.14 under this section shall have the same rights and duties as the system established
251.15 under paragraph (a). A new system shall be governed by a commission under section
251.16 256B.0951. The commissioner shall appoint the initial commission members based
251.17 on recommendations from advocates, families, service providers, and counties in the
251.18 geographic area included in the new system. Counties that choose to participate in a
251.19 new system shall have the duties assigned under section 256B.0952. The new system
251.20 shall establish a quality assurance process under section 256B.0953. The provisions of
251.21 section 256B.0954 shall apply to a new system established under this paragraph. The
251.22 commissioner shall delegate authority to a new system established under this paragraph
251.23 according to section 256B.0955.

251.24 (d) Effective July 1, 2007, the quality assurance system may be expanded to include
251.25 programs for persons with disabilities and older adults.

251.26 (e) Effective July 1, 2013, a provider of service located in a county listed in
251.27 paragraph (a) that is a non-opted-in county may opt in to the quality assurance system
251.28 provided the county where services are provided indicates its agreement with a county
251.29 with a delegation agreement with the Department of Human Services.

251.30 **EFFECTIVE DATE.** This section is effective July 1, 2013.

251.31 Sec. 16. Minnesota Statutes 2012, section 256B.0951, subdivision 1, is amended to read:

251.32 Subdivision 1. **Membership.** The Quality Assurance Commission is established.
251.33 The commission consists of at least 14 but not more than 21 members as follows: at
251.34 least three but not more than five members representing advocacy organizations; at
251.35 least three but not more than five members representing consumers, families, and their

252.1 legal representatives; at least three but not more than five members representing service
252.2 providers; at least three but not more than five members representing counties; and the
252.3 commissioner of human services or the commissioner's designee. The first commission
252.4 shall establish membership guidelines for the transition and recruitment of membership for
252.5 the commission's ongoing existence. Members of the commission who do not receive a
252.6 salary or wages from an employer for time spent on commission duties may receive a per
252.7 diem payment when performing commission duties and functions. All members may be
252.8 reimbursed for expenses related to commission activities. ~~Notwithstanding the provisions~~
252.9 ~~of section 15.059, subdivision 5, the commission expires on June 30, 2014.~~

252.10 Sec. 17. Minnesota Statutes 2012, section 256B.0951, subdivision 4, is amended to read:

252.11 Subd. 4. **Commission's authority to recommend variances of licensing**
252.12 **standards.** The commission may recommend to the commissioners of human services
252.13 and health variances from the standards governing licensure of programs for persons with
252.14 ~~developmental~~ disabilities in order to improve the quality of services by implementing
252.15 an alternative ~~developmental~~ disabilities licensing system if the commission determines
252.16 that the alternative licensing system does not adversely affect the health or safety of
252.17 persons being served by the licensed program nor compromise the qualifications of staff
252.18 to provide services.

252.19 Sec. 18. Minnesota Statutes 2012, section 256B.0952, subdivision 1, is amended to read:

252.20 Subdivision 1. **Notification.** Counties or providers shall give notice to the
252.21 commission and commissioners of human services and health of intent to join the
252.22 alternative quality assurance licensing system. A county or provider choosing to participate
252.23 in the alternative quality assurance licensing system commits to participate for three years.

252.24 Sec. 19. Minnesota Statutes 2012, section 256B.0952, subdivision 5, is amended to read:

252.25 Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised
252.26 of county staff; providers; consumers, families, and their legal representatives; members
252.27 of advocacy organizations; and other involved community members. Team members
252.28 must satisfactorily complete the training program approved by the commission and must
252.29 demonstrate performance-based competency. Team members are not considered to be
252.30 county employees for purposes of workers' compensation, unemployment insurance, or
252.31 state retirement laws solely on the basis of participation on a quality assurance team. ~~The~~
252.32 ~~county may pay~~ A per diem may be paid to team members for time spent on alternative

253.1 quality assurance process matters. All team members may be reimbursed for expenses
253.2 related to their participation in the alternative process.

253.3 Sec. 20. Minnesota Statutes 2012, section 256B.0955, is amended to read:

253.4 **256B.0955 DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.**

253.5 (a) Effective July 1, 1998, the commissioner of human services shall delegate
253.6 authority to perform licensing functions and activities, in accordance with section
253.7 245A.16, to counties participating in the alternative quality assurance licensing system.
253.8 The commissioner shall not license or reimburse a facility, program, or service for persons
253.9 with ~~developmental~~ disabilities in a county that participates in the alternative quality
253.10 assurance licensing system if the commissioner has received from the appropriate county
253.11 notification that the facility, program, or service has been reviewed by a quality assurance
253.12 team and has failed to qualify for licensure.

253.13 (b) The commissioner may conduct random licensing inspections based on outcomes
253.14 adopted under section 256B.0951 at facilities, programs, and services governed by the
253.15 alternative quality assurance licensing system. The role of such random inspections shall
253.16 be to verify that the alternative quality assurance licensing system protects the safety
253.17 and well-being of consumers and maintains the availability of high-quality services for
253.18 persons with developmental disabilities.

253.19 **EFFECTIVE DATE.** This section is effective July 1, 2013.

253.20 Sec. 21. Minnesota Statutes 2012, section 256B.097, subdivision 1, is amended to read:

253.21 Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to
253.22 Minnesotans with disabilities and to meet the requirements of the federally approved home
253.23 and community-based waivers under section 1915c of the Social Security Act, a State
253.24 Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving
253.25 disability services is enacted. This system is a partnership between the Department of
253.26 Human Services and the State Quality Council established under subdivision 3.

253.27 (b) This system is a result of the recommendations from the Department of Human
253.28 Services' licensing and alternative quality assurance study mandated under Laws 2005,
253.29 First Special Session chapter 4, article 7, section 57, and presented to the legislature
253.30 in February 2007.

253.31 (c) The disability services eligible under this section include:

253.32 (1) the home and community-based services waiver programs for persons with
253.33 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,

254.1 including brain injuries and services for those who qualify for nursing facility level of care
254.2 or hospital facility level of care and any other services licensed under chapter 245D;

254.3 (2) home care services under section 256B.0651;

254.4 (3) family support grants under section 252.32;

254.5 (4) consumer support grants under section 256.476;

254.6 (5) semi-independent living services under section 252.275; and

254.7 (6) services provided through an intermediate care facility for the developmentally
254.8 disabled.

254.9 (d) For purposes of this section, the following definitions apply:

254.10 (1) "commissioner" means the commissioner of human services;

254.11 (2) "council" means the State Quality Council under subdivision 3;

254.12 (3) "Quality Assurance Commission" means the commission under section
254.13 256B.0951; and

254.14 (4) "system" means the State Quality Assurance, Quality Improvement and
254.15 Licensing System under this section.

254.16 Sec. 22. Minnesota Statutes 2012, section 256B.097, subdivision 3, is amended to read:

254.17 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
254.18 Council which must define regional quality councils, and carry out a community-based,
254.19 person-directed quality review component, and a comprehensive system for effective
254.20 incident reporting, investigation, analysis, and follow-up.

254.21 (b) By August 1, 2011, the commissioner of human services shall appoint the
254.22 members of the initial State Quality Council. Members shall include representatives
254.23 from the following groups:

254.24 (1) disability service recipients and their family members;

254.25 (2) during the first ~~two~~ four years of the State Quality Council, there must be at least
254.26 three members from the Region 10 stakeholders. As regional quality councils are formed
254.27 under subdivision 4, each regional quality council shall appoint one member;

254.28 (3) disability service providers;

254.29 (4) disability advocacy groups; and

254.30 (5) county human services agencies and staff from the Department of Human
254.31 Services and Ombudsman for Mental Health and Developmental Disabilities.

254.32 (c) Members of the council who do not receive a salary or wages from an employer
254.33 for time spent on council duties may receive a per diem payment when performing council
254.34 duties and functions.

254.35 (d) The State Quality Council shall:

255.1 (1) assist the Department of Human Services in fulfilling federally mandated
255.2 obligations by monitoring disability service quality and quality assurance and
255.3 improvement practices in Minnesota;

255.4 (2) establish state quality improvement priorities with methods for achieving results
255.5 and provide an annual report to the legislative committees with jurisdiction over policy
255.6 and funding of disability services on the outcomes, improvement priorities, and activities
255.7 undertaken by the commission during the previous state fiscal year;

255.8 (3) identify issues pertaining to financial and personal risk that impede Minnesotans
255.9 with disabilities from optimizing choice of community-based services; and

255.10 (4) recommend to the chairs and ranking minority members of the legislative
255.11 committees with jurisdiction over human services and civil law by January 15, ~~2013~~
255.12 2014, statutory and rule changes related to the findings under clause (3) that promote
255.13 individualized service and housing choices balanced with appropriate individualized
255.14 protection.

255.15 (e) The State Quality Council, in partnership with the commissioner, shall:

255.16 (1) approve and direct implementation of the community-based, person-directed
255.17 system established in this section;

255.18 (2) recommend an appropriate method of funding this system, and determine the
255.19 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

255.20 (3) approve measurable outcomes in the areas of health and safety, consumer
255.21 evaluation, education and training, providers, and systems;

255.22 (4) establish variable licensure periods not to exceed three years based on outcomes
255.23 achieved; and

255.24 (5) in cooperation with the Quality Assurance Commission, design a transition plan
255.25 for licensed providers from Region 10 into the alternative licensing system ~~by July 1, 2013~~.

255.26 (f) The State Quality Council shall notify the commissioner of human services that a
255.27 facility, program, or service has been reviewed by quality assurance team members under
255.28 subdivision 4, paragraph (b), clause (13), and qualifies for a license.

255.29 (g) The State Quality Council, in partnership with the commissioner, shall establish
255.30 an ongoing review process for the system. The review shall take into account the
255.31 comprehensive nature of the system which is designed to evaluate the broad spectrum of
255.32 licensed and unlicensed entities that provide services to persons with disabilities. The
255.33 review shall address efficiencies and effectiveness of the system.

255.34 (h) The State Quality Council may recommend to the commissioner certain
255.35 variances from the standards governing licensure of programs for persons with disabilities
255.36 in order to improve the quality of services so long as the recommended variances do

256.1 not adversely affect the health or safety of persons being served or compromise the
256.2 qualifications of staff to provide services.

256.3 (i) The safety standards, rights, or procedural protections referenced under
256.4 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
256.5 recommendations to the commissioner or to the legislature in the report required under
256.6 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
256.7 procedural protections referenced under subdivision 2, paragraph (c).

256.8 (j) The State Quality Council may hire staff to perform the duties assigned in this
256.9 subdivision.

256.10 Sec. 23. Minnesota Statutes 2012, section 256B.431, subdivision 44, is amended to read:

256.11 Subd. 44. **Property rate increase increases for a facility in Bloomington effective**
256.12 **November 1, 2010 certain nursing facilities.** (a) Notwithstanding any other law to the
256.13 contrary, money available for moratorium projects under section 144A.073, subdivision
256.14 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception
256.15 project for a nursing facility in Bloomington licensed for 137 beds as of November 1,
256.16 2010, up to a total property rate adjustment of \$19.33.

256.17 (b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110
256.18 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow
256.19 \$1,129,463 of a completed construction project to increase the property payment rate.
256.20 Notwithstanding any other law to the contrary, money available under section 144A.073,
256.21 subdivision 11, after the completion of the moratorium exception approval process in 2013
256.22 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the
256.23 medical assistance budget for the increase in the replacement-cost-new limit.

256.24 (c) Effective July 1, 2012, any nursing facility in Dakota County licensed for
256.25 61 beds shall have their replacement-cost-new limit under subdivision 17e adjusted to
256.26 allow \$1,407,624 of a completed construction project to increase their property payment
256.27 rate. Effective September 1, 2013, or later, their replacement-cost-new limit under
256.28 subdivision 17e shall be adjusted to allow \$1,244,599 of a completed construction project
256.29 to increase the property payment rate. Notwithstanding any other law to the contrary,
256.30 money available under section 144A.073, subdivision 11, after the completion of the
256.31 moratorium exception approval process in 2013 under section 144A.073, subdivision 3,
256.32 shall be used to reduce the fiscal impact to the medical assistance budget for the increase
256.33 in the replacement-cost-new limit.

256.34 (d) Effective July 1, 2013, or later, any boarding care facility in Hennepin
256.35 County licensed for 101 beds shall be allowed to receive a property rate adjustment

257.1 for a construction project that takes action to come into compliance with Minnesota
257.2 Department of Labor and Industry elevator upgrade requirements, with costs below the
257.3 minimum threshold under subdivision 16. Only costs related to the construction project
257.4 that brings the facility into compliance with the elevator requirements shall be allowed.
257.5 Notwithstanding any other law to the contrary, money available under section 144A.073,
257.6 subdivision 11, after the completion of the moratorium exception approval process in
257.7 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to
257.8 the medical assistance program.

257.9 **EFFECTIVE DATE.** Paragraph (b) is effective retroactively from June 1, 2012.
257.10 Paragraph (c) is effective retroactively from July 1, 2012.

257.11 Sec. 24. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:

257.12 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
257.13 have their payment rates determined under this section rather than section 256B.431, the
257.14 commissioner shall establish a rate under this subdivision. The nursing facility must enter
257.15 into a written contract with the commissioner.

257.16 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
257.17 contract under this section is the payment rate the facility would have received under
257.18 section 256B.431.

257.19 (c) A nursing facility's case mix payment rates for the second and subsequent years
257.20 of a facility's contract under this section are the previous rate year's contract payment
257.21 rates plus an inflation adjustment and, for facilities reimbursed under this section or
257.22 section 256B.431, an adjustment to include the cost of any increase in Health Department
257.23 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
257.24 inflation adjustment must be based on the change in the Consumer Price Index-All Items
257.25 (United States City average) (CPI-U) forecasted by the commissioner of management and
257.26 budget's national economic consultant, as forecasted in the fourth quarter of the calendar
257.27 year preceding the rate year. The inflation adjustment must be based on the 12-month
257.28 period from the midpoint of the previous rate year to the midpoint of the rate year for
257.29 which the rate is being determined. For the rate years beginning on July 1, 1999, July 1,
257.30 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006,
257.31 July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall
257.32 apply only to the property-related payment rate. For the rate years beginning on October
257.33 1, 2011, ~~and~~ October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and
257.34 October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning
257.35 in 2005, adjustment to the property payment rate under this section and section 256B.431

258.1 shall be effective on October 1. In determining the amount of the property-related payment
258.2 rate adjustment under this paragraph, the commissioner shall determine the proportion of
258.3 the facility's rates that are property-related based on the facility's most recent cost report.

258.4 (d) The commissioner shall develop additional incentive-based payments of up to
258.5 five percent above a facility's operating payment rate for achieving outcomes specified
258.6 in a contract. The commissioner may solicit contract amendments and implement those
258.7 which, on a competitive basis, best meet the state's policy objectives. The commissioner
258.8 shall limit the amount of any incentive payment and the number of contract amendments
258.9 under this paragraph to operate the incentive payments within funds appropriated for this
258.10 purpose. The contract amendments may specify various levels of payment for various
258.11 levels of performance. Incentive payments to facilities under this paragraph may be in the
258.12 form of time-limited rate adjustments or onetime supplemental payments. In establishing
258.13 the specified outcomes and related criteria, the commissioner shall consider the following
258.14 state policy objectives:

258.15 (1) successful diversion or discharge of residents to the residents' prior home or other
258.16 community-based alternatives;

258.17 (2) adoption of new technology to improve quality or efficiency;

258.18 (3) improved quality as measured in the Nursing Home Report Card;

258.19 (4) reduced acute care costs; and

258.20 (5) any additional outcomes proposed by a nursing facility that the commissioner
258.21 finds desirable.

258.22 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
258.23 take action to come into compliance with existing or pending requirements of the life
258.24 safety code provisions or federal regulations governing sprinkler systems must receive
258.25 reimbursement for the costs associated with compliance if all of the following conditions
258.26 are met:

258.27 (1) the expenses associated with compliance occurred on or after January 1, 2005,
258.28 and before December 31, 2008;

258.29 (2) the costs were not otherwise reimbursed under subdivision 4f or section
258.30 144A.071 or 144A.073; and

258.31 (3) the total allowable costs reported under this paragraph are less than the minimum
258.32 threshold established under section 256B.431, subdivision 15, paragraph (e), and
258.33 subdivision 16.

258.34 The commissioner shall use money appropriated for this purpose to provide to qualifying
258.35 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
258.36 2008. Nursing facilities that have spent money or anticipate the need to spend money

259.1 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
259.2 system or (2) replacing all or portions of an existing sprinkler system may submit to the
259.3 commissioner by June 30, 2007, on a form provided by the commissioner the actual
259.4 costs of a completed project or the estimated costs, based on a project bid, of a planned
259.5 project. The commissioner shall calculate a rate adjustment equal to the allowable
259.6 costs of the project divided by the resident days reported for the report year ending
259.7 September 30, 2006. If the costs from all projects exceed the appropriation for this
259.8 purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the
259.9 qualifying facilities by reducing the rate adjustment determined for each facility by an
259.10 equal percentage. Facilities that used estimated costs when requesting the rate adjustment
259.11 shall report to the commissioner by January 31, 2009, on the use of this money on a
259.12 form provided by the commissioner. If the nursing facility fails to provide the report, the
259.13 commissioner shall recoup the money paid to the facility for this purpose. If the facility
259.14 reports expenditures allowable under this subdivision that are less than the amount received
259.15 in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

259.16 Sec. 25. Minnesota Statutes 2012, section 256B.434, is amended by adding a
259.17 subdivision to read:

259.18 Subd. 19a. Nursing facility rate adjustments beginning September 1, 2013. A
259.19 total of a five percent average rate adjustment shall be provided as described under this
259.20 subdivision and under section 256B.441, subdivision 46b.

259.21 (a) Beginning September 1, 2013, the commissioner shall make available to each
259.22 nursing facility reimbursed under this section a 3.75 percent operating payment rate
259.23 increase, in accordance with paragraphs (b) to (g).

259.24 (b) Seventy-five percent of the money resulting from the rate adjustment under
259.25 paragraph (a) must be used for increases in compensation-related costs for employees
259.26 directly employed by the nursing facility on or after the effective date of the rate
259.27 adjustment, except:

259.28 (1) the administrator;

259.29 (2) persons employed in the central office of a corporation that has an ownership
259.30 interest in the nursing facility or exercises control over the nursing facility; and

259.31 (3) persons paid by the nursing facility under a management contract.

259.32 (c) The commissioner shall allow as compensation-related costs all costs for:

259.33 (1) wage and salary increases effective after May 25, 2013;

259.34 (2) the employer's share of FICA taxes, Medicare taxes, state and federal
259.35 unemployment taxes, and workers' compensation;

260.1 (3) the employer's share of health and dental insurance, life insurance, disability
260.2 insurance, long-term care insurance, uniform allowance, and pensions; and

260.3 (4) other benefits provided and workforce needs, including the recruiting and
260.4 training of employees, subject to the approval of the commissioner.

260.5 (d) The portion of the rate adjustment under paragraph (a) that is not subject to the
260.6 requirements of paragraph (b) shall be provided to nursing facilities effective September 1,
260.7 2013. Nursing facilities may apply for the portion of the rate adjustment under paragraph
260.8 (a) that is subject to the requirements in paragraph (b). The application must be submitted
260.9 to the commissioner within six months of the effective date of the rate adjustment, and
260.10 the nursing facility must provide additional information required by the commissioner
260.11 within nine months of the effective date of the rate adjustment. The commissioner must
260.12 respond to all applications within three weeks of receipt. The commissioner may waive
260.13 the deadlines in this paragraph under extraordinary circumstances, to be determined at the
260.14 sole discretion of the commissioner. The application must contain:

260.15 (1) an estimate of the amounts of money that must be used as specified in paragraph
260.16 (b);

260.17 (2) a detailed distribution plan specifying the allowable compensation-related
260.18 increases the nursing facility will implement to use the funds available in clause (1);

260.19 (3) a description of how the nursing facility will notify eligible employees of
260.20 the contents of the approved application, which must provide for giving each eligible
260.21 employee a copy of the approved application, excluding the information required in clause
260.22 (1), or posting a copy of the approved application, excluding the information required in
260.23 clause (1), for a period of at least six weeks in an area of the nursing facility to which all
260.24 eligible employees have access; and

260.25 (4) instructions for employees who believe they have not received the
260.26 compensation-related increases specified in clause (2), as approved by the commissioner,
260.27 and which must include a mailing address, e-mail address, and the telephone number
260.28 that may be used by the employee to contact the commissioner or the commissioner's
260.29 representative.

260.30 (e) The commissioner shall ensure that cost increases in distribution plans under
260.31 paragraph (d), clause (2), that may be included in approved applications, comply with the
260.32 following requirements:

260.33 (1) a portion of the costs resulting from tenure-related wage or salary increases
260.34 may be considered to be allowable wage increases, according to formulas that the
260.35 commissioner shall provide, where employee retention is above the average statewide
260.36 rate of retention of direct-care employees;

261.1 (2) the annualized amount of increases in costs for the employer's share of health
261.2 and dental insurance, life insurance, disability insurance, and workers' compensation
261.3 shall be allowable compensation-related increases if they are effective on or after April
261.4 1, 2013, and prior to April 1, 2014; and

261.5 (3) for nursing facilities in which employees are represented by an exclusive
261.6 bargaining representative, the commissioner shall approve the application only upon
261.7 receipt of a letter of acceptance of the distribution plan, in regard to members of the
261.8 bargaining unit, signed by the exclusive bargaining agent, and dated after May 25, 2013.
261.9 Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of
261.10 this provision as having been met in regard to the members of the bargaining unit.

261.11 (f) The commissioner shall review applications received under paragraph (d) and
261.12 shall provide the portion of the rate adjustment under paragraph (b) if the requirements
261.13 of this statute have been met. The rate adjustment shall be effective September 1, 2013.
261.14 Notwithstanding paragraph (a), if the approved application distributes less money than is
261.15 available, the amount of the rate adjustment shall be reduced so that the amount of money
261.16 made available is equal to the amount to be distributed.

261.17 (g) The increase in this subdivision shall be applied as a percentage to operating
261.18 payment rates in effect on August 31, 2013. For each facility, the commissioner shall
261.19 determine the operating payment rate, not including any rate components resulting from
261.20 equitable cost-sharing for publicly owned nursing facility program participation under
261.21 section 256B.441, subdivision 55a, critical access nursing facility program participation
261.22 under section 256B.441, subdivision 63, or performance-based incentive payment
261.23 program participation under subdivision 4, paragraph (d), for a RUG class with a weight
261.24 of 1.00 in effect on August 31, 2013.

261.25 Sec. 26. Minnesota Statutes 2012, section 256B.434, is amended by adding a
261.26 subdivision to read:

261.27 Subd. 19b. **Nursing facility rate adjustments beginning October 1, 2015.** A
261.28 total of a 3.2 percent average rate adjustment shall be provided as described under this
261.29 subdivision and under section 256B.441, subdivision 46c.

261.30 (a) Beginning October 1, 2015, the commissioner shall make available to each
261.31 nursing facility reimbursed under this section a 2.4 percent operating payment rate
261.32 increase, in accordance with paragraphs (b) to (g).

261.33 (b) Seventy-five percent of the money resulting from the rate adjustment under
261.34 paragraph (a) must be used for increases in compensation-related costs for employees

262.1 directly employed by the nursing facility on or after the effective date of the rate
262.2 adjustment, except:

262.3 (1) the administrator;
262.4 (2) persons employed in the central office of a corporation that has an ownership
262.5 interest in the nursing facility or exercises control over the nursing facility; and
262.6 (3) persons paid by the nursing facility under a management contract.

262.7 (c) The commissioner shall allow as compensation-related costs all costs for:
262.8 (1) wage and salary increases effective after May 25, 2015;
262.9 (2) the employer's share of FICA taxes, Medicare taxes, state and federal
262.10 unemployment taxes, and workers' compensation;
262.11 (3) the employer's share of health and dental insurance, life insurance, disability
262.12 insurance, long-term care insurance, uniform allowance, and pensions; and
262.13 (4) other benefits provided and workforce needs, including the recruiting and
262.14 training of employees, subject to the approval of the commissioner.

262.15 (d) The portion of the rate adjustment under paragraph (a) that is not subject to the
262.16 requirements of paragraph (b) shall be provided to nursing facilities effective October 1,
262.17 2015. Nursing facilities may apply for the portion of the rate adjustment under paragraph
262.18 (a) that is subject to the requirements in paragraph (b). The application must be submitted
262.19 to the commissioner within six months of the effective date of the rate adjustment, and
262.20 the nursing facility must provide additional information required by the commissioner
262.21 within nine months of the effective date of the rate adjustment. The commissioner must
262.22 respond to all applications within three weeks of receipt. The commissioner may waive
262.23 the deadlines in this paragraph under extraordinary circumstances, to be determined at the
262.24 sole discretion of the commissioner. The application must contain:

262.25 (1) an estimate of the amounts of money that must be used as specified in paragraph
262.26 (b);
262.27 (2) a detailed distribution plan specifying the allowable compensation-related
262.28 increases the nursing facility will implement to use the funds available in clause (1);
262.29 (3) a description of how the nursing facility will notify eligible employees of
262.30 the contents of the approved application, which must provide for giving each eligible
262.31 employee a copy of the approved application, excluding the information required in clause
262.32 (1), or posting a copy of the approved application, excluding the information required in
262.33 clause (1), for a period of at least six weeks in an area of the nursing facility to which all
262.34 eligible employees have access; and
262.35 (4) instructions for employees who believe they have not received the
262.36 compensation-related increases specified in clause (2), as approved by the commissioner,

263.1 and which must include a mailing address, e-mail address, and the telephone number
263.2 that may be used by the employee to contact the commissioner or the commissioner's
263.3 representative.

263.4 (e) The commissioner shall ensure that cost increases in distribution plans under
263.5 paragraph (d), clause (2), that may be included in approved applications, comply with the
263.6 following requirements:

263.7 (1) a portion of the costs resulting from tenure-related wage or salary increases
263.8 may be considered to be allowable wage increases, according to formulas that the
263.9 commissioner shall provide, where employee retention is above the average statewide
263.10 rate of retention of direct-care employees;

263.11 (2) the annualized amount of increases in costs for the employer's share of health
263.12 and dental insurance, life insurance, disability insurance, and workers' compensation
263.13 shall be allowable compensation-related increases if they are effective on or after April
263.14 1, 2015, and prior to April 1, 2016; and

263.15 (3) for nursing facilities in which employees are represented by an exclusive
263.16 bargaining representative, the commissioner shall approve the application only upon
263.17 receipt of a letter of acceptance of the distribution plan, in regard to members of the
263.18 bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2015.

263.19 Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of
263.20 this provision as having been met in regard to the members of the bargaining unit.

263.21 (f) The commissioner shall review applications received under paragraph (d) and
263.22 shall provide the portion of the rate adjustment under paragraph (b) if the requirements
263.23 of this statute have been met. The rate adjustment shall be effective October 1, 2015.
263.24 Notwithstanding paragraph (a), if the approved application distributes less money than is
263.25 available, the amount of the rate adjustment shall be reduced so that the amount of money
263.26 made available is equal to the amount to be distributed.

263.27 (g) The increase in this subdivision shall be applied as a percentage to operating
263.28 payment rates in effect on September 30, 2015. For each facility, the commissioner shall
263.29 determine the operating payment rate, not including any rate components resulting from
263.30 equitable cost-sharing for publicly owned nursing facility program participation under
263.31 section 256B.441, subdivision 55a, critical access nursing facility program participation
263.32 under section 256B.441, subdivision 63, or performance-based incentive payment
263.33 program participation under subdivision 4, paragraph (d), for a RUG class with a weight
263.34 of 1.00 in effect on September 30, 2015.

263.35 Sec. 27. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

264.1 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
264.2 services shall calculate the amount of the planned closure rate adjustment available under
264.3 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

264.4 (1) the amount available is the net reduction of nursing facility beds multiplied
264.5 by \$2,080;

264.6 (2) the total number of beds in the nursing facility or facilities receiving the planned
264.7 closure rate adjustment must be identified;

264.8 (3) capacity days are determined by multiplying the number determined under
264.9 clause (2) by 365; and

264.10 (4) the planned closure rate adjustment is the amount available in clause (1), divided
264.11 by capacity days determined under clause (3).

264.12 (b) A planned closure rate adjustment under this section is effective on the first day
264.13 of the month following completion of closure of the facility designated for closure in
264.14 the application and becomes part of the nursing facility's ~~total operating~~ external fixed
264.15 payment rate.

264.16 ~~(c) Applicants may use the planned closure rate adjustment to allow for a property~~
264.17 ~~payment for a new nursing facility or an addition to an existing nursing facility or as an~~
264.18 ~~operating payment rate adjustment. Applications approved under this subdivision are~~
264.19 ~~exempt from other requirements for moratorium exceptions under section 144A.073,~~
264.20 ~~subdivisions 2 and 3.~~

264.21 ~~(d)~~ (c) Upon the request of a closing facility, the commissioner must allow the
264.22 facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

264.23 ~~(e)~~ (d) A facility that has received a planned closure rate adjustment may reassign it
264.24 to another facility that is under the same ownership at any time within three years of its
264.25 effective date. The amount of the adjustment shall be computed according to paragraph (a).

264.26 ~~(f)~~ (e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
264.27 the commissioner shall recalculate planned closure rate adjustments for facilities that
264.28 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
264.29 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
264.30 from the date the per bed dollar amount is increased.

264.31 ~~(g)~~ (f) For planned closures approved after June 30, 2009, the commissioner of
264.32 human services shall calculate the amount of the planned closure rate adjustment available
264.33 under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

264.34 ~~(h) Beginning~~ (g) Between July 16, 2011, and June 30, 2013, the commissioner shall
264.35 ~~no longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

265.1 Sec. 28. Minnesota Statutes 2012, section 256B.439, subdivision 1, is amended to read:

265.2 Subdivision 1. **Development and implementation of quality profiles.** (a) The
265.3 commissioner of human services, in cooperation with the commissioner of health,
265.4 shall develop and implement a quality ~~profile system~~ profiles for nursing facilities and,
265.5 beginning not later than July 1, ~~2004, other providers of long-term care services~~ 2014, for
265.6 home and community-based services providers, except when the quality profile system
265.7 would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. For
265.8 purposes of this section, home and community-based services providers are defined as
265.9 providers of home and community-based services under sections 256B.0913, 256B.0915,
265.10 256B.092, and 256B.49, and intermediate care facilities for persons with developmental
265.11 disabilities providers under section 256B.5013. To the extent possible, quality profiles
265.12 must be developed for providers of services to older adults and people with disabilities,
265.13 regardless of payor source, for the purposes of providing information to consumers. The
265.14 system quality profiles must be developed and implemented to the extent possible without
265.15 the collection of significant amounts of new data. To the extent possible, the system
265.16 using existing data sets maintained by the commissioners of health and human services
265.17 to the extent possible. The profiles must incorporate or be coordinated with information
265.18 on quality maintained by area agencies on aging, long-term care trade associations, the
265.19 ombudsman offices, counties, tribes, health plans, and other entities and the long-term
265.20 care database maintained under section 256.975, subdivision 7. The system profiles must
265.21 be designed to provide information on quality to:

- 265.22 (1) consumers and their families to facilitate informed choices of service providers;
265.23 (2) providers to enable them to measure the results of their quality improvement
265.24 efforts and compare quality achievements with other service providers; and
265.25 (3) public and private purchasers of long-term care services to enable them to
265.26 purchase high-quality care.

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

265.31 Sec. 29. Minnesota Statutes 2012, section 256B.439, subdivision 2, is amended to read:

265.32 Subd. 2. **Quality measurement tools for nursing facilities.** The commissioners
265.33 shall identify and apply existing quality measurement tools to:

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

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

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

266.6 Sec. 30. Minnesota Statutes 2012, section 256B.439, is amended by adding a
266.7 subdivision to read:

266.8 Subd. 2a. **Quality measurement tools for home and community-based services.**

266.9 (a) The commissioners shall identify and apply quality measurement tools to:

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

266.11 (2) address the needs of various users of home and community-based services.

266.12 (b) The tools must include, but not be limited to, surveys of consumers of home
266.13 and community-based services. The tools must be identified and applied, to the extent
266.14 possible, without requiring providers to supply information beyond state and federal
266.15 requirements, for purposes of this subdivision.

266.16 Sec. 31. Minnesota Statutes 2012, section 256B.439, is amended by adding a
266.17 subdivision to read:

266.18 Subd. 3a. **Consumer surveys for home and community-based services.**

266.19 Following identification of the quality measurement tool, and within the limits of the
266.20 appropriation, the commissioner shall conduct surveys of home and community-based
266.21 services consumers to develop quality profiles of providers. To the extent possible, surveys
266.22 must be conducted face-to-face by state employees or contractors. At the discretion of
266.23 the commissioner, surveys may be conducted by an alternative method. Surveys must be
266.24 conducted periodically to update quality profiles of individual service providers.

266.25 Sec. 32. Minnesota Statutes 2012, section 256B.439, is amended by adding a
266.26 subdivision to read:

266.27 Subd. 5. **Implementation of home and community-based services**

266.28 **performance-based incentive payment program.** By April 1, 2014, the commissioner
266.29 shall develop incentive-based grants for home and community-based services providers
266.30 for achieving outcomes specified in a contract. The commissioner may solicit proposals
266.31 from home and community-based services providers and implement those that, on
266.32 a competitive basis, best meet the state's policy objectives. The commissioner shall
266.33 determine the types of home and community-based services providers that will participate

267.1 in the program. The determination of participating provider types may be revised annually
267.2 by the commissioner. The commissioner shall limit the amount of any incentive-based
267.3 grants and the number of grants under this subdivision to operate the incentive payments
267.4 within funds appropriated for this purpose. The grant agreements may specify various
267.5 levels of payment for various levels of performance. In establishing the specified outcomes
267.6 and related criteria, the commissioner shall consider the following state policy objectives:

- 267.7 (1) provide more efficient, higher quality services;
267.8 (2) encourage home and community-based services providers to innovate;
267.9 (3) equip home and community-based services providers with organizational tools
267.10 and expertise to improve their quality;
267.11 (4) incentivize home and community-based services providers to invest in better
267.12 services; and
267.13 (5) disseminate successful performance improvement strategies statewide.

267.14 Sec. 33. Minnesota Statutes 2012, section 256B.439, is amended by adding a
267.15 subdivision to read:

267.16 **Subd. 6. Calculation of home and community-based services quality score.**

267.17 (a) The commissioner shall determine a quality score for each participating home and
267.18 community-based services provider using quality measures established in subdivisions
267.19 1 and 2a, according to methods determined by the commissioner in consultation
267.20 with stakeholders and experts. These methods shall be exempt from the rulemaking
267.21 requirements under chapter 14.

267.22 (b) For each quality measure, a score shall be determined with a maximum number
267.23 of points available and number of points assigned as determined by the commissioner
267.24 using the methodology established according to this subdivision. The determination of
267.25 the quality measures to be used and the methods of calculating scores may be revised
267.26 annually by the commissioner.

267.27 Sec. 34. Minnesota Statutes 2012, section 256B.439, is amended by adding a
267.28 subdivision to read:

267.29 **Subd. 7. Calculation of home and community-based services quality add-on.**

267.30 Effective July 1, 2015, the commissioner shall determine the quality add-on payment
267.31 for participating home and community-based services providers. The payment rate for
267.32 the quality add-on shall be a variable amount based on each provider's quality score as
267.33 determined in subdivisions 1 and 2a. The commissioner shall limit the types of home and
267.34 community-based services providers that may receive the quality add-on and the amount

268.1 of the quality add-on payments to operate the quality add-on within funds appropriated for
268.2 this purpose and based on the availability of the quality measures.

268.3 Sec. 35. Minnesota Statutes 2012, section 256B.441, subdivision 44, is amended to read:

268.4 Subd. 44. **Calculation of a quality score.** (a) The commissioner shall determine
268.5 a quality score for each nursing facility using quality measures established in section
268.6 256B.439, according to methods determined by the commissioner in consultation
268.7 with stakeholders and experts. These methods shall be exempt from the rulemaking
268.8 requirements under chapter 14.

268.9 (b) For each quality measure, a score shall be determined with a maximum number
268.10 of points available and number of points assigned as determined by the commissioner
268.11 using the methodology established according to this subdivision. The scores determined
268.12 for all quality measures shall be totaled. The determination of the quality measures to be
268.13 used and the methods of calculating scores may be revised annually by the commissioner.

268.14 (c) For the initial rate year under the new payment system, the quality measures
268.15 shall include:

- 268.16 (1) staff turnover;
268.17 (2) staff retention;
268.18 (3) use of pool staff;
268.19 (4) quality indicators from the minimum data set; and
268.20 (5) survey deficiencies.

268.21 ~~(d) For rate years beginning after October 1, 2006, when making revisions to the~~
268.22 ~~quality measures or method for calculating scores, the commissioner shall publish the~~
268.23 ~~methodology in the State Register at least 15 months prior to the start of the rate year for~~
268.24 ~~which the revised methodology is to be used for rate-setting purposes. The quality score~~
268.25 ~~used to determine payment rates shall be established for a rate year using data submitted~~
268.26 ~~in the statistical and cost report from the associated reporting year, and using data from~~
268.27 ~~other sources related to a period beginning no more than six months prior to the associated~~
268.28 ~~reporting year~~ Beginning July 1, 2013, the quality score shall be a value between zero and
268.29 100, using data as provided in the Minnesota nursing home report card, with 50 percent
268.30 derived from the Minnesota quality indicators score, 40 percent derived from the resident
268.31 quality of life score, and ten percent derived from the state inspection results score.

268.32 (e) The commissioner, in cooperation with the commissioner of health, may adjust
268.33 the formula in paragraph (d), or the methodology for computing the total quality score,
268.34 effective July 1 of any year beginning in 2014, with five months advance public notice.

269.1 In changing the formula, the commissioner shall consider quality measure priorities
269.2 registered by report card users, advise of stakeholders, and available research.

269.3 Sec. 36. Minnesota Statutes 2012, section 256B.441, is amended by adding a
269.4 subdivision to read:

269.5 Subd. 46b. **Calculation of quality add-on, with an average value of 1.25 percent,**
269.6 **effective September 1, 2013.** (a) The commissioner shall determine quality add-ons to
269.7 the operating payment rates for each facility. The increase in this subdivision shall be
269.8 applied as a percentage to operating payment rates in effect on August 31, 2013. For each
269.9 facility, the commissioner shall determine the operating payment rate, not including any
269.10 rate components resulting from equitable cost-sharing for publicly owned nursing facility
269.11 program participation under subdivision 55a, critical access nursing facility program
269.12 participation under subdivision 63, or performance-based incentive payment program
269.13 participation under section 256B.434, subdivision 4, paragraph (d), for a RUG class with a
269.14 weight of 1.00 in effect on August 31, 2013.

269.15 (b) For each facility, the commissioner shall compute a quality factor by subtracting
269.16 40 from the most recent quality score computed under subdivision 44, and then dividing
269.17 by 60. If the quality factor is less than zero, the commissioner shall use the value zero.

269.18 (c) The quality add-ons shall be the operating payment rates determined in paragraph
269.19 (a), multiplied by the quality factor determined in paragraph (b), and then multiplied by
269.20 3.2 percent. The commissioner shall implement the quality add-ons effective September
269.21 1, 2013.

269.22 Sec. 37. Minnesota Statutes 2012, section 256B.441, is amended by adding a
269.23 subdivision to read:

269.24 Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.**
269.25 The commissioner shall develop a quality improvement incentive program in consultation
269.26 with stakeholders. The annual funding pool available for quality improvement incentive
269.27 payments shall be equal to 0.8 percent of all operating payments, not including any rate
269.28 components resulting from equitable cost-sharing for publicly owned nursing facility
269.29 program participation under subdivision 55a, critical access nursing facility program
269.30 participation under subdivision 63, or performance-based incentive payment program
269.31 participation under section 256B.434, subdivision 4, paragraph (d). Beginning October 1,
269.32 2015, annual rate adjustments provided under this subdivision shall be effective for one
269.33 year, starting October 1 and ending the following September 30.

270.1 Sec. 38. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:

270.2 Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall
270.3 establish statewide priorities for individuals on the waiting list for community alternative
270.4 care, community alternatives for disabled individuals, and brain injury waiver services,
270.5 as of January 1, 2010. The statewide priorities must include, but are not limited to,
270.6 individuals who continue to have a need for waiver services after they have maximized the
270.7 use of state plan services and other funding resources, including natural supports, prior to
270.8 accessing waiver services, and who meet at least one of the following criteria:

270.9 (1) no longer require the intensity of services provided where they are currently
270.10 living; or

270.11 (2) make a request to move from an institutional setting.

270.12 (b) After the priorities in paragraph (a) are met, priority must also be given to
270.13 individuals who meet at least one of the following criteria:

270.14 (1) have unstable living situations due to the age, incapacity, or sudden loss of
270.15 the primary caregivers;

270.16 (2) are moving from an institution due to bed closures;

270.17 (3) experience a sudden closure of their current living arrangement;

270.18 (4) require protection from confirmed abuse, neglect, or exploitation;

270.19 (5) experience a sudden change in need that can no longer be met through state plan
270.20 services or other funding resources alone; or

270.21 (6) meet other priorities established by the department.

270.22 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
270.23 consideration the number of individuals waiting who meet statewide priorities and the
270.24 lead agencies' current use of waiver funds and existing service options. The commissioner
270.25 has the authority to transfer funds between counties, groups of counties, and tribes to
270.26 accommodate statewide priorities and resource needs while accounting for a necessary
270.27 base level reserve amount for each county, group of counties, and tribe.

270.28 ~~(e) The commissioner shall evaluate the impact of the use of statewide priorities and~~
270.29 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
270.30 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
270.31 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

270.32 Sec. 39. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

270.33 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments
270.34 shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.
270.35 With the permission of the recipient or the recipient's designated legal representative,

271.1 the recipient's current provider of services may submit a written report outlining their
271.2 recommendations regarding the recipient's care needs prepared by a direct service
271.3 employee with at least 20 hours of service to that client. The person conducting the
271.4 assessment or reassessment must notify the provider of the date by which this information
271.5 is to be submitted. This information shall be provided to the person conducting the
271.6 assessment and the person or the person's legal representative and must be considered
271.7 prior to the finalization of the assessment or reassessment.

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

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

271.18 (d) Recipients who are found eligible for home and community-based services under
271.19 this section before their 65th birthday may remain eligible for these services after their
271.20 65th birthday if they continue to meet all other eligibility factors.

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

271.32 Sec. 40. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:

271.33 Subd. 15. **Coordinated service and support plan; comprehensive transitional**
271.34 **service plan; maintenance service plan.** (a) Each recipient of home and community-based

272.1 waived services shall be provided a copy of the written coordinated service and support
272.2 plan which meets the requirements in section 256B.092, subdivision 1b.

272.3 (b) In developing the comprehensive transitional service plan, the individual
272.4 receiving services, the case manager, and the guardian, if applicable, will identify the
272.5 transitional service plan fundamental service outcome and anticipated timeline to achieve
272.6 this outcome. Within the first 20 days following a recipient's request for an assessment or
272.7 reassessment, the transitional service planning team must be identified. A team leader must
272.8 be identified who will be responsible for assigning responsibility and communicating with
272.9 team members to ensure implementation of the transition plan and ongoing assessment and
272.10 communication process. The team leader should be an individual, such as the case manager
272.11 or guardian, who has the opportunity to follow the recipient to the next level of service.

272.12 Within ten days following an assessment, a comprehensive transitional service plan
272.13 must be developed incorporating elements of a comprehensive functional assessment and
272.14 including short-term measurable outcomes and timelines for achievement of and reporting
272.15 on these outcomes. Functional milestones must also be identified and reported according
272.16 to the timelines agreed upon by the transitional service planning team. In addition, the
272.17 comprehensive transitional service plan must identify additional supports that may assist
272.18 in the achievement of the fundamental service outcome such as the development of greater
272.19 natural community support, increased collaboration among agencies, and technological
272.20 supports.

272.21 The timelines for reporting on functional milestones will prompt a reassessment of
272.22 services provided, the units of services, rates, and appropriate service providers. It is
272.23 the responsibility of the transitional service planning team leader to review functional
272.24 milestone reporting to determine if the milestones are consistent with observable skills
272.25 and that milestone achievement prompts any needed changes to the comprehensive
272.26 transitional service plan.

272.27 For those whose fundamental transitional service outcome involves the need to
272.28 procure housing, a plan for the recipient to seek the resources necessary to secure the least
272.29 restrictive housing possible should be incorporated into the plan, including employment
272.30 and public supports such as housing access and shelter needy funding.

272.31 (c) Counties and other agencies responsible for funding community placement and
272.32 ongoing community supportive services are responsible for the implementation of the
272.33 comprehensive transitional service plans. Oversight responsibilities include both ensuring
272.34 effective transitional service delivery and efficient utilization of funding resources.

272.35 (d) Following one year of transitional services, the transitional services planning team
272.36 will make a determination as to whether or not the individual receiving services requires

273.1 the current level of continuous and consistent support in order to maintain the recipient's
273.2 current level of functioning. Recipients who are determined to have not had a significant
273.3 change in functioning for 12 months must move from a transitional to a maintenance
273.4 service plan. Recipients on a maintenance service plan must be reassessed to determine if
273.5 the recipient would benefit from a transitional service plan at least every 12 months and at
273.6 other times when there has been a significant change in the recipient's functioning. This
273.7 assessment should consider any changes to technological or natural community supports.

273.8 (e) When a county is evaluating denials, reductions, or terminations of home and
273.9 community-based services under section 256B.49 for an individual, the case manager
273.10 shall offer to meet with the individual or the individual's guardian in order to discuss
273.11 the prioritization of service needs within the coordinated service and support plan,
273.12 comprehensive transitional service plan, or maintenance service plan. The reduction in
273.13 the authorized services for an individual due to changes in funding for waived services
273.14 may not exceed the amount needed to ensure medically necessary services to meet the
273.15 individual's health, safety, and welfare.

273.16 (f) At the time of reassessment, local agency case managers shall assess each recipient
273.17 of community alternatives for disabled individuals or brain injury waived services
273.18 currently residing in a licensed adult foster home that is not the primary residence of the
273.19 license holder, or in which the license holder is not the primary caregiver, to determine if
273.20 that recipient could appropriately be served in a community-living setting. If appropriate
273.21 for the recipient, the case manager shall offer the recipient, through a person-centered
273.22 planning process, the option to receive alternative housing and service options. In the
273.23 event that the recipient chooses to transfer from the adult foster home, the vacated bed
273.24 shall not be filled with another recipient of waiver services and group residential housing
273.25 and the licensed capacity shall be reduced accordingly, unless the savings required by the
273.26 licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7,
273.27 sections 1 and 40, paragraph (f), for foster care settings where the physical location is not
273.28 the primary residence of the license holder are met through voluntary changes described
273.29 in section 245A.03, subdivision 7, paragraph ~~(f)~~(e), or as provided under paragraph (a),
273.30 clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers,
273.31 the county agency, with the assistance of the department, shall facilitate a consolidation of
273.32 settings or closure. This reassessment process shall be completed by July 1, 2013.

273.33 Sec. 41. Minnesota Statutes 2012, section 256B.49, is amended by adding a
273.34 subdivision to read:

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

274.9 (1) conduct a functional assessment of the crisis incident as defined in section
274.10 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
274.11 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
274.12 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

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

274.25 **Subd. 26. Excess allocations.** County and tribal agencies will be responsible for
274.26 authorizations in excess of the allocation made by the commissioner. In the event a county
274.27 or tribal agency authorizes in excess of the allocation made by the commissioner for a
274.28 given allocation period, the county or tribal agency must submit a corrective action plan to
274.29 the commissioner. The plan must state the actions the agency will take to correct their
274.30 overspending for the year following the period when the overspending occurred. Failure
274.31 to correct overauthorizations shall result in recoupment of authorizations in excess of
274.32 the allocation. Nothing in this subdivision shall be construed as reducing the county's
274.33 responsibility to offer and make available feasible home and community-based options to
274.34 eligible waiver recipients within the resources allocated to them for that purpose.

275.1 Sec. 43. Minnesota Statutes 2012, section 256B.492, is amended to read:

275.2 **256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE**
275.3 **WITH DISABILITIES.**

275.4 (a) Individuals receiving services under a home and community-based waiver under
275.5 section 256B.092 or 256B.49 may receive services in the following settings:

275.6 (1) an individual's own home or family home;

275.7 (2) a licensed adult foster care setting of up to five people; and

275.8 (3) community living settings as defined in section 256B.49, subdivision 23, where
275.9 individuals with disabilities may reside in all of the units in a building of four or fewer
275.10 units, and no more than the greater of four or 25 percent of the units in a multifamily
275.11 building of more than four units, unless required by the Housing Opportunities for Persons
275.12 with AIDS Program.

275.13 (b) The settings in paragraph (a) must not:

275.14 (1) be located in a building that is a publicly or privately operated facility that
275.15 provides institutional treatment or custodial care;

275.16 (2) be located in a building on the grounds of or adjacent to a public or private
275.17 institution;

275.18 (3) be a housing complex designed expressly around an individual's diagnosis or
275.19 disability, unless required by the Housing Opportunities for Persons with AIDS Program;

275.20 (4) be segregated based on a disability, either physically or because of setting
275.21 characteristics, from the larger community; and

275.22 (5) have the qualities of an institution which include, but are not limited to:
275.23 regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions
275.24 agreed to and documented in the person's individual service plan shall not result in a
275.25 residence having the qualities of an institution as long as the restrictions for the person are
275.26 not imposed upon others in the same residence and are the least restrictive alternative,
275.27 imposed for the shortest possible time to meet the person's needs.

275.28 (c) The provisions of paragraphs (a) and (b) do not apply to any setting in which
275.29 individuals receive services under a home and community-based waiver as of July 1,
275.30 2012, and the setting does not meet the criteria of this section.

275.31 (d) Notwithstanding paragraph (c), a program in Hennepin County established as
275.32 part of a Hennepin County demonstration project is qualified for the exception allowed
275.33 under paragraph (c).

275.34 (e) The commissioner shall submit an amendment to the waiver plan no later than
275.35 December 31, 2012.

276.1 Sec. 44. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:

276.2 Subd. 2. **Planned closure process needs determination.** The commissioner shall
276.3 announce and implement a program for planned closure of adult foster care homes. Planned
276.4 closure shall be the preferred method for achieving necessary budgetary savings required by
276.5 the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph ~~(d)~~
276.6 (c). If additional closures are required to achieve the necessary savings, the commissioner
276.7 shall use the process and priorities in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c).

276.8 Sec. 45. Minnesota Statutes 2012, section 256B.501, is amended by adding a
276.9 subdivision to read:

276.10 Subd. 14. **Rate adjustment for ICF/DD in Cottonwood County.** The
276.11 commissioner of health shall decertify three beds in an intermediate care facility for
276.12 persons with developmental disabilities with 21 certified beds located in Cottonwood
276.13 County. The total payment rate shall be \$282.62 per bed, per day.

276.14 Sec. 46. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
276.15 subdivision to read:

276.16 Subd. 14. **Rate increase effective June 1, 2013.** For rate periods beginning on or
276.17 after June 1, 2013, the commissioner shall increase the total operating payment rate for
276.18 each facility reimbursed under this section by \$7.81 per day. The increase shall not be
276.19 subject to any annual percentage increase.

276.20 **EFFECTIVE DATE.** This section is effective June 1, 2013.

276.21 Sec. 47. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
276.22 subdivision to read:

276.23 Subd. 15. **ICF/DD rate increases effective April 1, 2014.** (a) Notwithstanding
276.24 subdivision 12, for each facility reimbursed under this section, for the rate period
276.25 beginning April 1, 2014, the commissioner shall increase operating payments equal to one
276.26 percent of the operating payment rates in effect on March 31, 2014.

276.27 (b) For each facility, the commissioner shall apply the rate increase based on
276.28 occupied beds, using the percentage specified in this subdivision multiplied by the total
276.29 payment rate, including the variable rate, but excluding the property-related payment
276.30 rate in effect on the preceding date. The total rate increase shall include the adjustment
276.31 provided in section 256B.501, subdivision 12.

277.1 Sec. 48. Minnesota Statutes 2012, section 256B.69, is amended by adding a
277.2 subdivision to read:

277.3 Subd. 32a. **Initiatives to improve early screening, diagnosis, and treatment of**
277.4 **children with autism spectrum disorder and other developmental conditions.** (a) The
277.5 commissioner shall require managed care plans and county-based purchasing plans, as
277.6 a condition of contract, to implement strategies that facilitate access for young children
277.7 between the ages of one and three years to periodic developmental and social-emotional
277.8 screenings, as recommended by the Minnesota Interagency Developmental Screening
277.9 Task Force, and that those children who do not meet milestones are provided access to
277.10 appropriate evaluation and assessment, including treatment recommendations, expected to
277.11 improve the child's functioning, with the goal of meeting milestones by age five.

277.12 (b) The following information from encounter data provided to the commissioner
277.13 shall be reported on the department's public Web site for each managed care plan and
277.14 county-based purchasing plan annually by July 31 of each year beginning in 2014:

277.15 (1) the number of children who received a diagnostic assessment;

277.16 (2) the total number of children ages one to six with a diagnosis of autism spectrum
277.17 disorder who received treatments;

277.18 (3) the number of children identified under clause (2) reported by each 12-month age
277.19 group beginning with age one and ending with age six; and

277.20 (4) the types of treatments provided to children identified under clause (2) listed by
277.21 billing code, including the number of units billed for each child.

277.22 (c) The managed care plans and county-based purchasing plans shall also report on
277.23 any barriers to providing screening, diagnosis, and treatment of young children between
277.24 the ages of one and three years, any strategies implemented to address those barriers,
277.25 and make recommendations on how to measure and report on the effectiveness of the
277.26 strategies implemented to facilitate access for young children to provide developmental
277.27 and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

277.28 Sec. 49. [256B.85] **COMMUNITY FIRST SERVICES AND SUPPORTS.**

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

277.33 (b) CFSS is a participant-controlled method of selecting and providing services
277.34 and supports that allows the participant maximum control of the services and supports.
277.35 Participants may choose the degree to which they direct and manage their supports by

278.1 choosing to have a significant and meaningful role in the management of services and
278.2 supports including by directly employing support workers with the necessary supports
278.3 to perform that function.

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

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

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

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

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

278.23 (d) "Behavior" means a description of a need for services and supports used to
278.24 determine the home care rating and additional service units. The presence of Level I
278.25 behavior is used to determine the home care rating. "Level I behavior" means physical
278.26 aggression towards self or others or destruction of property that requires the immediate
278.27 response of another person. If qualified for a home care rating as described in subdivision
278.28 8, additional service units can be added as described in subdivision 8, paragraph (f), for
278.29 the following behaviors:

278.30 (1) Level I behavior;

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

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

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

279.4 (1) tube feedings requiring:

279.5 (i) a gastrojejunostomy tube; or

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

279.7 (2) wounds described as:

279.8 (i) stage III or stage IV;

279.9 (ii) multiple wounds;

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

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

279.13 (3) parenteral therapy described as:

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

279.16 (ii) total parenteral nutrition (TPN) daily;

279.17 (4) respiratory interventions, including:

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

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

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

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

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

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

279.25 (5) insertion and maintenance of catheter, including:

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

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

279.29 (iii) bladder irrigations;

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

279.32 (7) neurological intervention, including:

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

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

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

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

280.9 (g) "Community first services and supports service delivery plan" or "service delivery
280.10 plan" means a written summary of the services and supports, that is based on the community
280.11 support plan identified in section 256B.0911 and coordinated services and support plan
280.12 and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined
280.13 by the participant to meet the assessed needs, using a person-centered planning process.

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

280.16 (i) "Dependency" in activities of daily living means a person requires hands-on
280.17 assistance or constant supervision and cueing to accomplish one or more of the activities
280.18 of daily living every day or on the days during the week that the activity is performed;
280.19 however, a child may not be found to be dependent in an activity of daily living if,
280.20 because of the child's age, an adult would either perform the activity for the child or assist
280.21 the child with the activity and the assistance needed is the assistance appropriate for
280.22 a typical child of the same age.

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

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

280.35 (l) "Budget model" means a service delivery method of CFSS that allows the use of
280.36 an individualized CFSS service delivery plan and service budget and provides assistance

281.1 from the financial management services contractor to facilitate participant employment of
281.2 support workers and the acquisition of supports and goods.

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

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

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

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

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

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

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

281.29 (q) "Participant's representative" means a parent, family member, advocate, or
281.30 other adult authorized by the participant to serve as a representative in connection with
281.31 the provision of CFSS. This authorization must be in writing or by another method
281.32 that clearly indicates the participant's free choice. The participant's representative must
281.33 have no financial interest in the provision of any services included in the participant's
281.34 service delivery plan and must be capable of providing the support necessary to assist
281.35 the participant in the use of CFSS. If through the assessment process described in
281.36 subdivision 5 a participant is determined to be in need of a participant's representative, one

282.1 must be selected. If the participant is unable to assist in the selection of a participant's
282.2 representative, the legal representative shall appoint one. Two persons may be designated
282.3 as a participant's representative for reasons such as divided households and court-ordered
282.4 custodies. Duties of a participant's representatives may include:

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

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

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

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

282.14 (1) include people chosen by the participant;

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

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

282.19 (4) reflect cultural considerations of the participant;

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

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

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

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

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

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

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

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

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

283.5 (u) "Support worker" means an employee of the agency provider or of the participant
283.6 who has direct contact with the participant and provides services as specified within the
283.7 participant's service delivery plan.

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

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

283.15 (1) is a recipient of medical assistance as determined under section 256B.055,
283.16 256B.056, or 256B.057, subdivisions 5 and 9;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

284.13 (d) The lead agency assessor may request a temporary authorization for CFSS
284.14 services. Authorization for a temporary level of CFSS services is limited to the time
284.15 specified by the commissioner, but shall not exceed 45 days. The level of services
284.16 authorized under this provision shall have no bearing on a future authorization.

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

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

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

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

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

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

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

285.3 (5) include individually identified goals and desired outcomes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

286.16 (6) transition costs, including:

286.17 (i) deposits for rent and utilities;

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

286.19 (iii) bedding;

286.20 (iv) basic kitchen supplies;

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

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

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

286.29 **Subd. 8. Determination of CFSS service methodology.** (a) All community first
286.30 services and supports must be authorized by the commissioner or the commissioner's
286.31 designee before services begin, except for the assessments established in section
286.32 256B.0911. The authorization for CFSS must be completed as soon as possible following
286.33 an assessment but no later than 40 calendar days from the date of the assessment.

286.34 (b) The amount of CFSS authorized must be based on the recipient's home care
286.35 rating described in subdivision 8, paragraphs (d) and (e), and any additional service units
286.36 for which the person qualifies as described in subdivision 8, paragraph (f).

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

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

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

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

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

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

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

287.17 (ii) Q home care rating requires Level 1 behavior and one to three dependencies in
287.18 ADLs and qualifies one for six service units;

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

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

287.23 (v) T home care rating requires four to six dependencies in ADLs and Level 1
287.24 behavior and qualifies one for 11 service units;

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

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

287.29 (viii) W home care rating requires seven to eight dependencies in ADLs and Level 1
287.30 behavior and qualifies one for 20 service units;

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

287.33 (x) EN home care rating includes ventilator dependency as defined in section
287.34 256B.0651, subdivision 1, paragraph (g). Recipients who meet the definition of
287.35 ventilator-dependent and the EN home care rating and utilize a combination of CFSS
287.36 and other home care services are limited to a total of 96 service units per day for those

288.1 services in combination. Additional units may be authorized when a recipient's assessment
288.2 indicates a need for two staff to perform activities. Additional time is limited to 16 service
288.3 units per day.

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

288.6 (1) 30 additional minutes per day for a dependency in each critical activity of daily
288.7 living as defined in subdivision 2, paragraph (h);

288.8 (2) 30 additional minutes per day for each complex health-related function as
288.9 defined in subdivision 2, paragraph (e); and

288.10 (3) 30 additional minutes per day for each behavior issue as defined in subdivision 2,
288.11 paragraph (d).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

289.7 (8) medical supplies and equipment;

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

289.9 (10) expenses for travel, lodging, or meals related to training the participant, the
289.10 participant's representative, legal representative, or paid or unpaid caregivers that exceed
289.11 \$500 in a 12-month period;

289.12 (11) experimental treatments;

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

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

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

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

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

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

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

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

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

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

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

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

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

290.6 (8) withhold and pay all applicable federal and state payroll taxes;

290.7 (9) make arrangements and pay unemployment insurance, taxes, workers'
290.8 compensation, liability insurance, and other benefits, if any;

290.9 (10) enter into a written agreement with the participant, participant's representative,
290.10 or legal representative that assigns roles and responsibilities to be performed before
290.11 services, supports, or goods are provided using a format established by the commissioner;

290.12 (11) report maltreatment as required under sections 626.556 and 626.557; and

290.13 (12) provide the participant with a copy of the service-related rights under
290.14 subdivision 19 at the start of services and supports.

290.15 Subd. 11. **Agency-provider model.** (a) The agency-provider model is limited to
290.16 the services provided by support workers and support specialists who are employed by
290.17 an agency-provider that is licensed according to chapter 245A or meets other criteria
290.18 established by the commissioner, including required training.

290.19 (b) The agency-provider shall allow the participant to have a significant role in the
290.20 selection and dismissal of the support workers for the delivery of the services and supports
290.21 specified in the participant's service delivery plan.

290.22 (c) A participant may use authorized units of CFSS services as needed within a
290.23 service authorization that is not greater than 12 months. Using authorized units in a
290.24 flexible manner in either the agency-provider model or the budget model does not increase
290.25 the total amount of services and supports authorized for a participant or included in the
290.26 participant's service delivery plan.

290.27 (d) A participant may share CFSS services. Two or three CFSS participants may
290.28 share services at the same time provided by the same support worker.

290.29 (e) The agency-provider must use a minimum of 72.5 percent of the revenue
290.30 generated by the medical assistance payment for CFSS for support worker wages and
290.31 benefits. The agency-provider must document how this requirement is being met. The
290.32 revenue generated by the support specialist and the reasonable costs associated with the
290.33 support specialist must not be used in making this calculation.

290.34 (f) The agency-provider model must be used by individuals who have been restricted
290.35 by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160
290.36 to 9505.2245.

291.1 Subd. 12. Requirements for enrollment of CFSS provider agencies. (a) All CFSS
291.2 provider agencies must provide, at the time of enrollment, reenrollment, and revalidation
291.3 as a CFSS provider agency in a format determined by the commissioner, information and
291.4 documentation that includes, but is not limited to, the following:

291.5 (1) the CFSS provider agency's current contact information including address,
291.6 telephone number, and e-mail address;

291.7 (2) proof of surety bond coverage. Upon new enrollment, or if the provider agency's
291.8 Medicaid revenue in the previous calendar year is less than or equal to \$300,000, the
291.9 provider agency must purchase a performance bond of \$50,000. If the provider agency's
291.10 Medicaid revenue in the previous calendar year is greater than \$300,000, the provider
291.11 agency must purchase a performance bond of \$100,000. The performance bond must be
291.12 in a form approved by the commissioner, must be renewed annually, and must allow for
291.13 recovery of costs and fees in pursuing a claim on the bond;

291.14 (3) proof of fidelity bond coverage in the amount of \$20,000;

291.15 (4) proof of workers' compensation insurance coverage;

291.16 (5) proof of liability insurance;

291.17 (6) a description of the CFSS provider agency's organization identifying the names
291.18 or all owners, managing employees, staff, board of directors, and the affiliations of the
291.19 directors, owners, or staff to other service providers;

291.20 (7) a copy of the CFSS provider agency's written policies and procedures including:
291.21 hiring of employees; training requirements; service delivery; and employee and consumer
291.22 safety including process for notification and resolution of consumer grievances,
291.23 identification and prevention of communicable diseases, and employee misconduct;

291.24 (8) copies of all other forms the CFSS provider agency uses in the course of daily
291.25 business including, but not limited to:

291.26 (i) a copy of the CFSS provider agency's time sheet if the time sheet varies from
291.27 the standard time sheet for CFSS services approved by the commissioner, and a letter
291.28 requesting approval of the CFSS provider agency's nonstandard time sheet; and

291.29 (ii) the CFSS provider agency's template for the CFSS care plan;

291.30 (9) a list of all training and classes that the CFSS provider agency requires of its
291.31 staff providing CFSS services;

291.32 (10) documentation that the CFSS provider agency and staff have successfully
291.33 completed all the training required by this section;

291.34 (11) documentation of the agency's marketing practices;

291.35 (12) disclosure of ownership, leasing, or management of all residential properties
291.36 that are used or could be used for providing home care services;

292.1 (13) documentation that the agency will use at least the following percentages of
292.2 revenue generated from the medical assistance rate paid for CFSS services for employee
292.3 personal care assistant wages and benefits: 72.5 percent of revenue from CFSS providers.
292.4 The revenue generated by the support specialist and the reasonable costs associated with
292.5 the support specialist shall not be used in making this calculation; and

292.6 (14) documentation that the agency does not burden recipients' free exercise of their
292.7 right to choose service providers by requiring personal care assistants to sign an agreement
292.8 not to work with any particular CFSS recipient or for another CFSS provider agency after
292.9 leaving the agency and that the agency is not taking action on any such agreements or
292.10 requirements regardless of the date signed.

292.11 (b) CFSS provider agencies shall provide to the commissioner the information
292.12 specified in paragraph (a).

292.13 (c) All CFSS provider agencies shall require all employees in management and
292.14 supervisory positions and owners of the agency who are active in the day-to-day
292.15 management and operations of the agency to complete mandatory training as determined
292.16 by the commissioner. Employees in management and supervisory positions and owners
292.17 who are active in the day-to-day operations of an agency who have completed the required
292.18 training as an employee with a CFSS provider agency do not need to repeat the required
292.19 training if they are hired by another agency, if they have completed the training within
292.20 the past three years. CFSS provider agency billing staff shall complete training about
292.21 CFSS program financial management. Any new owners or employees in management
292.22 and supervisory positions involved in the day-to-day operations are required to complete
292.23 mandatory training as a requisite of working for the agency. CFSS provider agencies
292.24 certified for participation in Medicare as home health agencies are exempt from the
292.25 training required in this subdivision.

292.26 Subd. 13. **Budget model.** (a) Under the budget model participants can exercise
292.27 more responsibility and control over the services and supports described and budgeted
292.28 within the CFSS service delivery plan. Under this model, participants may use their
292.29 budget allocation to:

292.30 (1) directly employ support workers;

292.31 (2) obtain supports and goods as defined in subdivision 7; and

292.32 (3) choose a range of support assistance services from the financial management
292.33 services (FMS) contractor related to:

292.34 (i) assistance in managing the budget to meet the service delivery plan needs,
292.35 consistent with federal and state laws and regulations;

293.1 (ii) the employment, training, supervision, and evaluation of workers by the
293.2 participant;

293.3 (iii) acquisition and payment for supports and goods; and

293.4 (iv) evaluation of individual service outcomes as needed for the scope of the
293.5 participant's degree of control and responsibility.

293.6 (b) Participants who are unable to fulfill any of the functions listed in paragraph (a)
293.7 may authorize a legal representative or participant's representative to do so on their behalf.

293.8 (c) The FMS contractor shall not provide CFSS services and supports under the
293.9 agency-provider service model. The FMS contractor shall provide service functions as
293.10 determined by the commissioner that include but are not limited to:

293.11 (1) information and consultation about CFSS;

293.12 (2) assistance with the development of the service delivery plan and budget model
293.13 as requested by the participant;

293.14 (3) billing and making payments for budget model expenditures;

293.15 (4) assisting participants in fulfilling employer-related requirements according to
293.16 Internal Revenue Code Procedure 70-6, section 3504, Agency Employer Tax Liability,
293.17 regulation 137036-08, which includes assistance with filing and paying payroll taxes, and
293.18 obtaining worker compensation coverage;

293.19 (5) data recording and reporting of participant spending; and

293.20 (6) other duties established in the contract with the department, including with
293.21 respect to providing assistance to the participant, participant's representative, or legal
293.22 representative in performing their employer responsibilities regarding support workers.

293.23 The support worker shall not be considered the employee of the financial management
293.24 services contractor.

293.25 (d) A participant who requests to purchase goods and supports along with support
293.26 worker services under the agency-provider model must use the budget model with
293.27 a service delivery plan that specifies the amount of services to be authorized to the
293.28 agency-provider and the expenditures to be paid by the FMS contractor.

293.29 (e) The FMS contractor shall:

293.30 (1) not limit or restrict the participant's choice of service or support providers or
293.31 service delivery models consistent with any applicable state and federal requirements;

293.32 (2) provide the participant and the targeted case manager, if applicable, with a
293.33 monthly written summary of the spending for services and supports that were billed
293.34 against the spending budget;

293.35 (3) be knowledgeable of state and federal employment regulations, including those
293.36 under the Fair Labor Standards Act of 1938, and comply with the requirements under the

294.1 Internal Revenue Service Revenue Code Procedure 70-6, Section 35-4, Agency Employer
294.2 Tax Liability for vendor or fiscal employer agent, and any requirements necessary to
294.3 process employer and employee deductions, provide appropriate and timely submission of
294.4 employer tax liabilities, and maintain documentation to support medical assistance claims;
294.5 (4) have current and adequate liability insurance and bonding and sufficient cash
294.6 flow as determined by the commissioner and have on staff or under contract a certified
294.7 public accountant or an individual with a baccalaureate degree in accounting;
294.8 (5) assume fiscal accountability for state funds designated for the program; and
294.9 (6) maintain documentation of receipts, invoices, and bills to track all services and
294.10 supports expenditures for any goods purchased and maintain time records of support
294.11 workers. The documentation and time records must be maintained for a minimum of
294.12 five years from the claim date and be available for audit or review upon request by the
294.13 commissioner. Claims submitted by the FMS contractor to the commissioner for payment
294.14 must correspond with services, amounts, and time periods as authorized in the participant's
294.15 spending budget and service plan.

294.16 (f) The commissioner of human services shall:
294.17 (1) establish rates and payment methodology for the FMS contractor;
294.18 (2) identify a process to ensure quality and performance standards for the FMS
294.19 contractor and ensure statewide access to FMS contractors; and
294.20 (3) establish a uniform protocol for delivering and administering CFSS services
294.21 to be used by eligible FMS contractors.

294.22 (g) The commissioner of human services shall disenroll or exclude participants from
294.23 the budget model and transfer them to the agency-provider model under the following
294.24 circumstances that include but are not limited to:
294.25 (1) when a participant has been restricted by the Minnesota restricted recipient
294.26 program, the participant may be excluded for a specified time period under Minnesota
294.27 Rules, parts 9505.2160 to 9505.2245;
294.28 (2) when a participant exits the budget model during the participant's service plan
294.29 year. Upon transfer, the participant shall not access the budget model for the remainder of
294.30 that service plan year; or
294.31 (3) when the department determines that the participant or participant's representative
294.32 or legal representative cannot manage participant responsibilities under the budget model.
294.33 The commissioner must develop policies for determining if a participant is unable to
294.34 manage responsibilities under a budget model.

295.1 (h) A participant may appeal under section 256.045, subdivision 3, in writing to the
295.2 department to contest the department's decision under paragraph (c), clause (3), to remove
295.3 or exclude the participant from the budget model.

295.4 Subd. 14. **Participant's responsibilities under budget model.** (a) A participant
295.5 using the budget model must use an FMS contractor or vendor that is under contract with
295.6 the department. Upon a determination of eligibility and completion of the assessment and
295.7 community support plan, the participant shall choose a FMS contractor from a list of
295.8 eligible vendors maintained by the department.

295.9 (b) When the participant, participant's representative, or legal representative
295.10 chooses to be the employer of the support worker, they are responsible for the hiring and
295.11 supervision of the support worker, including, but not limited to, recruiting, interviewing,
295.12 training, scheduling, and discharging the support worker consistent with federal and
295.13 state laws and regulations.

295.14 (c) In addition to the employer responsibilities in paragraph (b), the participant,
295.15 participant's representative, or legal representative is responsible for:

295.16 (1) tracking the services provided and all expenditures for goods or other supports;

295.17 (2) preparing and submitting time sheets, signed by both the participant and support
295.18 worker, to the FMS contractor on a regular basis and in a timely manner according to
295.19 the FMS contractor's procedures;

295.20 (3) notifying the FMS contractor within ten days of any changes in circumstances
295.21 affecting the CFSS service plan or in the participant's place of residence including, but
295.22 not limited to, any hospitalization of the participant or change in the participant's address,
295.23 telephone number, or employment;

295.24 (4) notifying the FMS contractor of any changes in the employment status of each
295.25 participant support worker; and

295.26 (5) reporting any problems resulting from the quality of services rendered by the
295.27 support worker to the FMS contractor. If the participant is unable to resolve any problems
295.28 resulting from the quality of service rendered by the support worker with the assistance of
295.29 the FMS contractor, the participant shall report the situation to the department.

295.30 Subd. 15. **Documentation of support services provided.** (a) Support services
295.31 provided to a participant by a support worker employed by either an agency-provider
295.32 or the participant acting as the employer must be documented daily by each support
295.33 worker, on a time sheet form approved by the commissioner. All documentation may be
295.34 Web-based, electronic, or paper documentation. The completed form must be submitted
295.35 on a monthly basis to the provider or the participant and the FMS contractor selected by

296.1 the participant to provide assistance with meeting the participant's employer obligations
296.2 and kept in the recipient's health record.

296.3 (b) The activity documentation must correspond to the written service delivery plan
296.4 and be reviewed by the agency provider or the participant and the FMS contractor when
296.5 the participant is acting as the employer of the support worker.

296.6 (c) The time sheet must be on a form approved by the commissioner documenting
296.7 time the support worker provides services in the home. The following criteria must be
296.8 included in the time sheet:

296.9 (1) full name of the support worker and individual provider number;

296.10 (2) provider name and telephone numbers, if an agency-provider is responsible for
296.11 delivery services under the written service plan;

296.12 (3) full name of the participant;

296.13 (4) consecutive dates, including month, day, and year, and arrival and departure
296.14 times with a.m. or p.m. notations;

296.15 (5) signatures of the participant or the participant's representative;

296.16 (6) personal signature of the support worker;

296.17 (7) any shared care provided, if applicable;

296.18 (8) a statement that it is a federal crime to provide false information on CFSS
296.19 billings for medical assistance payments; and

296.20 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

296.21 Subd. 16. **Support workers requirements.** (a) Support workers shall:

296.22 (1) enroll with the department as a support worker after a background study under
296.23 chapter 245C has been completed and the support worker has received a notice from the
296.24 commissioner that:

296.25 (i) the support worker is not disqualified under section 245C.14; or

296.26 (ii) is disqualified, but the support worker has received a set-aside of the
296.27 disqualification under section 245C.22;

296.28 (2) have the ability to effectively communicate with the participant or the
296.29 participant's representative;

296.30 (3) have the skills and ability to provide the services and supports according to the
296.31 person's CFSS service delivery plan and respond appropriately to the participant's needs;

296.32 (4) not be a participant of CFSS, unless the support services provided by the support
296.33 worker differ from those provided to the support worker;

296.34 (5) complete the basic standardized training as determined by the commissioner
296.35 before completing enrollment. The training must be available in languages other than
296.36 English and to those who need accommodations due to disabilities. Support worker

297.1 training must include successful completion of the following training components: basic
297.2 first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles
297.3 and responsibilities of support workers including information about basic body mechanics,
297.4 emergency preparedness, orientation to positive behavioral practices, orientation to
297.5 responding to a mental health crisis, fraud issues, time cards and documentation, and an
297.6 overview of person-centered planning and self-direction. Upon completion of the training
297.7 components, the support worker must pass the certification test to provide assistance
297.8 to participants;

297.9 (6) complete training and orientation on the participant's individual needs; and

297.10 (7) maintain the privacy and confidentiality of the participant, and not independently
297.11 determine the medication dose or time for medications for the participant.

297.12 (b) The commissioner may deny or terminate a support worker's provider enrollment
297.13 and provider number if the support worker:

297.14 (1) lacks the skills, knowledge, or ability to adequately or safely perform the
297.15 required work;

297.16 (2) fails to provide the authorized services required by the participant employer;

297.17 (3) has been intoxicated by alcohol or drugs while providing authorized services to
297.18 the participant or while in the participant's home;

297.19 (4) has manufactured or distributed drugs while providing authorized services to the
297.20 participant or while in the participant's home; or

297.21 (5) has been excluded as a provider by the commissioner of human services, or the
297.22 United States Department of Health and Human Services, Office of Inspector General,
297.23 from participation in Medicaid, Medicare, or any other federal health care program.

297.24 (c) A support worker may appeal in writing to the commissioner to contest the
297.25 decision to terminate the support worker's provider enrollment and provider number.

297.26 Subd. 17. **Support specialist requirements and payments.** The commissioner
297.27 shall develop qualifications, scope of functions, and payment rates and service limits for a
297.28 support specialist that may provide additional or specialized assistance necessary to plan,
297.29 implement, arrange, augment, or evaluate services and supports.

297.30 Subd. 18. **Service unit and budget allocation requirements and limits.** (a) For the
297.31 agency-provider model, services will be authorized in units of service. The total service
297.32 unit amount must be established based upon the assessed need for CFSS services, and must
297.33 not exceed the maximum number of units available as determined under subdivision 8.

297.34 (b) For the budget model, the budget allocation allowed for services and supports
297.35 is established by multiplying the number of units authorized under subdivision 8 by the
297.36 payment rate established by the commissioner.

298.1 Subd. 19. **Support system.** (a) The commissioner shall provide information,
298.2 consultation, training, and assistance to ensure the participant is able to manage the
298.3 services and supports and budgets, if applicable. This support shall include individual
298.4 consultation on how to select and employ workers, manage responsibilities under CFSS,
298.5 and evaluate personal outcomes.

298.6 (b) The commissioner shall provide assistance with the development of risk
298.7 management agreements.

298.8 Subd. 20. **Service-related rights.** (a) Participants must be provided with adequate
298.9 information, counseling, training, and assistance, as needed, to ensure that the participant
298.10 is able to choose and manage services, models, and budgets. This support shall include
298.11 information regarding:

298.12 (1) person-centered planning;

298.13 (2) the range and scope of individual choices;

298.14 (3) the process for changing plans, services and budgets;

298.15 (4) the grievance process;

298.16 (5) individual rights;

298.17 (6) identifying and assessing appropriate services;

298.18 (7) risks and responsibilities; and

298.19 (8) risk management.

298.20 (b) The commissioner must ensure that the participant has a copy of the most recent
298.21 community support plan and service delivery plan.

298.22 (c) A participant who appeals a reduction in previously authorized CFSS services
298.23 may continue previously authorized services pending an appeal in accordance with section
298.24 256.045.

298.25 (d) If the units of service or budget allocation for CFSS are reduced, denied, or
298.26 terminated, the commissioner must provide notice of the reasons for the reduction in the
298.27 participant's notice of denial, termination, or reduction.

298.28 (e) If all or part of a service delivery plan is denied approval, the commissioner must
298.29 provide a notice that describes the basis of the denial.

298.30 Subd. 21. **Development and Implementation Council.** The commissioner
298.31 shall establish a Development and Implementation Council of which the majority of
298.32 members are individuals with disabilities, elderly individuals, and their representatives.
298.33 The commissioner shall consult and collaborate with the council when developing and
298.34 implementing this section for at least the first five years of operation. The commissioner,
298.35 in consultation with the council, shall provide recommendations on how to improve the
298.36 quality and integrity of CFSS, reduce the paper documentation required in subdivisions

299.1 10, 12, and 15, make use of electronic means of documentation and online reporting in
299.2 order to reduce administrative costs and improve training to the legislative chairs of the
299.3 health and human services policy and finance committees by February 1, 2014.

299.4 Subd. 22. **Quality assurance and risk management system.** (a) The commissioner
299.5 shall establish quality assurance and risk management measures for use in developing and
299.6 implementing CFSS, including those that (1) recognize the roles and responsibilities of
299.7 those involved in obtaining CFSS, and (2) ensure the appropriateness of such plans and
299.8 budgets based upon a recipient's resources and capabilities. Risk management measures
299.9 must include background studies, and backup and emergency plans, including disaster
299.10 planning.

299.11 (b) The commissioner shall provide ongoing technical assistance and resource and
299.12 educational materials for CFSS participants.

299.13 (c) Performance assessment measures, such as a participant's satisfaction with the
299.14 services and supports, and ongoing monitoring of health and well-being shall be identified
299.15 in consultation with the council established in subdivision 21.

299.16 (d) Data reporting requirements will be developed in consultation with the council
299.17 established in subdivision 21.

299.18 Subd. 23. **Commissioner's access.** When the commissioner is investigating a
299.19 possible overpayment of Medicaid funds, the commissioner must be given immediate
299.20 access without prior notice to the agency provider or FMS contractor's office during
299.21 regular business hours and to documentation and records related to services provided and
299.22 submission of claims for services provided. Denying the commissioner access to records
299.23 is cause for immediate suspension of payment and terminating the agency provider's
299.24 enrollment according to section 256B.064 or terminating the FMS contract.

299.25 Subd. 24. **CFSS agency-providers; background studies.** CFSS agency-providers
299.26 enrolled to provide personal care assistance services under the medical assistance program
299.27 shall comply with the following:

299.28 (1) owners who have a five percent interest or more and all managing employees
299.29 are subject to a background study as provided in chapter 245C. This applies to currently
299.30 enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS
299.31 agency-provider. "Managing employee" has the same meaning as Code of Federal
299.32 Regulations, title 42, section 455. An organization is barred from enrollment if:

299.33 (i) the organization has not initiated background studies on owners managing
299.34 employees; or

299.35 (ii) the organization has initiated background studies on owners and managing
299.36 employees, but the commissioner has sent the organization a notice that an owner or

300.1 managing employee of the organization has been disqualified under section 245C.14, and
300.2 the owner or managing employee has not received a set-aside of the disqualification
300.3 under section 245C.22;

300.4 (2) a background study must be initiated and completed for all support specialists; and

300.5 (3) a background study must be initiated and completed for all support workers.

300.6 Subd. 25. **Commissioner recommendations required.** In consultation with
300.7 the Development and Implementation Council described in subdivision 21 and other
300.8 stakeholders, the commissioner shall develop recommendations for revisions to
300.9 subdivisions 12, 15, and 16, that promote self-direction in the following areas:

300.10 (1) CFSS provider and support worker enrollment, qualification, and disqualification
300.11 criteria;

300.12 (2) documentation requirements that are consistent with state and federal
300.13 requirements; and

300.14 (3) provisions to maintain program integrity and assure fiscal accountability for
300.15 goods and services purchased through CFSS.

300.16 The recommendations shall be provided to the chairs and ranking minority members
300.17 of the legislative committees and divisions with jurisdiction over health and human
300.18 services policy and finance by November 15, 2013.

300.19 **EFFECTIVE DATE.** This section is effective upon federal approval but no earlier
300.20 than April 1, 2014. The service will begin 90 days after federal approval or April 1,
300.21 2014, whichever is later. The commissioner of human services shall notify the revisor of
300.22 statutes when this occurs.

300.23 Sec. 50. Minnesota Statutes 2012, section 256D.44, subdivision 5, is amended to read:

300.24 Subd. 5. **Special needs.** In addition to the state standards of assistance established in
300.25 subdivisions 1 to 4, payments are allowed for the following special needs of recipients of
300.26 Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
300.27 center, or a group residential housing facility.

300.28 (a) The county agency shall pay a monthly allowance for medically prescribed
300.29 diets if the cost of those additional dietary needs cannot be met through some other
300.30 maintenance benefit. The need for special diets or dietary items must be prescribed by
300.31 a licensed physician. Costs for special diets shall be determined as percentages of the
300.32 allotment for a one-person household under the thrifty food plan as defined by the United
300.33 States Department of Agriculture. The types of diets and the percentages of the thrifty
300.34 food plan that are covered are as follows:

300.35 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

301.1 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
301.2 of thrifty food plan;

301.3 (3) controlled protein diet, less than 40 grams and requires special products, 125
301.4 percent of thrifty food plan;

301.5 (4) low cholesterol diet, 25 percent of thrifty food plan;

301.6 (5) high residue diet, 20 percent of thrifty food plan;

301.7 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;

301.8 (7) gluten-free diet, 25 percent of thrifty food plan;

301.9 (8) lactose-free diet, 25 percent of thrifty food plan;

301.10 (9) antidumping diet, 15 percent of thrifty food plan;

301.11 (10) hypoglycemic diet, 15 percent of thrifty food plan; or

301.12 (11) ketogenic diet, 25 percent of thrifty food plan.

301.13 (b) Payment for nonrecurring special needs must be allowed for necessary home
301.14 repairs or necessary repairs or replacement of household furniture and appliances using
301.15 the payment standard of the AFDC program in effect on July 16, 1996, for these expenses,
301.16 as long as other funding sources are not available.

301.17 (c) A fee for guardian or conservator service is allowed at a reasonable rate
301.18 negotiated by the county or approved by the court. This rate shall not exceed five percent
301.19 of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the
301.20 guardian or conservator is a member of the county agency staff, no fee is allowed.

301.21 (d) The county agency shall continue to pay a monthly allowance of \$68 for
301.22 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
301.23 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
301.24 until the person has not received Minnesota supplemental aid for one full calendar month
301.25 or until the person's living arrangement changes and the person no longer meets the criteria
301.26 for the restaurant meal allowance, whichever occurs first.

301.27 (e) A fee of ten percent of the recipient's gross income or \$25, whichever is less,
301.28 is allowed for representative payee services provided by an agency that meets the
301.29 requirements under SSI regulations to charge a fee for representative payee services. This
301.30 special need is available to all recipients of Minnesota supplemental aid regardless of
301.31 their living arrangement.

301.32 (f)(1) Notwithstanding the language in this subdivision, an amount equal to the
301.33 maximum allotment authorized by the federal Food Stamp Program for a single individual
301.34 which is in effect on the first day of July of each year will be added to the standards of
301.35 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify
301.36 as shelter needy and are: (i) relocating from an institution, or an adult mental health

302.1 residential treatment program under section 256B.0622; (ii) eligible for the self-directed
302.2 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and
302.3 community-based waiver recipients living in their own home or rented or leased apartment
302.4 which is not owned, operated, or controlled by a provider of service not related by blood
302.5 or marriage, unless allowed under paragraph (g).

302.6 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the
302.7 shelter needy benefit under this paragraph is considered a household of one. An eligible
302.8 individual who receives this benefit prior to age 65 may continue to receive the benefit
302.9 after the age of 65.

302.10 (3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that
302.11 exceed 40 percent of the assistance unit's gross income before the application of this
302.12 special needs standard. "Gross income" for the purposes of this section is the applicant's or
302.13 recipient's income as defined in section 256D.35, subdivision 10, or the standard specified
302.14 in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or
302.15 state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be
302.16 considered shelter needy for purposes of this paragraph.

302.17 (g) Notwithstanding this subdivision, to access housing and services as provided
302.18 in paragraph (f), the recipient may choose housing that may be owned, operated, or
302.19 controlled by the recipient's service provider. In a multifamily building of more than four
302.20 units, the maximum number of units that may be used by recipients of this program shall
302.21 be the greater of four units or 25 percent of the units in the building, unless required by the
302.22 Housing Opportunities for Persons with AIDS Program. In multifamily buildings of four
302.23 or fewer units, all of the units may be used by recipients of this program. When housing is
302.24 controlled by the service provider, the individual may choose the individual's own service
302.25 provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is
302.26 controlled by the service provider, the service provider shall implement a plan with the
302.27 recipient to transition the lease to the recipient's name. Within two years of signing the
302.28 initial lease, the service provider shall transfer the lease entered into under this subdivision
302.29 to the recipient. In the event the landlord denies this transfer, the commissioner may
302.30 approve an exception within sufficient time to ensure the continued occupancy by the
302.31 recipient. This paragraph expires June 30, 2016.

302.32 Sec. 51. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
302.33 3, as amended by Laws 2012, chapter 247, article 4, section 43, is amended to read:

302.34 Subd. 3. **Forecasted Programs**

303.1 The amounts that may be spent from this
 303.2 appropriation for each purpose are as follows:

303.3 **(a) MFIP/DWP Grants**

303.4	Appropriations by Fund		
303.5	General	84,680,000	91,978,000
303.6	Federal TANF	84,425,000	75,417,000

303.7 (b) MFIP Child Care Assistance Grants	55,456,000	30,923,000
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303.8 (c) General Assistance Grants	49,192,000	46,938,000
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303.9 **General Assistance Standard.** The
 303.10 commissioner shall set the monthly standard
 303.11 of assistance for general assistance units
 303.12 consisting of an adult recipient who is
 303.13 childless and unmarried or living apart
 303.14 from parents or a legal guardian at \$203.

303.15 The commissioner may reduce this amount
 303.16 according to Laws 1997, chapter 85, article
 303.17 3, section 54.

303.18 **Emergency General Assistance.** The
 303.19 amount appropriated for emergency general
 303.20 assistance funds is limited to no more than
 303.21 \$6,689,812 in fiscal year 2012 and \$6,729,812
 303.22 in fiscal year 2013. Funds to counties shall
 303.23 be allocated by the commissioner using the
 303.24 allocation method specified in Minnesota
 303.25 Statutes, section 256D.06.

303.26 (d) Minnesota Supplemental Aid Grants	38,095,000	39,120,000
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303.27 (e) Group Residential Housing Grants	121,080,000	129,238,000
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303.28 (f) MinnesotaCare Grants	295,046,000	317,272,000
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303.29 This appropriation is from the health care
 303.30 access fund.

303.31 (g) Medical Assistance Grants	4,501,582,000	4,437,282,000
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303.32 **Managed Care Incentive Payments.** The
 303.33 commissioner shall not make managed care

304.1 incentive payments for expanding preventive
304.2 services during fiscal years beginning July 1,
304.3 2011, and July 1, 2012.

304.4 **Reduction of Rates for Congregate**

304.5 **Living for Individuals with Lower Needs.**

304.6 Beginning October 1, 2011, lead agencies
304.7 must reduce rates in effect on January 1, 2011,
304.8 by ten percent for individuals with lower
304.9 needs living in foster care settings where the
304.10 license holder does not share the residence
304.11 with recipients on the CADI and DD waivers
304.12 and customized living settings for CADI.

304.13 Lead agencies shall consult with providers to
304.14 review individual service plans and identify
304.15 changes or modifications to reduce the
304.16 utilization of services while maintaining the
304.17 health and safety of the individual receiving
304.18 services. Lead agencies must adjust contracts
304.19 within 60 days of the effective date. If
304.20 federal waiver approval is obtained under
304.21 the long-term care realignment waiver
304.22 application submitted on February 13,
304.23 2012, and federal financial participation is
304.24 authorized for the alternative care program,
304.25 the commissioner shall adjust this payment
304.26 rate reduction from ten to five percent for
304.27 services rendered on or after July 1, 2012, or
304.28 the first day of the month following federal
304.29 approval, whichever is later. Effective
304.30 August 1, 2013, this provision does not apply
304.31 to individuals whose primary diagnosis is
304.32 mental illness and who are living in foster
304.33 care settings where the license holder is
304.34 also (1) a provider of assertive community
304.35 treatment (ACT) or adult rehabilitative
304.36 mental health services (ARMHS) as defined

305.1 in Minnesota Statutes, section 256B.0623;
305.2 (2) a mental health center or mental health
305.3 clinic certified under Minnesota Rules, parts
305.4 9520.0750 to 9520.0870; or (3) a provider
305.5 of intensive residential treatment services
305.6 (IRTS) licensed under Minnesota Rules,
305.7 parts 9520.0500 to 9520.0670.

305.8 **Reduction of Lead Agency Waiver**
305.9 **Allocations to Implement Rate Reductions**
305.10 **for Congregate Living for Individuals**
305.11 **with Lower Needs.** Beginning October 1,
305.12 2011, the commissioner shall reduce lead
305.13 agency waiver allocations to implement the
305.14 reduction of rates for individuals with lower
305.15 needs living in foster care settings where the
305.16 license holder does not share the residence
305.17 with recipients on the CADI and DD waivers
305.18 and customized living settings for CADI.

305.19 **Reduce customized living and 24-hour**
305.20 **customized living component rates.**
305.21 Effective July 1, 2011, the commissioner
305.22 shall reduce elderly waiver customized living
305.23 and 24-hour customized living component
305.24 service spending by five percent through
305.25 reductions in component rates and service
305.26 rate limits. The commissioner shall adjust
305.27 the elderly waiver capitation payment
305.28 rates for managed care organizations paid
305.29 under Minnesota Statutes, section 256B.69,
305.30 subdivisions 6a and 23, to reflect reductions
305.31 in component spending for customized living
305.32 services and 24-hour customized living
305.33 services under Minnesota Statutes, section
305.34 256B.0915, subdivisions 3e and 3h, for the
305.35 contract period beginning January 1, 2012.
305.36 To implement the reduction specified in

306.1 this provision, capitation rates paid by the
306.2 commissioner to managed care organizations
306.3 under Minnesota Statutes, section 256B.69,
306.4 shall reflect a ten percent reduction for the
306.5 specified services for the period January 1,
306.6 2012, to June 30, 2012, and a five percent
306.7 reduction for those services on or after July
306.8 1, 2012.

306.9 **Limit Growth in the Developmental**
306.10 **Disability Waiver.** The commissioner
306.11 shall limit growth in the developmental
306.12 disability waiver to six diversion allocations
306.13 per month beginning July 1, 2011, through
306.14 June 30, 2013, and 15 diversion allocations
306.15 per month beginning July 1, 2013, through
306.16 June 30, 2015. Waiver allocations shall
306.17 be targeted to individuals who meet the
306.18 priorities for accessing waiver services
306.19 identified in Minnesota Statutes, 256B.092,
306.20 subdivision 12. The limits do not include
306.21 conversions from intermediate care facilities
306.22 for persons with developmental disabilities.
306.23 Notwithstanding any contrary provisions in
306.24 this article, this paragraph expires June 30,
306.25 2015.

306.26 **Limit Growth in the Community**
306.27 **Alternatives for Disabled Individuals**
306.28 **Waiver.** The commissioner shall limit
306.29 growth in the community alternatives for
306.30 disabled individuals waiver to 60 allocations
306.31 per month beginning July 1, 2011, through
306.32 June 30, 2013, and 85 allocations per
306.33 month beginning July 1, 2013, through
306.34 June 30, 2015. Waiver allocations must
306.35 be targeted to individuals who meet the
306.36 priorities for accessing waiver services

307.1 identified in Minnesota Statutes, section
 307.2 256B.49, subdivision 11a. The limits include
 307.3 conversions and diversions, unless the
 307.4 commissioner has approved a plan to convert
 307.5 funding due to the closure or downsizing
 307.6 of a residential facility or nursing facility
 307.7 to serve directly affected individuals on
 307.8 the community alternatives for disabled
 307.9 individuals waiver. Notwithstanding any
 307.10 contrary provisions in this article, this
 307.11 paragraph expires June 30, 2015.

307.12 **Personal Care Assistance Relative**
 307.13 **Care.** The commissioner shall adjust the
 307.14 capitation payment rates for managed care
 307.15 organizations paid under Minnesota Statutes,
 307.16 section 256B.69, to reflect the rate reductions
 307.17 for personal care assistance provided by
 307.18 a relative pursuant to Minnesota Statutes,
 307.19 section 256B.0659, subdivision 11. This rate
 307.20 reduction is effective July 1, 2013.

307.21 (h) Alternative Care Grants	46,421,000	46,035,000
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307.22 **Alternative Care Transfer.** Any money
 307.23 allocated to the alternative care program that
 307.24 is not spent for the purposes indicated does
 307.25 not cancel but shall be transferred to the
 307.26 medical assistance account.

307.27 (i) Chemical Dependency Entitlement Grants	94,675,000	93,298,000
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307.28 **EFFECTIVE DATE.** This section is effective August 1, 2013.

307.29 Sec. 52. Laws 2012, chapter 247, article 6, section 4, is amended to read:

307.30 Sec. 4. BOARD OF NURSING HOME		
307.31 ADMINISTRATORS	\$	-0- \$ 10,000

307.32 **Administrative Services Unit.** This
 307.33 appropriation is to provide a grant to the

308.1 Minnesota Ambulance Association to
308.2 coordinate and prepare an assessment of
308.3 the extent and costs of uncompensated care
308.4 as a direct result of emergency responses
308.5 on interstate highways in Minnesota.

308.6 The study will collect appropriate
308.7 information from medical response units
308.8 and ambulance services regulated under
308.9 Minnesota Statutes, chapter 144E, and to
308.10 the extent possible, firefighting agencies.
308.11 In preparing the assessment, the Minnesota
308.12 Ambulance Association shall consult with
308.13 its membership, the Minnesota Fire Chiefs
308.14 Association, the Office of the State Fire
308.15 Marshal, and the Emergency Medical
308.16 Services Regulatory Board. The findings
308.17 of the assessment will be reported to the
308.18 chairs and ranking minority members of the
308.19 legislative committees with jurisdiction over
308.20 health and public safety by January 1, 2013.

308.21 This is a onetime appropriation.

308.22 Sec. 53. **RECOMMENDATIONS FOR CONCENTRATION LIMITS ON HOME**
308.23 **AND COMMUNITY-BASED SETTINGS.**

308.24 The commissioner of human services shall consult with the Minnesota Olmstead
308.25 subcabinet, advocates, providers, and city representatives to develop recommendations
308.26 on concentration limits on home and community-based settings, as defined in
308.27 Minnesota Statutes, section 256B.492, as well as any other exceptions to the definition.
308.28 The recommendations must be consistent with Minnesota's Olmstead plan. The
308.29 recommendations and proposed legislation must be submitted to the chairs and ranking
308.30 minority members of the legislative committees with jurisdiction over health and human
308.31 services policy and finance by February 1, 2014.

308.32 Sec. 54. **TRAINING OF AUTISM SERVICE PROVIDERS.**

308.33 The commissioners of health and human services shall ensure that the departments'
308.34 autism-related service providers receive training in culturally appropriate approaches to

309.1 servicing the Somali, Latino, Hmong, and Indigenous American Indian communities, and
309.2 other cultural groups experiencing a disproportionate incidence of autism.

309.3 **Sec. 55. DIRECTION TO COMMISSIONER; SPOUSAL DISREGARD.**

309.4 The commissioner of human services shall request authority, in whatever form is
309.5 necessary, from the federal Centers for Medicare and Medicaid Services to allow persons
309.6 under age 65 participating in the home and community-based services waivers to continue
309.7 to use the disregard of the nonassisted spouse's income and assets instead of the spousal
309.8 impoverishment provisions under the federal Patient Protection and Affordable Care Act,
309.9 Public Law 111-148, section 2404, as amended by the federal Health Care and Education
309.10 Reconciliation Act of 2010, Public Law 111-152, and any amendments to, or regulations
309.11 or guidance issued under, those acts.

309.12 **Sec. 56. DIRECTION TO COMMISSIONER; ABA.**

309.13 By January 1, 2014, the commissioner of human services shall apply to the federal
309.14 Centers for Medicare and Medicaid Services for a waiver or other authority to provide
309.15 applied behavioral analysis services to children with autism spectrum disorder and related
309.16 conditions under the medical assistance program.

309.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

309.18 **Sec. 57. RECOMMENDATIONS ON RAISING THE ASSET LIMITS FOR**
309.19 **SENIORS AND PERSONS WITH DISABILITIES.**

309.20 The commissioner of human services shall consult with interested stakeholders to
309.21 develop recommendations and a request for a federal 1115 demonstration waiver in order
309.22 to increase the asset limit for individuals eligible for medical assistance due to disability
309.23 or age who are not residing in a nursing facility, intermediate care facility for persons
309.24 with developmental disabilities, or other institution whose costs for room and board are
309.25 covered by medical assistance or state funds. The recommendations must be provided to
309.26 the legislative committees and divisions with jurisdiction over health and human services
309.27 policy and finance by February 1, 2014.

309.28 **Sec. 58. NURSING HOME LEVEL OF CARE REPORT.**

309.29 (a) The commissioner of human services shall report on the impact of the
309.30 modification to the nursing facility level of care to be implemented January 1, 2014,
309.31 including the following:

310.1 (1) the number of individuals who lose eligibility for home and community-based
310.2 services waivers under Minnesota Statutes, sections 256B.0915 and 256B.49, and
310.3 alternative care under Minnesota Statutes, section 256B.0913;

310.4 (2) the number of individuals who lose eligibility for medical assistance; and

310.5 (3) for individuals reported under clauses (1) and (2), and to the extent possible:

310.6 (i) their living situation before and after nursing facility level of care implementation;

310.7 and

310.8 (ii) the programs or services they received before and after nursing facility level of
310.9 care implementation, including, but not limited to, personal care assistant services and
310.10 essential community supports.

310.11 (b) The commissioner of human services shall report to the chairs and ranking
310.12 minority members of the legislative committees and divisions with jurisdiction over health
310.13 and human services policy and finance with the information required under paragraph

310.14 (a). A preliminary report shall be submitted on October 1, 2014, and a final report shall
310.15 be submitted February 15, 2015.

310.16 **Sec. 59. ASSISTIVE TECHNOLOGY EQUIPMENT FOR HOME AND**
310.17 **COMMUNITY-BASED SERVICES WAIVERS FUNDING DEVELOPMENT.**

310.18 (a) For the purposes of this section, "assistive technology equipment" includes
310.19 computer tablets, passive sensors, and other forms of technology allowing increased
310.20 safety and independence, and used by those receiving services through a home and
310.21 community-based services waiver under Minnesota Statutes, sections 256B.0915,
310.22 256B.092, and 256B.49.

310.23 (b) The commissioner of human services shall develop recommendations for
310.24 assistive technology equipment funding to enable individuals receiving services identified
310.25 in paragraph (a) to live in the least restrictive setting possible. In developing the funding,
310.26 the commissioner shall examine funding for the following:

310.27 (1) an assessment process to match the appropriate assistive technology equipment
310.28 with the waiver recipient, including when the recipient's condition changes or progresses;

310.29 (2) the use of monitoring services, if applicable, to the assistive technology
310.30 equipment identified in clause (1);

310.31 (3) the leasing of assistive technology equipment as a possible alternative to
310.32 purchasing the equipment; and

310.33 (4) ongoing support services, such as technological support.

310.34 (c) The commissioner shall provide the chairs and ranking minority members of the
310.35 legislative committees and divisions with jurisdiction over health and human services

311.1 policy and finance a recommendation for implementing an assistive technology equipment
311.2 program as developed in paragraph (b) by February 1, 2014.

311.3 **Sec. 60. PROVIDER RATE AND GRANT INCREASE EFFECTIVE APRIL**
311.4 **1, 2014.**

311.5 (a) The commissioner of human services shall increase reimbursement rates, grants,
311.6 allocations, individual limits, and rate limits, as applicable, by one percent for the rate
311.7 period beginning April 1, 2014, for services rendered on or after those dates. County or
311.8 tribal contracts for services specified in this section must be amended to pass through
311.9 these rate increases within 60 days of the effective date.

311.10 (b) The rate changes described in this section must be provided to:

311.11 (1) home and community-based waived services for persons with developmental
311.12 disabilities or related conditions, including consumer-directed community supports, under
311.13 Minnesota Statutes, section 256B.501;

311.14 (2) waived services under community alternatives for disabled individuals,
311.15 including consumer-directed community supports, under Minnesota Statutes, section
311.16 256B.49;

311.17 (3) community alternative care waived services, including consumer-directed
311.18 community supports, under Minnesota Statutes, section 256B.49;

311.19 (4) brain injury waived services, including consumer-directed community
311.20 supports, under Minnesota Statutes, section 256B.49;

311.21 (5) home and community-based waived services for the elderly under Minnesota
311.22 Statutes, section 256B.0915;

311.23 (6) nursing services and home health services under Minnesota Statutes, section
311.24 256B.0625, subdivision 6a;

311.25 (7) personal care services and qualified professional supervision of personal care
311.26 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

311.27 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
311.28 subdivision 7;

311.29 (9) day training and habilitation services for adults with developmental disabilities
311.30 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
311.31 additional cost of rate adjustments on day training and habilitation services, provided as a
311.32 social service, formerly funded under Minnesota Statutes 2010, chapter 256M;

311.33 (10) alternative care services under Minnesota Statutes, section 256B.0913;

311.34 (11) living skills training programs for persons with intractable epilepsy who need
311.35 assistance in the transition to independent living under Laws 1988, chapter 689;

312.1 (12) semi-independent living services (SILS) under Minnesota Statutes, section
312.2 252.275, including SILS funding under county social services grants formerly funded
312.3 under Minnesota Statutes, chapter 256M;

312.4 (13) consumer support grants under Minnesota Statutes, section 256.476;

312.5 (14) family support grants under Minnesota Statutes, section 252.32;

312.6 (15) housing access grants under Minnesota Statutes, sections 256B.0658 and
312.7 256B.0917, subdivision 14;

312.8 (16) self-advocacy grants under Laws 2009, chapter 101;

312.9 (17) technology grants under Laws 2009, chapter 79;

312.10 (18) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
312.11 and 256B.0928; and

312.12 (19) community support services for deaf and hard-of-hearing adults with mental
312.13 illness who use or wish to use sign language as their primary means of communication
312.14 under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing
312.15 grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9;
312.16 and Laws 1997, First Special Session chapter 5, section 20.

312.17 (c) A managed care plan receiving state payments for the services in this section
312.18 must include these increases in their payments to providers. To implement the rate increase
312.19 in this section, capitation rates paid by the commissioner to managed care organizations
312.20 under Minnesota Statutes, section 256B.69, shall reflect a one percent increase for the
312.21 specified services for the period beginning April 1, 2014.

312.22 (d) Counties shall increase the budget for each recipient of consumer-directed
312.23 community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

312.24 **Sec. 61. SAFETY NET FOR HOME AND COMMUNITY-BASED SERVICES**
312.25 **WAIVERS.**

312.26 The commissioner of human services shall submit a request by December 31, 2013,
312.27 to the federal government to amend the home and community-based services waivers for
312.28 individuals with disabilities authorized under Minnesota Statutes, section 256B.49, to
312.29 modify the financial management of the home and community-based services waivers
312.30 to provide a state-administered safety net when costs for an individual increase above
312.31 an identified threshold. The implementation of the safety net may result in a decreased
312.32 allocation for individual counties, tribes, or collaboratives of counties or tribes, but must
312.33 not result in a net decreased statewide allocation.

312.34 **Sec. 62. SHARED LIVING MODEL.**

313.1 The commissioner of human services shall develop and promote a shared living model
313.2 option for individuals receiving services through the home and community-based services
313.3 waivers for individuals with disabilities, authorized under Minnesota Statutes, section
313.4 256B.092 or 256B.49, as an option for individuals who require 24-hour assistance. The
313.5 option must be a companion model with a limit of one or two individuals receiving support
313.6 in the home, planned respite for the caregiver, and the availability of intensive training
313.7 and support on the needs of the individual or individuals. Any necessary amendments to
313.8 implement the model must be submitted to the federal government by December 31, 2013.

313.9 Sec. 63. **MONEY FOLLOWS THE PERSON GRANT.**

313.10 The commissioner of human services shall submit to the federal government all
313.11 necessary waiver amendments to implement the Money Follows the Person federal grant
313.12 by December 31, 2013.

313.13 Sec. 64. **REPEALER.**

313.14 Minnesota Statutes 2012, sections 256B.0917, subdivision 14; 256B.096,
313.15 subdivisions 1, 2, 3, and 4; 256B.14, subdivision 3a; and 256B.5012, subdivision 13, and
313.16 Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012,
313.17 chapter 247, article 4, section 42, and Laws 2012, chapter 298, section 3, are repealed.

313.18 **ARTICLE 8**

313.19 **WAIVER PROVIDER STANDARDS**

313.20 Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a
313.21 subdivision to read:

313.22 Subd. 7c. **Human services license holders.** Section 245D.095, subdivision 3,
313.23 requires certain license holders to protect service recipient records in accordance with
313.24 specified provisions of this chapter.

313.25 Sec. 2. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:

313.26 Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity
313.27 licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under
313.28 section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47,
313.29 an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts
313.30 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or
313.31 a hospice provider licensed under sections 144A.75 to 144A.755.

314.1 Sec. 3. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:

314.2 Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this
314.3 subdivision, "health care facility" means a facility:

314.4 (1) licensed by the commissioner of health as a hospital, boarding care home or
314.5 supervised living facility under sections 144.50 to 144.58, or a nursing home under
314.6 chapter 144A;

314.7 (2) registered by the commissioner of health as a housing with services establishment
314.8 as defined in section 144D.01; or

314.9 (3) licensed by the commissioner of human services as a residential facility under
314.10 chapter 245A to provide adult foster care, adult mental health treatment, chemical
314.11 dependency treatment to adults, or residential services to persons with developmental
314.12 disabilities.

314.13 (b) Prior to admission to a health care facility, a person required to register under
314.14 this section shall disclose to:

314.15 (1) the health care facility employee processing the admission the person's status
314.16 as a registered predatory offender under this section; and

314.17 (2) the person's corrections agent, or if the person does not have an assigned
314.18 corrections agent, the law enforcement authority with whom the person is currently
314.19 required to register, that inpatient admission will occur.

314.20 (c) A law enforcement authority or corrections agent who receives notice under
314.21 paragraph (b) or who knows that a person required to register under this section is
314.22 planning to be admitted and receive, or has been admitted and is receiving health care
314.23 at a health care facility shall notify the administrator of the facility and deliver a fact
314.24 sheet to the administrator containing the following information: (1) name and physical
314.25 description of the offender; (2) the offender's conviction history, including the dates of
314.26 conviction; (3) the risk level classification assigned to the offender under section 244.052,
314.27 if any; and (4) the profile of likely victims.

314.28 (d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care
314.29 facility receives a fact sheet under paragraph (c) that includes a risk level classification for
314.30 the offender, and if the facility admits the offender, the facility shall distribute the fact
314.31 sheet to all residents at the facility. If the facility determines that distribution to a resident
314.32 is not appropriate given the resident's medical, emotional, or mental status, the facility
314.33 shall distribute the fact sheet to the patient's next of kin or emergency contact.

314.34 Sec. 4. **[245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY**
314.35 **MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**

315.1 Subdivision 1. **Rules.** The commissioner of human services shall, within 24 months
315.2 of enactment of this section, adopt rules governing the use of positive support strategies,
315.3 safety interventions, and emergency use of manual restraint in facilities and services
315.4 licensed under chapter 245D.

315.5 Subd. 2. **Data collection.** (a) The commissioner shall, with stakeholder input,
315.6 develop data collection elements specific to incidents of emergency use of manual restraint
315.7 and positive support transition plans for persons receiving services from providers
315.8 governed under chapter 245D effective January 1, 2014. Providers shall report the data in
315.9 a format and at a frequency determined by the commissioner of human services. Providers
315.10 shall submit the data to the commissioner and the Office of the Ombudsman for Mental
315.11 Health and Developmental Disabilities.

315.12 (b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts
315.13 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures
315.14 identified in Minnesota Rules, part 9525.2740, in a format and at a frequency determined
315.15 by the commissioner. Providers shall submit the data to the commissioner and the Office
315.16 of the Ombudsman for Mental Health and Developmental Disabilities.

315.17 Sec. 5. Minnesota Statutes 2012, section 245.91, is amended by adding a subdivision
315.18 to read:

315.19 Subd. 3a. **Emergency use of manual restraint.** "Emergency use of manual
315.20 restraint" has the meaning given in section 245D.02, subdivision 8a, and applies to
315.21 services licensed under chapter 245D.

315.22 Sec. 6. Minnesota Statutes 2012, section 245.94, subdivision 2, is amended to read:

315.23 Subd. 2. **Matters appropriate for review.** (a) In selecting matters for review by the
315.24 office, the ombudsman shall give particular attention to unusual deaths or injuries of a
315.25 client or reports of emergency use of manual restraint as identified in section 245D.061,
315.26 served by an agency, facility, or program, or actions of an agency, facility, or program that:

315.27 (1) may be contrary to law or rule;

315.28 (2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of
315.29 an agency, facility, or program;

315.30 (3) may be mistaken in law or arbitrary in the ascertainment of facts;

315.31 (4) may be unclear or inadequately explained, when reasons should have been
315.32 revealed;

315.33 (5) may result in abuse or neglect of a person receiving treatment;

316.1 (6) may disregard the rights of a client or other individual served by an agency
316.2 or facility;

316.3 (7) may impede or promote independence, community integration, and productivity
316.4 for clients; or

316.5 (8) may impede or improve the monitoring or evaluation of services provided to
316.6 clients.

316.7 (b) The ombudsman shall, in selecting matters for review and in the course of the
316.8 review, avoid duplicating other investigations or regulatory efforts.

316.9 Sec. 7. Minnesota Statutes 2012, section 245.94, subdivision 2a, is amended to read:

316.10 Subd. 2a. **Mandatory reporting.** Within 24 hours after a client suffers death or
316.11 serious injury, the agency, facility, or program director shall notify the ombudsman of the
316.12 death or serious injury. The emergency use of manual restraint must be reported to the
316.13 ombudsman as required under section 245D.061, subdivision 10. The ombudsman is
316.14 authorized to receive identifying information about a deceased client according to Code of
316.15 Federal Regulations, title 42, section 2.15, paragraph (b).

316.16 Sec. 8. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:

316.17 Subd. 10. **Nonresidential program.** "Nonresidential program" means care,
316.18 supervision, rehabilitation, training or habilitation of a person provided outside the
316.19 person's own home and provided for fewer than 24 hours a day, including adult day
316.20 care programs; and chemical dependency or chemical abuse programs that are located
316.21 in a nursing home or hospital and receive public funds for providing chemical abuse or
316.22 chemical dependency treatment services under chapter 254B. Nonresidential programs
316.23 include home and community-based services ~~and semi-independent living services~~ for
316.24 persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in
316.25 or outside of a person's own home under chapter 245D.

316.26 Sec. 9. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:

316.27 Subd. 14. **Residential program.** "Residential program" means a program
316.28 that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training,
316.29 education, habilitation, or treatment outside a person's own home, including a program
316.30 in an intermediate care facility for four or more persons with developmental disabilities;
316.31 and chemical dependency or chemical abuse programs that are located in a hospital
316.32 or nursing home and receive public funds for providing chemical abuse or chemical
316.33 dependency treatment services under chapter 254B. Residential programs include home

317.1 and community-based services for persons with ~~developmental~~ disabilities or persons age
317.2 65 and older that are provided in or outside of a person's own home under chapter 245D.

317.3 Sec. 10. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

317.4 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial
317.5 license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340,
317.6 or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under
317.7 this chapter for a physical location that will not be the primary residence of the license
317.8 holder for the entire period of licensure. If a license is issued during this moratorium, and
317.9 the license holder changes the license holder's primary residence away from the physical
317.10 location of the foster care license, the commissioner shall revoke the license according
317.11 to section 245A.07. The commissioner shall not issue an initial license for a community
317.12 residential setting licensed under chapter 245D. Exceptions to the moratorium include:

317.13 (1) foster care settings that are required to be registered under chapter 144D;

317.14 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
317.15 community residential setting licenses replacing adult foster care licenses in existence on
317.16 December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

317.17 (3) new foster care licenses or community residential setting licenses determined to
317.18 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
317.19 ICF/MR, or regional treatment center, or restructuring of state-operated services that
317.20 limits the capacity of state-operated facilities;

317.21 (4) new foster care licenses or community residential setting licenses determined
317.22 to be needed by the commissioner under paragraph (b) for persons requiring hospital
317.23 level care; or

317.24 (5) new foster care licenses or community residential setting licenses determined to
317.25 be needed by the commissioner for the transition of people from personal care assistance
317.26 to the home and community-based services.

317.27 (b) The commissioner shall determine the need for newly licensed foster care
317.28 homes or community residential settings as defined under this subdivision. As part of the
317.29 determination, the commissioner shall consider the availability of foster care capacity in
317.30 the area in which the licensee seeks to operate, and the recommendation of the local
317.31 county board. The determination by the commissioner must be final. A determination of
317.32 need is not required for a change in ownership at the same address.

317.33 (c) The commissioner shall study the effects of the license moratorium under this
317.34 subdivision and shall report back to the legislature by January 15, 2011. This study shall
317.35 include, but is not limited to the following:

318.1 (1) the overall capacity and utilization of foster care beds where the physical location
318.2 is not the primary residence of the license holder prior to and after implementation
318.3 of the moratorium;

318.4 (2) the overall capacity and utilization of foster care beds where the physical
318.5 location is the primary residence of the license holder prior to and after implementation
318.6 of the moratorium; and

318.7 (3) the number of licensed and occupied ICF/MR beds prior to and after
318.8 implementation of the moratorium.

318.9 (d) When a ~~foster care recipient~~ an adult resident served by the program moves out
318.10 of a foster home that is not the primary residence of the license holder according to section
318.11 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the
318.12 county shall immediately inform the Department of Human Services Licensing Division.
318.13 The department shall decrease the statewide licensed capacity for adult foster care settings
318.14 where the physical location is not the primary residence of the license holder, or for adult
318.15 community residential settings, if the voluntary changes described in paragraph (f) are
318.16 not sufficient to meet the savings required by reductions in licensed bed capacity under
318.17 Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f),
318.18 and maintain statewide long-term care residential services capacity within budgetary
318.19 limits. Implementation of the statewide licensed capacity reduction shall begin on July
318.20 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the
318.21 needs determination process. Under this paragraph, the commissioner has the authority
318.22 to reduce unused licensed capacity of a current foster care program, or the community
318.23 residential settings, to accomplish the consolidation or closure of settings. A decreased
318.24 licensed capacity according to this paragraph is not subject to appeal under this chapter.

318.25 (e) Residential settings that would otherwise be subject to the decreased license
318.26 capacity established in paragraph (d) shall be exempt under the following circumstances:

318.27 (1) until August 1, 2013, the license holder's beds occupied by residents whose
318.28 primary diagnosis is mental illness and the license holder is:

318.29 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
318.30 health services (ARMHS) as defined in section 256B.0623;

318.31 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
318.32 9520.0870;

318.33 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
318.34 9520.0870; or

318.35 (iv) a provider of intensive residential treatment services (IRTS) licensed under
318.36 Minnesota Rules, parts 9520.0500 to 9520.0670; or

319.1 (2) the license holder is certified under the requirements in subdivision 6a or section
319.2 245D.33.

319.3 (f) A resource need determination process, managed at the state level, using the
319.4 available reports required by section 144A.351, and other data and information shall
319.5 be used to determine where the reduced capacity required under paragraph (d) will be
319.6 implemented. The commissioner shall consult with the stakeholders described in section
319.7 144A.351, and employ a variety of methods to improve the state's capacity to meet
319.8 long-term care service needs within budgetary limits, including seeking proposals from
319.9 service providers or lead agencies to change service type, capacity, or location to improve
319.10 services, increase the independence of residents, and better meet needs identified by the
319.11 long-term care services reports and statewide data and information. By February 1 of each
319.12 year, the commissioner shall provide information and data on the overall capacity of
319.13 licensed long-term care services, actions taken under this subdivision to manage statewide
319.14 long-term care services and supports resources, and any recommendations for change to
319.15 the legislative committees with jurisdiction over health and human services budget.

319.16 (g) At the time of application and reapplication for licensure, the applicant and the
319.17 license holder that are subject to the moratorium or an exclusion established in paragraph
319.18 (a) are required to inform the commissioner whether the physical location where the foster
319.19 care will be provided is or will be the primary residence of the license holder for the entire
319.20 period of licensure. If the primary residence of the applicant or license holder changes, the
319.21 applicant or license holder must notify the commissioner immediately. The commissioner
319.22 shall print on the foster care license certificate whether or not the physical location is the
319.23 primary residence of the license holder.

319.24 (h) License holders of foster care homes identified under paragraph (g) that are not
319.25 the primary residence of the license holder and that also provide services in the foster care
319.26 home that are covered by a federally approved home and community-based services
319.27 waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the
319.28 human services licensing division that the license holder provides or intends to provide
319.29 these waiver-funded services. ~~These license holders must be considered registered under~~
319.30 ~~section 256B.092, subdivision 11, paragraph (c), and this registration status must be~~
319.31 ~~identified on their license certificates.~~

319.32 Sec. 11. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

319.33 Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall
319.34 prohibit a program that is excluded from licensure under subdivision 2, paragraph
319.35 (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any

320.1 application received from such an excluded provider is processed in the same manner as
320.2 all other applications for child care center licensure.

320.3 Sec. 12. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

320.4 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
320.5 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
320.6 person receiving supported living services may provide licensed services to that person if:

320.7 (1) the person who receives supported living services received these services in a
320.8 residential site on July 1, 2005;

320.9 (2) the services under clause (1) were provided in a corporate foster care setting for
320.10 adults and were funded by the developmental disabilities home and community-based
320.11 services waiver defined in section 256B.092;

320.12 (3) the individual who is related obtains and maintains both a license under chapter
320.13 245B or successor licensing requirements for the provision of supported living services
320.14 and an adult foster care license under Minnesota Rules, parts 9555.5105 to 9555.6265; and

320.15 (4) the individual who is related is not the guardian of the person receiving supported
320.16 living services.

320.17 Sec. 13. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:

320.18 Subd. 3. **Implementation.** (a) The commissioner shall implement the
320.19 responsibilities of this chapter according to the timelines in paragraphs (b) and (c)
320.20 only within the limits of available appropriations or other administrative cost recovery
320.21 methodology.

320.22 (b) The licensure of home and community-based services according to this section
320.23 shall be implemented January 1, 2014. License applications shall be received and
320.24 processed on a phased-in schedule as determined by the commissioner beginning July
320.25 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that
320.26 the application is complete according to section 245A.04.

320.27 (c) Within the limits of available appropriations or other administrative cost recovery
320.28 methodology, implementation of compliance monitoring must be phased in after January
320.29 1, 2014.

320.30 (1) Applicants who do not currently hold a license issued under ~~this chapter~~ 245B
320.31 must receive an initial compliance monitoring visit after 12 months of the effective date of
320.32 the initial license for the purpose of providing technical assistance on how to achieve and
320.33 maintain compliance with the applicable law or rules governing the provision of home and
320.34 community-based services under chapter 245D. If during the review the commissioner

321.1 finds that the license holder has failed to achieve compliance with an applicable law or
321.2 rule and this failure does not imminently endanger the health, safety, or rights of the
321.3 persons served by the program, the commissioner may issue a licensing review report with
321.4 recommendations for achieving and maintaining compliance.

321.5 (2) Applicants who do currently hold a license issued under this chapter must receive
321.6 a compliance monitoring visit after 24 months of the effective date of the initial license.

321.7 (d) Nothing in this subdivision shall be construed to limit the commissioner's
321.8 authority to suspend or revoke a license or issue a fine at any time under section 245A.07,
321.9 or ~~make~~ issue correction orders and make a license conditional for failure to comply with
321.10 applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity
321.11 of the violation of law or rule and the effect of the violation on the health, safety, or
321.12 rights of persons served by the program.

321.13 Sec. 14. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

321.14 Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license
321.15 under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is
321.16 based on a disqualification for which reconsideration was requested and which was not
321.17 set aside under section 245C.22, the scope of the contested case hearing shall include the
321.18 disqualification and the licensing sanction or denial of a license, unless otherwise specified
321.19 in this subdivision. When the licensing sanction or denial of a license is based on a
321.20 determination of maltreatment under section 626.556 or 626.557, or a disqualification for
321.21 serious or recurring maltreatment which was not set aside, the scope of the contested case
321.22 hearing shall include the maltreatment determination, disqualification, and the licensing
321.23 sanction or denial of a license, unless otherwise specified in this subdivision. In such
321.24 cases, a fair hearing under section 256.045 shall not be conducted as provided for in
321.25 sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

321.26 (b) Except for family child care and child foster care, reconsideration of a
321.27 maltreatment determination under sections 626.556, subdivision 10i, and 626.557,
321.28 subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall
321.29 not be conducted when:

321.30 (1) a denial of a license under section 245A.05, or a licensing sanction under section
321.31 245A.07, is based on a determination that the license holder is responsible for maltreatment
321.32 or the disqualification of a license holder is based on serious or recurring maltreatment;

321.33 (2) the denial of a license or licensing sanction is issued at the same time as the
321.34 maltreatment determination or disqualification; and

322.1 (3) the license holder appeals the maltreatment determination or disqualification,
322.2 and denial of a license or licensing sanction. In these cases, a fair hearing shall not be
322.3 conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision
322.4 9d. The scope of the contested case hearing must include the maltreatment determination,
322.5 disqualification, and denial of a license or licensing sanction.

322.6 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
322.7 determination or disqualification, but does not appeal the denial of a license or a licensing
322.8 sanction, reconsideration of the maltreatment determination shall be conducted under
322.9 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
322.10 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
322.11 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
322.12 626.557, subdivision 9d.

322.13 (c) In consolidated contested case hearings regarding sanctions issued in family child
322.14 care, child foster care, family adult day services, ~~and adult foster care,~~ and community
322.15 residential settings, the county attorney shall defend the commissioner's orders in
322.16 accordance with section 245A.16, subdivision 4.

322.17 (d) The commissioner's final order under subdivision 5 is the final agency action
322.18 on the issue of maltreatment and disqualification, including for purposes of subsequent
322.19 background studies under chapter 245C and is the only administrative appeal of the final
322.20 agency determination, specifically, including a challenge to the accuracy and completeness
322.21 of data under section 13.04.

322.22 (e) When consolidated hearings under this subdivision involve a licensing sanction
322.23 based on a previous maltreatment determination for which the commissioner has issued
322.24 a final order in an appeal of that determination under section 256.045, or the individual
322.25 failed to exercise the right to appeal the previous maltreatment determination under
322.26 section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is
322.27 conclusive on the issue of maltreatment. In such cases, the scope of the administrative
322.28 law judge's review shall be limited to the disqualification and the licensing sanction or
322.29 denial of a license. In the case of a denial of a license or a licensing sanction issued to
322.30 a facility based on a maltreatment determination regarding an individual who is not the
322.31 license holder or a household member, the scope of the administrative law judge's review
322.32 includes the maltreatment determination.

322.33 (f) The hearings of all parties may be consolidated into a single contested case
322.34 hearing upon consent of all parties and the administrative law judge, if:

323.1 (1) a maltreatment determination or disqualification, which was not set aside under
 323.2 section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing
 323.3 sanction under section 245A.07;

323.4 (2) the disqualified subject is an individual other than the license holder and upon
 323.5 whom a background study must be conducted under section 245C.03; and

323.6 (3) the individual has a hearing right under section 245C.27.

323.7 (g) When a denial of a license under section 245A.05 or a licensing sanction under
 323.8 section 245A.07 is based on a disqualification for which reconsideration was requested
 323.9 and was not set aside under section 245C.22, and the individual otherwise has no hearing
 323.10 right under section 245C.27, the scope of the administrative law judge's review shall
 323.11 include the denial or sanction and a determination whether the disqualification should
 323.12 be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In
 323.13 determining whether the disqualification should be set aside, the administrative law judge
 323.14 shall consider the factors under section 245C.22, subdivision 4, to determine whether the
 323.15 individual poses a risk of harm to any person receiving services from the license holder.

323.16 (h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction
 323.17 under section 245A.07 is based on the termination of a variance under section 245C.30,
 323.18 subdivision 4, the scope of the administrative law judge's review shall include the sanction
 323.19 and a determination whether the disqualification should be set aside, unless section
 323.20 245C.24 prohibits the set-aside of the disqualification. In determining whether the
 323.21 disqualification should be set aside, the administrative law judge shall consider the factors
 323.22 under section 245C.22, subdivision 4, to determine whether the individual poses a risk of
 323.23 harm to any person receiving services from the license holder.

323.24 Sec. 15. Minnesota Statutes 2012, section 245A.10, is amended to read:

323.25 **245A.10 FEES.**

323.26 Subdivision 1. **Application or license fee required, programs exempt from fee.**

323.27 (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation
 323.28 of applications and inspection of programs which are licensed under this chapter.

323.29 (b) Except as provided under subdivision 2, no application or license fee shall be
 323.30 charged for child foster care, adult foster care, ~~or~~ family and group family child care, or
 323.31 a community residential setting.

323.32 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
 323.33 purposes of family and group family child care licensing under this chapter, a county
 323.34 agency may charge a fee to an applicant or license holder to recover the actual cost of
 323.35 background studies, but in any case not to exceed \$100 annually. A county agency may

324.1 also charge a license fee to an applicant or license holder not to exceed \$50 for a one-year
324.2 license or \$100 for a two-year license.

324.3 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
324.4 applicant for authorization to recover the actual cost of background studies completed
324.5 under section 119B.125, but in any case not to exceed \$100 annually.

324.6 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

324.7 (1) in cases of financial hardship;

324.8 (2) if the county has a shortage of providers in the county's area;

324.9 (3) for new providers; or

324.10 (4) for providers who have attained at least 16 hours of training before seeking
324.11 initial licensure.

324.12 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
324.13 an installment basis for up to one year. If the provider is receiving child care assistance
324.14 payments from the state, the provider may have the fees under paragraph (a) or (b)
324.15 deducted from the child care assistance payments for up to one year and the state shall
324.16 reimburse the county for the county fees collected in this manner.

324.17 (e) For purposes of adult foster care and child foster care licensing, and licensing
324.18 the physical plant of a community residential setting, under this chapter, a county agency
324.19 may charge a fee to a corporate applicant or corporate license holder to recover the actual
324.20 cost of licensing inspections, not to exceed \$500 annually.

324.21 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the
324.22 following circumstances:

324.23 (1) in cases of financial hardship;

324.24 (2) if the county has a shortage of providers in the county's area; or

324.25 (3) for new providers.

324.26 **Subd. 3. Application fee for initial license or certification.** (a) For fees required
324.27 under subdivision 1, an applicant for an initial license or certification issued by the
324.28 commissioner shall submit a \$500 application fee with each new application required
324.29 under this subdivision. An applicant for an initial day services facility license under
324.30 chapter 245D shall submit a \$250 application fee with each new application. The
324.31 application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license
324.32 or certification fee that expires on December 31. The commissioner shall not process an
324.33 application until the application fee is paid.

324.34 (b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license
324.35 to provide services at a specific location.

325.1 (1) ~~For a license to provide residential-based habilitation services to persons with~~
325.2 ~~developmental disabilities under chapter 245B, an applicant shall submit an application~~
325.3 ~~for each county in which the services will be provided. Upon licensure, the license~~
325.4 ~~holder may provide services to persons in that county plus no more than three persons~~
325.5 ~~at any one time in each of up to ten additional counties. A license holder in one county~~
325.6 ~~may not provide services under the home and community-based waiver for persons with~~
325.7 ~~developmental disabilities to more than three people in a second county without holding~~
325.8 ~~a separate license for that second county. Applicants or licensees providing services~~
325.9 ~~under this clause to not more than three persons remain subject to the inspection fees~~
325.10 ~~established in section 245A.10, subdivision 2, for each location. The license issued by~~
325.11 ~~the commissioner must state the name of each additional county where services are being~~
325.12 ~~provided to persons with developmental disabilities. A license holder must notify the~~
325.13 ~~commissioner before making any changes that would alter the license information listed~~
325.14 ~~under section 245A.04, subdivision 7, paragraph (a), including any additional counties~~
325.15 ~~where persons with developmental disabilities are being served. For a license to provide~~
325.16 home and community-based services to persons with disabilities or age 65 and older under
325.17 chapter 245D, an applicant shall submit an application to provide services statewide.
325.18 Notwithstanding paragraph (a), applications received by the commissioner between July 1,
325.19 2013, and December 31, 2013, for licensure of services provided under chapter 245D must
325.20 include an application fee that is equal to the annual license renewal fee under subdivision
325.21 4, paragraph (b), or \$500, whichever is less. Applications received by the commissioner
325.22 after January 1, 2014, must include the application fee required under paragraph (a).
325.23 Applicants who meet the modified application criteria identified in section 245A.042,
325.24 subdivision 2, are exempt from paying an application fee.

325.25 (2) ~~For a license to provide supported employment, crisis respite, or~~
325.26 ~~semi-independent living services to persons with developmental disabilities under chapter~~
325.27 ~~245B, an applicant shall submit a single application to provide services statewide.~~

325.28 (3) For a license to provide independent living assistance for youth under section
325.29 245A.22, an applicant shall submit a single application to provide services statewide.

325.30 (4) (3) For a license for a private agency to provide foster care or adoption services
325.31 under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single
325.32 application to provide services statewide.

325.33 (c) The initial application fee charged under this subdivision does not include the
325.34 temporary license surcharge under section 16E.22.

325.35 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers
325.36 shall pay an annual nonrefundable license fee based on the following schedule:

326.1		Child Care Center
326.2	Licensed Capacity	License Fee
326.3	1 to 24 persons	\$200
326.4	25 to 49 persons	\$300
326.5	50 to 74 persons	\$400
326.6	75 to 99 persons	\$500
326.7	100 to 124 persons	\$600
326.8	125 to 149 persons	\$700
326.9	150 to 174 persons	\$800
326.10	175 to 199 persons	\$900
326.11	200 to 224 persons	\$1,000
326.12	225 or more persons	\$1,100

326.13 ~~(b) A day training and habilitation program serving persons with developmental~~
 326.14 ~~disabilities or related conditions shall pay an annual nonrefundable license fee based on~~
 326.15 ~~the following schedule:~~

326.16	Licensed Capacity	License Fee
326.17	1 to 24 persons	\$800
326.18	25 to 49 persons	\$1,000
326.19	50 to 74 persons	\$1,200
326.20	75 to 99 persons	\$1,400
326.21	100 to 124 persons	\$1,600
326.22	125 to 149 persons	\$1,800
326.23	150 or more persons	\$2,000

326.24 ~~Except as provided in paragraph (c), when a day training and habilitation program~~
 326.25 ~~serves more than 50 percent of the same persons in two or more locations in a community,~~
 326.26 ~~the day training and habilitation program shall pay a license fee based on the licensed~~
 326.27 ~~capacity of the largest facility and the other facility or facilities shall be charged a license~~
 326.28 ~~fee based on a licensed capacity of a residential program serving one to 24 persons.~~

326.29 ~~(c) When a day training and habilitation program serving persons with developmental~~
 326.30 ~~disabilities or related conditions seeks a single license allowed under section 245B.07,~~
 326.31 ~~subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed~~
 326.32 ~~capacity for each location.~~

326.33 ~~(d) A program licensed to provide supported employment services to persons~~
 326.34 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 326.35 ~~license fee of \$650.~~

326.36 ~~(e) A program licensed to provide crisis respite services to persons with~~
 326.37 ~~developmental disabilities under chapter 245B shall pay an annual nonrefundable license~~
 326.38 ~~fee of \$700.~~

327.1 ~~(f) A program licensed to provide semi-independent living services to persons~~
 327.2 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 327.3 ~~license fee of \$700.~~

327.4 ~~(g) A program licensed to provide residential-based habilitation services under the~~
 327.5 ~~home and community-based waiver for persons with developmental disabilities shall pay~~
 327.6 ~~an annual license fee that includes a base rate of \$690 plus \$60 times the number of clients~~
 327.7 ~~served on the first day of July of the current license year.~~

327.8 ~~(h) A residential program certified by the Department of Health as an intermediate~~
 327.9 ~~care facility for persons with developmental disabilities (ICF/MR) and a noncertified~~
 327.10 ~~residential program licensed to provide health or rehabilitative services for persons~~
 327.11 ~~with developmental disabilities shall pay an annual nonrefundable license fee based on~~
 327.12 ~~the following schedule:~~

327.13	Licensed Capacity	License Fee
327.14	1 to 24 persons	\$535
327.15	25 to 49 persons	\$735
327.16	50 or more persons	\$935

327.17 (b)(1) A program licensed to provide one or more of the home and community-based
 327.18 services and supports identified under chapter 245D to persons with disabilities or age
 327.19 65 and older, shall pay an annual nonrefundable license fee based on revenues derived
 327.20 from the provision of services that would require licensure under chapter 245D during the
 327.21 calendar year immediately preceding the year in which the license fee is paid, according to
 327.22 the following schedule:

327.23	<u>License Holder Annual Revenue</u>	<u>License Fee</u>
327.24	<u>less than or equal to \$10,000</u>	<u>\$200</u>
327.25	<u>greater than \$10,000 but less than or equal</u>	
327.26	<u>to \$25,000</u>	<u>\$300</u>
327.27	<u>greater than \$25,000 but less than or equal</u>	
327.28	<u>to \$50,000</u>	<u>\$400</u>
327.29	<u>greater than \$50,000 but less than or equal</u>	
327.30	<u>to \$100,000</u>	<u>\$500</u>
327.31	<u>greater than \$100,000 but less than or equal</u>	
327.32	<u>to \$150,000</u>	<u>\$600</u>
327.33	<u>greater than \$150,000 but less than or equal</u>	
327.34	<u>to \$200,000</u>	<u>\$800</u>
327.35	<u>greater than \$200,000 but less than or equal</u>	
327.36	<u>to \$250,000</u>	<u>\$1,000</u>
327.37	<u>greater than \$250,000 but less than or equal</u>	
327.38	<u>to \$300,000</u>	<u>\$1,200</u>
327.39	<u>greater than \$300,000 but less than or equal</u>	
327.40	<u>to \$350,000</u>	<u>\$1,400</u>

328.1	<u>greater than \$350,000 but less than or equal</u>	
328.2	<u>to \$400,000</u>	<u>\$1,600</u>
328.3	<u>greater than \$400,000 but less than or equal</u>	
328.4	<u>to \$450,000</u>	<u>\$1,800</u>
328.5	<u>greater than \$450,000 but less than or equal</u>	
328.6	<u>to \$500,000</u>	<u>\$2,000</u>
328.7	<u>greater than \$500,000 but less than or equal</u>	
328.8	<u>to \$600,000</u>	<u>\$2,250</u>
328.9	<u>greater than \$600,000 but less than or equal</u>	
328.10	<u>to \$700,000</u>	<u>\$2,500</u>
328.11	<u>greater than \$700,000 but less than or equal</u>	
328.12	<u>to \$800,000</u>	<u>\$2,750</u>
328.13	<u>greater than \$800,000 but less than or equal</u>	
328.14	<u>to \$900,000</u>	<u>\$3,000</u>
328.15	<u>greater than \$900,000 but less than or equal</u>	
328.16	<u>to \$1,000,000</u>	<u>\$3,250</u>
328.17	<u>greater than \$1,000,000 but less than or</u>	
328.18	<u>equal to \$1,250,000</u>	<u>\$3,500</u>
328.19	<u>greater than \$1,250,000 but less than or</u>	
328.20	<u>equal to \$1,500,000</u>	<u>\$3,750</u>
328.21	<u>greater than \$1,500,000 but less than or</u>	
328.22	<u>equal to \$1,750,000</u>	<u>\$4,000</u>
328.23	<u>greater than \$1,750,000 but less than or</u>	
328.24	<u>equal to \$2,000,000</u>	<u>\$4,250</u>
328.25	<u>greater than \$2,000,000 but less than or</u>	
328.26	<u>equal to \$2,500,000</u>	<u>\$4,500</u>
328.27	<u>greater than \$2,500,000 but less than or</u>	
328.28	<u>equal to \$3,000,000</u>	<u>\$4,750</u>
328.29	<u>greater than \$3,000,000 but less than or</u>	
328.30	<u>equal to \$3,500,000</u>	<u>\$5,000</u>
328.31	<u>greater than \$3,500,000 but less than or</u>	
328.32	<u>equal to \$4,000,000</u>	<u>\$5,500</u>
328.33	<u>greater than \$4,000,000 but less than or</u>	
328.34	<u>equal to \$4,500,000</u>	<u>\$6,000</u>
328.35	<u>greater than \$4,500,000 but less than or</u>	
328.36	<u>equal to \$5,000,000</u>	<u>\$6,500</u>
328.37	<u>greater than \$5,000,000 but less than or</u>	
328.38	<u>equal to \$7,500,000</u>	<u>\$7,000</u>
328.39	<u>greater than \$7,500,000 but less than or</u>	
328.40	<u>equal to \$10,000,000</u>	<u>\$8,500</u>
328.41	<u>greater than \$10,000,000 but less than or</u>	
328.42	<u>equal to \$12,500,000</u>	<u>\$10,000</u>
328.43	<u>greater than \$12,500,000 but less than or</u>	
328.44	<u>equal to \$15,000,000</u>	<u>\$14,000</u>
328.45	<u>greater than \$15,000,000</u>	<u>\$18,000</u>

328.46 (2) If requested, the license holder shall provide the commissioner information to
 328.47 verify the license holder's annual revenues or other information as needed, including
 328.48 copies of documents submitted to the Department of Revenue.

329.1 (3) At each annual renewal, a license holder may elect to pay the highest renewal
 329.2 fee, and not provide annual revenue information to the commissioner.

329.3 (4) A license holder that knowingly provides the commissioner incorrect revenue
 329.4 amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in
 329.5 the amount of double the fee the provider should have paid.

329.6 (5) Notwithstanding clause (1), a license holder providing services under one or
 329.7 more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual
 329.8 license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid
 329.9 by the license holder for all licenses held under chapter 245B for calendar year 2013.
 329.10 For calendar year 2017 and thereafter, the license holder shall pay an annual license fee
 329.11 according to clause (1).

329.12 ~~(i)~~ (c) A chemical dependency treatment program licensed under Minnesota Rules,
 329.13 parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an
 329.14 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

329.21 ~~(j)~~ (d) A chemical dependency program licensed under Minnesota Rules, parts
 329.22 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual
 329.23 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

329.28 ~~(k)~~ (e) Except for child foster care, a residential facility licensed under Minnesota
 329.29 Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee
 329.30 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

330.1 ~~(f)~~ (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to
 330.2 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license
 330.3 fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	\$2,525
25 or more persons	\$2,725

330.7 ~~(g)~~ (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to
 330.8 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
 330.9 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

330.16 ~~(h)~~ (h) A program licensed to provide independent living assistance for youth under
 330.17 section 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

330.18 ~~(i)~~ (i) A private agency licensed to provide foster care and adoption services under
 330.19 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable
 330.20 license fee of \$875.

330.21 ~~(j)~~ (j) A program licensed as an adult day care center licensed under Minnesota
 330.22 Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based
 330.23 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

330.30 ~~(k)~~ (k) A program licensed to provide treatment services to persons with sexual
 330.31 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
 330.32 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

330.33 ~~(l)~~ (l) A mental health center or mental health clinic requesting certification for
 330.34 purposes of insurance and subscriber contract reimbursement under Minnesota Rules,
 330.35 parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the
 330.36 mental health center or mental health clinic provides services at a primary location with

331.1 satellite facilities, the satellite facilities shall be certified with the primary location without
331.2 an additional charge.

331.3 **Subd. 6. License not issued until license or certification fee is paid.** The
331.4 commissioner shall not issue a license or certification until the license or certification fee
331.5 is paid. The commissioner shall send a bill for the license or certification fee to the billing
331.6 address identified by the license holder. If the license holder does not submit the license or
331.7 certification fee payment by the due date, the commissioner shall send the license holder
331.8 a past due notice. If the license holder fails to pay the license or certification fee by the
331.9 due date on the past due notice, the commissioner shall send a final notice to the license
331.10 holder informing the license holder that the program license will expire on December 31
331.11 unless the license fee is paid before December 31. If a license expires, the program is no
331.12 longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2,
331.13 must not operate after the expiration date. After a license expires, if the former license
331.14 holder wishes to provide licensed services, the former license holder must submit a new
331.15 license application and application fee under subdivision 3.

331.16 **Subd. 7. Human services licensing fees to recover expenditures.** Notwithstanding
331.17 section 16A.1285, subdivision 2, related to activities for which the commissioner charges
331.18 a fee, the commissioner must plan to fully recover direct expenditures for licensing
331.19 activities under this chapter over a five-year period. The commissioner may have
331.20 anticipated expenditures in excess of anticipated revenues in a biennium by using surplus
331.21 revenues accumulated in previous bienniums.

331.22 **Subd. 8. Deposit of license fees.** A human services licensing account is created in
331.23 the state government special revenue fund. Fees collected under subdivisions 3 and 4 must
331.24 be deposited in the human services licensing account and are annually appropriated to the
331.25 commissioner for licensing activities authorized under this chapter.

331.26 **EFFECTIVE DATE.** This section is effective July 1, 2013.

331.27 Sec. 16. Minnesota Statutes 2012, section 245A.11, subdivision 2a, is amended to read:

331.28 **Subd. 2a. Adult foster care and community residential setting license capacity.**

331.29 (a) The commissioner shall issue adult foster care and community residential setting
331.30 licenses with a maximum licensed capacity of four beds, including nonstaff roomers and
331.31 boarders, except that the commissioner may issue a license with a capacity of five beds,
331.32 including roomers and boarders, according to paragraphs (b) to (f).

331.33 (b) ~~An adult foster care~~ The license holder may have a maximum license capacity
331.34 of five if all persons in care are age 55 or over and do not have a serious and persistent
331.35 mental illness or a developmental disability.

332.1 (c) The commissioner may grant variances to paragraph (b) to allow a ~~foster care~~
332.2 ~~provider facility~~ with a licensed capacity of five persons to admit an individual under the
332.3 age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of
332.4 the variance is recommended by the county in which the licensed ~~foster care provider~~
332.5 facility is located.

332.6 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
332.7 bed for emergency crisis services for a person with serious and persistent mental illness
332.8 or a developmental disability, regardless of age, if the variance complies with section
332.9 245A.04, subdivision 9, and approval of the variance is recommended by the county in
332.10 which the licensed ~~foster care provider~~ facility is located.

332.11 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of a
332.12 fifth bed for respite services, as defined in section 245A.02, for persons with disabilities,
332.13 regardless of age, if the variance complies with sections 245A.03, subdivision 7, and
332.14 245A.04, subdivision 9, and approval of the variance is recommended by the county in
332.15 which the licensed ~~foster care provider~~ facility is ~~licensed~~ located. Respite care may be
332.16 provided under the following conditions:

332.17 (1) staffing ratios cannot be reduced below the approved level for the individuals
332.18 being served in the home on a permanent basis;

332.19 (2) no more than two different individuals can be accepted for respite services in
332.20 any calendar month and the total respite days may not exceed 120 days per program in
332.21 any calendar year;

332.22 (3) the person receiving respite services must have his or her own bedroom, which
332.23 could be used for alternative purposes when not used as a respite bedroom, and cannot be
332.24 the room of another person who lives in the ~~foster care home~~ facility; and

332.25 (4) individuals living in the ~~foster care home~~ facility must be notified when the
332.26 variance is approved. The provider must give 60 days' notice in writing to the residents
332.27 and their legal representatives prior to accepting the first respite placement. Notice must
332.28 be given to residents at least two days prior to service initiation, or as soon as the license
332.29 holder is able if they receive notice of the need for respite less than two days prior to
332.30 initiation, each time a respite client will be served, unless the requirement for this notice is
332.31 waived by the resident or legal guardian.

332.32 (f) The commissioner may issue an adult foster care or community residential setting
332.33 license with a capacity of five adults if the fifth bed does not increase the overall statewide
332.34 capacity of licensed adult foster care or community residential setting beds in homes that
332.35 are not the primary residence of the license holder, as identified in a plan submitted to the

333.1 commissioner by the county, when the capacity is recommended by the county licensing
333.2 agency of the county in which the facility is located and if the recommendation verifies that:

333.3 (1) the facility meets the physical environment requirements in the adult foster
333.4 care licensing rule;

333.5 (2) the five-bed living arrangement is specified for each resident in the resident's:

333.6 (i) individualized plan of care;

333.7 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

333.8 (iii) individual resident placement agreement under Minnesota Rules, part
333.9 9555.5105, subpart 19, if required;

333.10 (3) the license holder obtains written and signed informed consent from each
333.11 resident or resident's legal representative documenting the resident's informed choice
333.12 to remain living in the home and that the resident's refusal to consent would not have
333.13 resulted in service termination; and

333.14 (4) the facility was licensed for adult foster care before March 1, 2011.

333.15 (g) The commissioner shall not issue a new adult foster care license under paragraph
333.16 (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care
333.17 license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five
333.18 adults if the license holder continues to comply with the requirements in paragraph (f).

333.19 Sec. 17. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

333.20 Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The
333.21 commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts
333.22 requiring a caregiver to be present in an adult foster care home during normal sleeping
333.23 hours to allow for alternative methods of overnight supervision. The commissioner may
333.24 grant the variance if the local county licensing agency recommends the variance and the
333.25 county recommendation includes documentation verifying that:

333.26 (1) the county has approved the license holder's plan for alternative methods of
333.27 providing overnight supervision and determined the plan protects the residents' health,
333.28 safety, and rights;

333.29 (2) the license holder has obtained written and signed informed consent from
333.30 each resident or each resident's legal representative documenting the resident's or legal
333.31 representative's agreement with the alternative method of overnight supervision; and

333.32 (3) the alternative method of providing overnight supervision, which may include
333.33 the use of technology, is specified for each resident in the resident's: (i) individualized
333.34 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if

334.1 required; or (iii) individual resident placement agreement under Minnesota Rules, part
334.2 9555.5105, subpart 19, if required.

334.3 (b) To be eligible for a variance under paragraph (a), the adult foster care license
334.4 holder must not have had a conditional license issued under section 245A.06, or any
334.5 other licensing sanction issued under section 245A.07 during the prior 24 months based
334.6 on failure to provide adequate supervision, health care services, or resident safety in
334.7 the adult foster care home.

334.8 (c) A license holder requesting a variance under this subdivision to utilize
334.9 technology as a component of a plan for alternative overnight supervision may request
334.10 the commissioner's review in the absence of a county recommendation. Upon receipt of
334.11 such a request from a license holder, the commissioner shall review the variance request
334.12 with the county.

334.13 (d) A variance granted by the commissioner according to this subdivision before
334.14 January 1, 2014, to a license holder for an adult foster care home must transfer with the
334.15 license when the license converts to a community residential setting license under chapter
334.16 245D. The terms and conditions of the variance remain in effect as approved at the time
334.17 the variance was granted.

334.18 Sec. 18. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:

334.19 Subd. 7a. **Alternate overnight supervision technology; adult foster care license**
334.20 **and community residential setting licenses.** (a) The commissioner may grant an
334.21 applicant or license holder an adult foster care or community residential setting license
334.22 for a residence that does not have a caregiver in the residence during normal sleeping
334.23 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section
334.24 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder
334.25 when an incident occurs that may jeopardize the health, safety, or rights of a foster
334.26 care recipient. The applicant or license holder must comply with all other requirements
334.27 under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under
334.28 chapter 245D, and the requirements under this subdivision. The license printed by the
334.29 commissioner must state in bold and large font:

334.30 (1) that the facility is under electronic monitoring; and

334.31 (2) the telephone number of the county's common entry point for making reports of
334.32 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

334.33 (b) Applications for a license under this section must be submitted directly to
334.34 the Department of Human Services licensing division. The licensing division must
334.35 immediately notify the ~~host county and lead county contract agency and the host county~~

335.1 licensing agency. The licensing division must collaborate with the county licensing
335.2 agency in the review of the application and the licensing of the program.

335.3 (c) Before a license is issued by the commissioner, and for the duration of the
335.4 license, the applicant or license holder must establish, maintain, and document the
335.5 implementation of written policies and procedures addressing the requirements in
335.6 paragraphs (d) through (f).

335.7 (d) The applicant or license holder must have policies and procedures that:

335.8 (1) establish characteristics of target populations that will be admitted into the home,
335.9 and characteristics of populations that will not be accepted into the home;

335.10 (2) explain the discharge process when a ~~foster care recipient~~ resident served by the
335.11 program requires overnight supervision or other services that cannot be provided by the
335.12 license holder due to the limited hours that the license holder is on site;

335.13 (3) describe the types of events to which the program will respond with a physical
335.14 presence when those events occur in the home during time when staff are not on site, and
335.15 how the license holder's response plan meets the requirements in paragraph (e), clause
335.16 (1) or (2);

335.17 (4) establish a process for documenting a review of the implementation and
335.18 effectiveness of the response protocol for the response required under paragraph (e),
335.19 clause (1) or (2). The documentation must include:

335.20 (i) a description of the triggering incident;

335.21 (ii) the date and time of the triggering incident;

335.22 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);

335.23 (iv) whether the response met the resident's needs;

335.24 (v) whether the existing policies and response protocols were followed; and

335.25 (vi) whether the existing policies and protocols are adequate or need modification.

335.26 When no physical presence response is completed for a three-month period, the
335.27 license holder's written policies and procedures must require a physical presence response
335.28 drill to be conducted for which the effectiveness of the response protocol under paragraph
335.29 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

335.30 (5) establish that emergency and nonemergency phone numbers are posted in a
335.31 prominent location in a common area of the home where they can be easily observed by a
335.32 person responding to an incident who is not otherwise affiliated with the home.

335.33 (e) The license holder must document and include in the license application which
335.34 response alternative under clause (1) or (2) is in place for responding to situations that
335.35 present a serious risk to the health, safety, or rights of ~~people receiving foster care services~~
335.36 in the home residents served by the program:

336.1 (1) response alternative (1) requires only the technology to provide an electronic
336.2 notification or alert to the license holder that an event is underway that requires a response.
336.3 Under this alternative, no more than ten minutes will pass before the license holder will be
336.4 physically present on site to respond to the situation; or

336.5 (2) response alternative (2) requires the electronic notification and alert system under
336.6 alternative (1), but more than ten minutes may pass before the license holder is present on
336.7 site to respond to the situation. Under alternative (2), all of the following conditions are met:

336.8 (i) the license holder has a written description of the interactive technological
336.9 applications that will assist the license holder in communicating with and assessing the
336.10 needs related to the care, health, and safety of the foster care recipients. This interactive
336.11 technology must permit the license holder to remotely assess the well being of the ~~foster~~
336.12 ~~care recipient~~ resident served by the program without requiring the initiation of the
336.13 foster care recipient. Requiring the foster care recipient to initiate a telephone call does
336.14 not meet this requirement;

336.15 (ii) the license holder documents how the remote license holder is qualified and
336.16 capable of meeting the needs of the foster care recipients and assessing foster care
336.17 recipients' needs under item (i) during the absence of the license holder on site;

336.18 (iii) the license holder maintains written procedures to dispatch emergency response
336.19 personnel to the site in the event of an identified emergency; and

336.20 (iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual~~
336.21 ~~service plan~~ coordinated service and support plan under ~~section~~ sections 256B.0913,
336.22 subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49,
336.23 subdivision 15, if required, or individual resident placement agreement under Minnesota
336.24 Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time,
336.25 which may be greater than ten minutes, for the license holder to be on site for that ~~foster~~
336.26 ~~care recipient~~ resident.

336.27 (f) Each ~~foster care recipient's~~ resident's placement agreement, individual service
336.28 agreement, and plan must clearly state that the adult foster care or community residential
336.29 setting license category is a program without the presence of a caregiver in the residence
336.30 during normal sleeping hours; the protocols in place for responding to situations that
336.31 present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents
336.32 served by the program under paragraph (e), clause (1) or (2); and a signed informed
336.33 consent from each ~~foster care recipient~~ resident served by the program or the person's
336.34 legal representative documenting the person's or legal representative's agreement with
336.35 placement in the program. If electronic monitoring technology is used in the home, the
336.36 informed consent form must also explain the following:

337.1 (1) how any electronic monitoring is incorporated into the alternative supervision
337.2 system;

337.3 (2) the backup system for any electronic monitoring in times of electrical outages or
337.4 other equipment malfunctions;

337.5 (3) how the caregivers or direct support staff are trained on the use of the technology;

337.6 (4) the event types and license holder response times established under paragraph (e);

337.7 (5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy

337.8 related to electronic monitoring and related to any electronically recorded data generated

337.9 by the monitoring system. A ~~foster care recipient~~ resident served by the program may

337.10 not be removed from a program under this subdivision for failure to consent to electronic

337.11 monitoring. The consent form must explain where and how the electronically recorded

337.12 data is stored, with whom it will be shared, and how long it is retained; and

337.13 (6) the risks and benefits of the alternative overnight supervision system.

337.14 The written explanations under clauses (1) to (6) may be accomplished through

337.15 cross-references to other policies and procedures as long as they are explained to the

337.16 person giving consent, and the person giving consent is offered a copy.

337.17 (g) Nothing in this section requires the applicant or license holder to develop or

337.18 maintain separate or duplicative policies, procedures, documentation, consent forms, or

337.19 individual plans that may be required for other licensing standards, if the requirements of

337.20 this section are incorporated into those documents.

337.21 (h) The commissioner may grant variances to the requirements of this section

337.22 according to section 245A.04, subdivision 9.

337.23 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning

337.24 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and

337.25 contractors affiliated with the license holder.

337.26 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to

337.27 remotely determine what action the license holder needs to take to protect the well-being

337.28 of the foster care recipient.

337.29 (k) The commissioner shall evaluate license applications using the requirements

337.30 in paragraphs (d) to (f). The commissioner shall provide detailed application forms,

337.31 including a checklist of criteria needed for approval.

337.32 (l) To be eligible for a license under paragraph (a), the adult foster care or community

337.33 residential setting license holder must not have had a conditional license issued under

337.34 section 245A.06 or any licensing sanction under section 245A.07 during the prior 24

337.35 months based on failure to provide adequate supervision, health care services, or resident

337.36 safety in the adult foster care home or community residential setting.

338.1 (m) The commissioner shall review an application for an alternative overnight
338.2 supervision license within 60 days of receipt of the application. When the commissioner
338.3 receives an application that is incomplete because the applicant failed to submit required
338.4 documents or that is substantially deficient because the documents submitted do not meet
338.5 licensing requirements, the commissioner shall provide the applicant written notice
338.6 that the application is incomplete or substantially deficient. In the written notice to the
338.7 applicant, the commissioner shall identify documents that are missing or deficient and
338.8 give the applicant 45 days to resubmit a second application that is substantially complete.
338.9 An applicant's failure to submit a substantially complete application after receiving
338.10 notice from the commissioner is a basis for license denial under section 245A.05. The
338.11 commissioner shall complete subsequent review within 30 days.

338.12 (n) Once the application is considered complete under paragraph (m), the
338.13 commissioner will approve or deny an application for an alternative overnight supervision
338.14 license within 60 days.

338.15 (o) For the purposes of this subdivision, "supervision" means:

338.16 (1) oversight by a caregiver or direct support staff as specified in the individual
338.17 resident's place agreement or coordinated service and support plan and awareness of the
338.18 resident's needs and activities; and

338.19 (2) the presence of a caregiver or direct support staff in a residence during normal
338.20 sleeping hours, unless a determination has been made and documented in the individual's
338.21 coordinated service and support plan that the individual does not require the presence of a
338.22 caregiver or direct support staff during normal sleeping hours.

338.23 Sec. 19. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:

338.24 Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care
338.25 or community residential setting license holder who creates, collects, records, maintains,
338.26 stores, or discloses any individually identifiable recipient data, whether in an electronic
338.27 or any other format, must comply with the privacy and security provisions of applicable
338.28 privacy laws and regulations, including:

338.29 (1) the federal Health Insurance Portability and Accountability Act of 1996
338.30 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
338.31 title 45, part 160, and subparts A and E of part 164; and

338.32 (2) the Minnesota Government Data Practices Act as codified in chapter 13.

338.33 (b) For purposes of licensure, the license holder shall be monitored for compliance
338.34 with the following data privacy and security provisions:

339.1 (1) the license holder must control access to data on ~~foster care recipients~~ residents
339.2 served by the program according to the definitions of public and private data on individuals
339.3 under section 13.02; classification of the data on individuals as private under section
339.4 13.46, subdivision 2; and control over the collection, storage, use, access, protection,
339.5 and contracting related to data according to section 13.05, in which the license holder is
339.6 assigned the duties of a government entity;

339.7 (2) the license holder must provide each ~~foster care recipient~~ resident served by
339.8 the program with a notice that meets the requirements under section 13.04, in which
339.9 the license holder is assigned the duties of the government entity, and that meets the
339.10 requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall
339.11 describe the purpose for collection of the data, and to whom and why it may be disclosed
339.12 pursuant to law. The notice must inform the ~~recipient~~ individual that the license holder
339.13 uses electronic monitoring and, if applicable, that recording technology is used;

339.14 (3) the license holder must not install monitoring cameras in bathrooms;

339.15 (4) electronic monitoring cameras must not be concealed from the ~~foster care~~
339.16 ~~recipients~~ residents served by the program; and

339.17 (5) electronic video and audio recordings of ~~foster care recipients~~ residents served
339.18 by the program shall be stored by the license holder for five days unless: (i) a ~~foster care~~
339.19 ~~recipient~~ resident served by the program or legal representative requests that the recording
339.20 be held longer based on a specific report of alleged maltreatment; or (ii) the recording
339.21 captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or
339.22 a crime under chapter 609. When requested by a ~~recipient~~ resident served by the program
339.23 or when a recording captures an incident or event of alleged maltreatment or a crime, the
339.24 license holder must maintain the recording in a secured area for no longer than 30 days
339.25 to give the investigating agency an opportunity to make a copy of the recording. The
339.26 investigating agency will maintain the electronic video or audio recordings as required in
339.27 section 626.557, subdivision 12b.

339.28 (c) The commissioner shall develop, and make available to license holders and
339.29 county licensing workers, a checklist of the data privacy provisions to be monitored
339.30 for purposes of licensure.

339.31 Sec. 20. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:

339.32 Subd. 8. **Community residential setting license.** (a) The commissioner shall
339.33 establish provider standards for residential support services that integrate service standards
339.34 and the residential setting under one license. The commissioner shall propose statutory
339.35 language and an implementation plan for licensing requirements for residential support

340.1 services to the legislature by January 15, 2012, as a component of the quality outcome
340.2 standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

340.3 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
340.4 for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105
340.5 to 9555.6265, ~~or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340;~~
340.6 and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b)~~ section
340.7 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

340.8 Sec. 21. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:

340.9 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
340.10 private agencies that have been designated or licensed by the commissioner to perform
340.11 licensing functions and activities under section 245A.04 and background studies for family
340.12 child care under chapter 245C; to recommend denial of applicants under section 245A.05;
340.13 to issue correction orders, to issue variances, and recommend a conditional license under
340.14 section 245A.06, or to recommend suspending or revoking a license or issuing a fine under
340.15 section 245A.07, shall comply with rules and directives of the commissioner governing
340.16 those functions and with this section. The following variances are excluded from the
340.17 delegation of variance authority and may be issued only by the commissioner:

340.18 (1) dual licensure of family child care and child foster care, dual licensure of child
340.19 and adult foster care, and adult foster care and family child care;

340.20 (2) adult foster care maximum capacity;

340.21 (3) adult foster care minimum age requirement;

340.22 (4) child foster care maximum age requirement;

340.23 (5) variances regarding disqualified individuals except that county agencies may
340.24 issue variances under section 245C.30 regarding disqualified individuals when the county
340.25 is responsible for conducting a consolidated reconsideration according to sections 245C.25
340.26 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
340.27 and a disqualification based on serious or recurring maltreatment; ~~and~~

340.28 (6) the required presence of a caregiver in the adult foster care residence during
340.29 normal sleeping hours; and

340.30 (7) variances for community residential setting licenses under chapter 245D.

340.31 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency
340.32 must not grant a license holder a variance to exceed the maximum allowable family child
340.33 care license capacity of 14 children.

340.34 (b) County agencies must report information about disqualification reconsiderations
340.35 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances

341.1 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
341.2 prescribed by the commissioner.

341.3 (c) For family day care programs, the commissioner may authorize licensing reviews
341.4 every two years after a licensee has had at least one annual review.

341.5 (d) For family adult day services programs, the commissioner may authorize
341.6 licensing reviews every two years after a licensee has had at least one annual review.

341.7 (e) A license issued under this section may be issued for up to two years.

341.8 (f) During implementation of chapter 245D, the commissioner shall consider:

341.9 (1) the role of counties in quality assurance;

341.10 (2) the duties of county licensing staff; and

341.11 (3) the possible use of joint powers agreements, according to section 471.59, with
341.12 counties through which some licensing duties under chapter 245D may be delegated by
341.13 the commissioner to the counties.

341.14 Any consideration related to this paragraph must meet all of the requirements of the
341.15 corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

341.16 Sec. 22. Minnesota Statutes 2012, section 245D.02, is amended to read:

341.17 **245D.02 DEFINITIONS.**

341.18 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given
341.19 them in this section.

341.20 Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given
341.21 in section 245A.02, subdivision 2b.

341.22 Subd. 2a. **Authorized representative.** "Authorized representative" means a parent,
341.23 family member, advocate, or other adult authorized by the person or the person's legal
341.24 representative, to serve as a representative in connection with the provision of services
341.25 licensed under this chapter. This authorization must be in writing or by another method
341.26 that clearly indicates the person's free choice. The authorized representative must have no
341.27 financial interest in the provision of any services included in the person's service delivery
341.28 plan and must be capable of providing the support necessary to assist the person in the use
341.29 of home and community-based services licensed under this chapter.

341.30 Subd. 2b. **Aversive procedure.** "Aversive procedure" means the application of
341.31 an aversive stimulus contingent upon the occurrence of a behavior for the purposes of
341.32 reducing or eliminating the behavior.

341.33 Subd. 2c. **Aversive stimulus.** "Aversive stimulus" means an object, event, or
341.34 situation that is presented immediately following a behavior in an attempt to suppress the
341.35 behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines.

342.1 Subd. 3. **Case manager.** "Case manager" means the individual designated
342.2 to provide waiver case management services, care coordination, or long-term care
342.3 consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,
342.4 or successor provisions.

342.5 Subd. 3a. **Certification.** "Certification" means the commissioner's written
342.6 authorization for a license holder to provide specialized services based on certification
342.7 standards in section 245D.33. The term certification and its derivatives have the same
342.8 meaning and may be substituted for the term licensure and its derivatives in this chapter
342.9 and chapter 245A.

342.10 Subd. 3b. **Chemical restraint.** "Chemical restraint" means the administration of
342.11 a drug or medication to control the person's behavior or restrict the person's freedom
342.12 of movement and is not a standard treatment or dosage for the person's medical or
342.13 psychological condition.

342.14 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the
342.15 Department of Human Services or the commissioner's designated representative.

342.16 Subd. 4a. **Community residential setting.** "Community residential setting" means
342.17 a residential program as identified in section 245A.11, subdivision 8, where residential
342.18 supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause
342.19 (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant
342.20 of the facility licensed according to this chapter, and the license holder does not reside
342.21 in the facility.

342.22 Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support
342.23 plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision
342.24 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.

342.25 Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated
342.26 service and support plan addendum" means the documentation that this chapter requires
342.27 of the license holder for each person receiving services.

342.28 Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster
342.29 residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340,
342.30 or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to
342.31 9555.6265, where the license holder does not live in the home.

342.32 Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence"
342.33 or "culturally competent" means the ability and the will to respond to the unique needs of
342.34 a person that arise from the person's culture and the ability to use the person's culture as a
342.35 resource or tool to assist with the intervention and help meet the person's needs.

343.1 Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed
343.2 according to this chapter at which persons receive day services licensed under this chapter
343.3 from the license holder's direct support staff for a cumulative total of more than 30 days
343.4 within any 12-month period and the license holder is the owner, lessor, or tenant of the
343.5 facility.

343.6 Subd. 5. **Department.** "Department" means the Department of Human Services.

343.7 Subd. 5a. **Deprivation procedure.** "Deprivation procedure" means the removal of a
343.8 positive reinforcer following a response resulting in, or intended to result in, a decrease in
343.9 the frequency, duration, or intensity of that response. Oftentimes the positive reinforcer
343.10 available is goods, services, or activities to which the person is normally entitled. The
343.11 removal is often in the form of a delay or postponement of the positive reinforcer.

343.12 Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
343.13 subdivision 11, and is used interchangeably with the term "direct support service."

343.14 Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means
343.15 employees of the license holder who have direct contact with persons served by the
343.16 program and includes temporary staff or subcontractors, regardless of employer, providing
343.17 program services for hire under the control of the license holder who have direct contact
343.18 with persons served by the program.

343.19 Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

343.20 Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary
343.21 daily operation of the program including, but not limited to, fires, severe weather, natural
343.22 disasters, power failures, or other events that threaten the immediate health and safety of
343.23 a person receiving services and that require calling 911, emergency evacuation, moving
343.24 to an emergency shelter, or temporary closure or relocation of the program to another
343.25 facility or service site for more than 24 hours.

343.26 Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual
343.27 restraint" means using a manual restraint when a person poses an imminent risk of
343.28 physical harm to self or others and is the least restrictive intervention that would achieve
343.29 safety. Property damage, verbal aggression, or a person's refusal to receive or participate
343.30 in treatment or programming on their own, do not constitute an emergency.

343.31 Subd. 8b. **Expanded support team.** "Expanded support team" means the members
343.32 of the support team defined in subdivision 46, and a licensed health or mental health
343.33 professional or other licensed, certified, or qualified professionals or consultants working
343.34 with the person and included in the team at the request of the person or the person's legal
343.35 representative.

344.1 Subd. 8c. **Family foster care.** "Family foster care" means a child foster family
 344.2 setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult
 344.3 foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265,
 344.4 where the license holder lives in the home.

344.5 Subd. 9. **Health services.** "Health services" means any service or treatment
 344.6 consistent with the physical and mental health needs of the person, such as medication
 344.7 administration and monitoring, medical, dental, nutritional, health monitoring, wellness
 344.8 education, and exercise.

344.9 Subd. 10. **Home and community-based services.** "Home and community-based
 344.10 services" means the services subject to the provisions of this chapter identified in section
 344.11 245D.03, subdivision 1, and as defined in:

344.12 (1) the federal ~~federal~~ federally approved waiver plans governed by United States Code,
 344.13 title 42, sections 1396 et seq., or the state's alternative care program according to section
 344.14 256B.0913, including the waivers for persons with disabilities under section 256B.49,
 344.15 subdivision 11, including the brain injury (BI) waiver, ~~plan~~; the community alternative
 344.16 care (CAC) waiver, ~~plan~~; the community alternatives for disabled individuals (CADI)
 344.17 waiver, ~~plan~~; the developmental disability (DD) waiver, ~~plan~~ under section 256B.092,
 344.18 subdivision 5; the elderly waiver (EW), ~~and plan~~ under section 256B.0915, subdivision 1;
 344.19 or successor plans respective to each waiver; or

344.20 (2) the alternative care (AC) program under section 256B.0913.

344.21 Subd. 11. **Incident.** "Incident" means an occurrence ~~that affects the~~ which involves
 344.22 a person and requires the program to make a response that is not a part of the program's
 344.23 ordinary provision of services to a that person, and includes any of the following:

344.24 (1) serious injury of a person as determined by section 245.91, subdivision 6;

344.25 (2) a person's death;

344.26 (3) any medical emergency, unexpected serious illness, or significant unexpected
 344.27 change in an illness or medical condition, ~~or the mental health status~~ of a person that
 344.28 requires calling the program to call 911 ~~or a mental health crisis intervention team,~~
 344.29 physician treatment, or hospitalization;

344.30 (4) any mental health crisis that requires the program to call 911 or a mental health
 344.31 crisis intervention team;

344.32 (5) an act or situation involving a person that requires the program to call 911,
 344.33 law enforcement, or the fire department;

344.34 ~~(4)~~ (6) a person's unauthorized or unexplained absence from a program;

344.35 ~~(5)~~ (7) physical aggression conduct by a person receiving services against another
 344.36 person receiving services that causes physical pain, injury, or persistent emotional distress;

345.1 ~~including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting,~~
345.2 ~~pushing, and spitting;~~

345.3 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with
345.4 a person's opportunities to participate in or receive service or support;

345.5 (ii) places the person in actual and reasonable fear of harm;

345.6 (iii) places the person in actual and reasonable fear of damage to property of the
345.7 person; or

345.8 (iv) substantially disrupts the orderly operation of the program;

345.9 ~~(6)~~ (8) any sexual activity between persons receiving services involving force or
345.10 coercion as defined under section 609.341, subdivisions 3 and 14; or

345.11 (9) any emergency use of manual restraint as identified in section 245D.061; or

345.12 ~~(7)~~ (10) a report of alleged or suspected child or vulnerable adult maltreatment
345.13 under section 626.556 or 626.557.

345.14 **Subd. 11a. Intermediate care facility for persons with developmental disabilities**
345.15 **or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or
345.16 "ICF/DD" means a residential program licensed to serve four or more persons with
345.17 developmental disabilities under section 252.28 and chapter 245A and licensed as a
345.18 supervised living facility under chapter 144, which together are certified by the Department
345.19 of Health as an intermediate care facility for persons with developmental disabilities.

345.20 **Subd. 11b. Least restrictive alternative.** "Least restrictive alternative" means
345.21 the alternative method for providing supports and services that is the least intrusive and
345.22 most normalized given the level of supervision and protection required for the person.
345.23 This level of supervision and protection allows risk taking to the extent that there is no
345.24 reasonable likelihood that serious harm will happen to the person or others.

345.25 **Subd. 12. Legal representative.** "Legal representative" means the parent of a
345.26 person who is under 18 years of age, a court-appointed guardian, or other representative
345.27 with legal authority to make decisions about services for a person. Other representatives
345.28 with legal authority to make decisions include but are not limited to a health care agent or
345.29 an attorney-in-fact authorized through a health care directive or power of attorney.

345.30 **Subd. 13. License.** "License" has the meaning given in section 245A.02,
345.31 subdivision 8.

345.32 **Subd. 14. Licensed health professional.** "Licensed health professional" means a
345.33 person licensed in Minnesota to practice those professions described in section 214.01,
345.34 subdivision 2.

345.35 **Subd. 15. License holder.** "License holder" has the meaning given in section
345.36 245A.02, subdivision 9.

346.1 Subd. 15a. **Manual restraint.** "Manual restraint" means physical intervention
346.2 intended to hold a person immobile or limit a person's voluntary movement by using body
346.3 contact as the only source of physical restraint.

346.4 Subd. 15b. **Mechanical restraint.** Except for devices worn by the person that
346.5 trigger electronic alarms to warn staff that a person is leaving a room or area, which
346.6 do not, in and of themselves, restrict freedom of movement, or the use of adaptive aids
346.7 or equipment or orthotic devices ordered by a health care professional used to treat or
346.8 manage a medical condition, "mechanical restraint" means the use of devices, materials,
346.9 or equipment attached or adjacent to the person's body, or the use of practices that are
346.10 intended to restrict freedom of movement or normal access to one's body or body parts,
346.11 or limits a person's voluntary movement or holds a person immobile as an intervention
346.12 precipitated by a person's behavior. The term applies to the use of mechanical restraint
346.13 used to prevent injury with persons who engage in self-injurious behaviors, such as
346.14 head-banging, gouging, or other actions resulting in tissue damage that have caused or
346.15 could cause medical problems resulting from the self-injury.

346.16 Subd. 16. **Medication.** "Medication" means a prescription drug or over-the-counter
346.17 drug. For purposes of this chapter, "medication" includes dietary supplements.

346.18 ~~Subd. 17. **Medication administration.** "Medication administration" means~~
346.19 ~~performing the following set of tasks to ensure a person takes both prescription and~~
346.20 ~~over-the-counter medications and treatments according to orders issued by appropriately~~
346.21 ~~licensed professionals, and includes the following:~~

346.22 (1) checking the person's medication record;

346.23 (2) preparing the medication for administration;

346.24 (3) administering the medication to the person;

346.25 (4) documenting the administration of the medication or the reason for not
346.26 administering the medication; and

346.27 (5) reporting to the prescriber or a nurse any concerns about the medication,
346.28 including side effects, adverse reactions, effectiveness, or the person's refusal to take the
346.29 medication or the person's self-administration of the medication.

346.30 ~~Subd. 18. **Medication assistance.** "Medication assistance" means providing verbal~~
346.31 ~~or visual reminders to take regularly scheduled medication, which includes either of~~
346.32 ~~the following:~~

346.33 (1) bringing to the person and opening a container of previously set up medications
346.34 and emptying the container into the person's hand or opening and giving the medications
346.35 in the original container to the person, or bringing to the person liquids or food to
346.36 accompany the medication; or

347.1 ~~(2) providing verbal or visual reminders to perform regularly scheduled treatments~~
347.2 ~~and exercises.~~

347.3 ~~Subd. 19. **Medication management.** "Medication management" means the~~
347.4 ~~provision of any of the following:~~

347.5 ~~(1) medication-related services to a person;~~

347.6 ~~(2) medication setup;~~

347.7 ~~(3) medication administration;~~

347.8 ~~(4) medication storage and security;~~

347.9 ~~(5) medication documentation and charting;~~

347.10 ~~(6) verification and monitoring of effectiveness of systems to ensure safe medication~~
347.11 ~~handling and administration;~~

347.12 ~~(7) coordination of medication refills;~~

347.13 ~~(8) handling changes to prescriptions and implementation of those changes;~~

347.14 ~~(9) communicating with the pharmacy; or~~

347.15 ~~(10) coordination and communication with prescriber.~~

347.16 ~~For the purposes of this chapter, medication management does not mean "medication~~
347.17 ~~therapy management services" as identified in section 256B.0625, subdivision 13h.~~

347.18 ~~Subd. 20. **Mental health crisis intervention team.** "Mental health crisis~~
347.19 ~~intervention team" means a mental health crisis response providers provider as identified~~
347.20 ~~in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944,~~
347.21 ~~subdivision 1, paragraph (d), for children.~~

347.22 ~~Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that~~
347.23 ~~enables individuals with disabilities to interact with nondisabled persons to the fullest~~
347.24 ~~extent possible.~~

347.25 ~~Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that~~
347.26 ~~is not required by federal law to bear the statement "Caution: Federal law prohibits~~
347.27 ~~dispensing without prescription."~~

347.28 ~~Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by~~
347.29 ~~the person that can be observed, measured, and determined reliable and valid.~~

347.30 ~~Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision~~
347.31 ~~11.~~

347.32 ~~Subd. 23. **Person with a disability.** "Person with a disability" means a person~~
347.33 ~~determined to have a disability by the commissioner's state medical review team as~~
347.34 ~~identified in section 256B.055, subdivision 7, the Social Security Administration, or~~
347.35 ~~the person is determined to have a developmental disability as defined in Minnesota~~

348.1 Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section
348.2 252.27, subdivision 1a.

348.3 Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter
348.4 147.

348.5 Subd. 23b. **Positive support transition plan.** "Positive support transition plan"
348.6 means the plan required in section 245D.06, subdivision 5, paragraph (b), to be developed
348.7 by the expanded support team to implement positive support strategies to:

348.8 (1) eliminate the use of prohibited procedures as identified in section 245D.06,
348.9 subdivision 5, paragraph (a);

348.10 (2) avoid the emergency use of manual restraint as identified in section 245D.061; and

348.11 (3) prevent the person from physically harming self or others.

348.12 Subd. 24. **Prescriber.** "Prescriber" means a licensed practitioner as defined in
348.13 section 151.01, subdivision 23, person who is authorized under section 148.235; 151.01,
348.14 subdivision 23; or 151.37 to prescribe drugs. For the purposes of this chapter, the term
348.15 "prescriber" is used interchangeably with "physician."

348.16 Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section
348.17 151.01, subdivision 16.

348.18 Subd. 26. **Program.** "Program" means either the nonresidential or residential
348.19 program as defined in section 245A.02, subdivisions 10 and 14.

348.20 Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any
348.21 medication prescribed to treat the symptoms of mental illness that affect thought processes,
348.22 mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic
348.23 (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and
348.24 stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder.
348.25 Other miscellaneous medications are considered to be a psychotropic medication when
348.26 they are specifically prescribed to treat a mental illness or to control or alter behavior.

348.27 Subd. 28. **Restraint.** "Restraint" means ~~physical or mechanical~~ manual restraint
348.28 as defined in subdivision 15a or mechanical restraint as defined in subdivision 15b, or
348.29 any other form of restraint that results in limiting of the free and normal movement of
348.30 body or limbs.

348.31 Subd. 29. **Seclusion.** "Seclusion" means ~~separating a person from others in a way~~
348.32 that prevents social contact and prevents the person from leaving the situation if he or she
348.33 chooses the placement of a person alone in a room from which exit is prohibited by a staff
348.34 person or a mechanism such as a lock, a device, or an object positioned to hold the door
348.35 closed or otherwise prevent the person from leaving the room.

349.1 Subd. 29a. **Self-determination.** "Self-determination" means the person makes
349.2 decisions independently, plans for the person's own future, determines how money is spent
349.3 for the person's supports, and takes responsibility for making these decisions. If a person
349.4 has a legal representative, the legal representative's decision-making authority is limited to
349.5 the scope of authority granted by the court or allowed in the document authorizing the
349.6 legal representative to act.

349.7 Subd. 29b. **Semi-independent living services.** "Semi-independent living services"
349.8 has the meaning given in section 252.275.

349.9 Subd. 30. **Service.** "Service" means care, training, supervision, counseling,
349.10 consultation, or medication assistance assigned to the license holder in the coordinated
349.11 service and support plan.

349.12 ~~Subd. 31. **Service plan.** "Service plan" means the individual service plan or~~
349.13 ~~individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,~~
349.14 ~~or successor provisions, and includes any support plans or service needs identified as~~
349.15 ~~a result of long-term care consultation, or a support team meeting that includes the~~
349.16 ~~participation of the person, the person's legal representative, and case manager, or assigned~~
349.17 ~~to a license holder through an authorized service agreement.~~

349.18 Subd. 32. **Service site.** "Service site" means the location where the service is
349.19 provided to the person, including, but not limited to, a facility licensed according to
349.20 chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's
349.21 own home; or a community-based location.

349.22 ~~Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a~~
349.23 ~~person served by the facility, agency, or program.~~

349.24 Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning
349.25 given in Minnesota Rules, part 4665.0100, subpart 10.

349.26 Subd. 33b. **Supervision.** (a) "Supervision" means:

349.27 (1) oversight by direct support staff as specified in the person's coordinated service
349.28 and support plan or coordinated service and support plan addendum and awareness of
349.29 the person's needs and activities;

349.30 (2) responding to situations that present a serious risk to the health, safety, or rights
349.31 of the person while services are being provided; and

349.32 (3) the presence of direct support staff at a service site while services are being
349.33 provided, unless a determination has been made and documented in the person's coordinated
349.34 service and support plan or coordinated service and support plan addendum that the person
349.35 does not require the presence of direct support staff while services are being provided.

350.1 (b) For the purposes of this definition, "while services are being provided," means
 350.2 any period of time during which the license holder will seek reimbursement for services.

350.3 Subd. 34. **Support team.** "Support team" means the service planning team
 350.4 identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in
 350.5 Minnesota Rules, part 9525.0004, subpart 14.

350.6 Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an
 350.7 ongoing activity to a room, either locked or unlocked, or otherwise separating a person
 350.8 from others in a way that prevents social contact and prevents the person from leaving
 350.9 the situation if the person chooses. For the purpose of chapter 245D, "time out" does
 350.10 not mean voluntary removal or self-removal for the purpose of calming, prevention of
 350.11 escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out"
 350.12 does not include a person voluntarily moving from an ongoing activity to an unlocked
 350.13 room or otherwise separating from a situation or social contact with others if the person
 350.14 chooses. For the purposes of this definition, "voluntarily" means without being forced,
 350.15 compelled, or coerced.

350.16 ~~Subd. 35. **Unit of government.** "Unit of government" means every city, county,~~
 350.17 ~~town, school district, other political subdivisions of the state, and any agency of the state~~
 350.18 ~~or the United States, and includes any instrumentality of a unit of government.~~

350.19 Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than
 350.20 medications, ordered or prescribed by a licensed health or mental health professional,
 350.21 provided to a person to cure, rehabilitate, or ease symptoms.

350.22 Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the
 350.23 license holder, provides direct services without pay to a person served by the license holder.

350.24 **EFFECTIVE DATE.** This section is effective January 1, 2014.

350.25 Sec. 23. Minnesota Statutes 2012, section 245D.03, is amended to read:

350.26 **245D.03 APPLICABILITY AND EFFECT.**

350.27 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of
 350.28 home and community-based services to persons with disabilities and persons age 65 and
 350.29 older pursuant to this chapter. The licensing standards in this chapter govern the provision
 350.30 of the following basic support services: and intensive support services.

350.31 ~~(1) housing access coordination as defined under the current BI, CADI, and DD~~
 350.32 ~~waiver plans or successor plans;~~

350.33 ~~(2) respite services as defined under the current CADI, BI, CAC, DD, and EW~~
 350.34 ~~waiver plans or successor plans when the provider is an individual who is not an employee~~

- 351.1 ~~of a residential or nonresidential program licensed by the Department of Human Services~~
 351.2 ~~or the Department of Health that is otherwise providing the respite service;~~
- 351.3 ~~(3) behavioral programming as defined under the current BI and CADI waiver~~
 351.4 ~~plans or successor plans;~~
- 351.5 ~~(4) specialist services as defined under the current DD waiver plan or successor plans;~~
- 351.6 ~~(5) companion services as defined under the current BI, CADI, and EW waiver~~
 351.7 ~~plans or successor plans, excluding companion services provided under the Corporation~~
 351.8 ~~for National and Community Services Senior Companion Program established under the~~
 351.9 ~~Domestic Volunteer Service Act of 1973, Public Law 98-288;~~
- 351.10 ~~(6) personal support as defined under the current DD waiver plan or successor plans;~~
- 351.11 ~~(7) 24-hour emergency assistance, on-call and personal emergency response as~~
 351.12 ~~defined under the current CADI and DD waiver plans or successor plans;~~
- 351.13 ~~(8) night supervision services as defined under the current BI waiver plan or~~
 351.14 ~~successor plans;~~
- 351.15 ~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW~~
 351.16 ~~waiver plans or successor plans, excluding providers licensed by the Department of Health~~
 351.17 ~~under chapter 144A and those providers providing cleaning services only;~~
- 351.18 ~~(10) independent living skills training as defined under the current BI and CADI~~
 351.19 ~~waiver plans or successor plans;~~
- 351.20 ~~(11) prevocational services as defined under the current BI and CADI waiver plans~~
 351.21 ~~or successor plans;~~
- 351.22 ~~(12) structured day services as defined under the current BI waiver plan or successor~~
 351.23 ~~plans; or~~
- 351.24 ~~(13) supported employment as defined under the current BI and CADI waiver plans~~
 351.25 ~~or successor plans.~~
- 351.26 (b) Basic support services provide the level of assistance, supervision, and care that
 351.27 is necessary to ensure the health and safety of the person and do not include services that
 351.28 are specifically directed toward the training, treatment, habilitation, or rehabilitation of
 351.29 the person. Basic support services include:
- 351.30 (1) in-home and out-of-home respite care services as defined in section 245A.02,
 351.31 subdivision 15, and under the brain injury, community alternative care, community
 351.32 alternatives for disabled individuals, developmental disability, and elderly waiver plans;
- 351.33 (2) companion services as defined under the brain injury, community alternatives for
 351.34 disabled individuals, and elderly waiver plans, excluding companion services provided
 351.35 under the Corporation for National and Community Services Senior Companion Program
 351.36 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

- 352.1 (3) personal support as defined under the developmental disability waiver plan;
352.2 (4) 24-hour emergency assistance, personal emergency response as defined under the
352.3 community alternatives for disabled individuals and developmental disability waiver plans;
352.4 (5) night supervision services as defined under the brain injury waiver plan; and
352.5 (6) homemaker services as defined under the community alternatives for disabled
352.6 individuals, brain injury, community alternative care, developmental disability, and elderly
352.7 waiver plans, excluding providers licensed by the Department of Health under chapter
352.8 144A and those providers providing cleaning services only.
- 352.9 (c) Intensive support services provide assistance, supervision, and care that is
352.10 necessary to ensure the health and safety of the person and services specifically directed
352.11 toward the training, habilitation, or rehabilitation of the person. Intensive support services
352.12 include:
- 352.13 (1) intervention services, including:
- 352.14 (i) behavioral support services as defined under the brain injury and community
352.15 alternatives for disabled individuals waiver plans;
- 352.16 (ii) in-home or out-of-home crisis respite services as defined under the developmental
352.17 disability waiver plan; and
- 352.18 (iii) specialist services as defined under the current developmental disability waiver
352.19 plan;
- 352.20 (2) in-home support services, including:
- 352.21 (i) in-home family support and supported living services as defined under the
352.22 developmental disability waiver plan;
- 352.23 (ii) independent living services training as defined under the brain injury and
352.24 community alternatives for disabled individuals waiver plans; and
- 352.25 (iii) semi-independent living services;
- 352.26 (3) residential supports and services, including:
- 352.27 (i) supported living services as defined under the developmental disability waiver
352.28 plan provided in a family or corporate child foster care residence, a family adult foster
352.29 care residence, a community residential setting, or a supervised living facility;
- 352.30 (ii) foster care services as defined in the brain injury, community alternative care,
352.31 and community alternatives for disabled individuals waiver plans provided in a family or
352.32 corporate child foster care residence, a family adult foster care residence, or a community
352.33 residential setting; and
- 352.34 (iii) residential services provided in a supervised living facility that is certified by
352.35 the Department of Health as an ICF/DD;
- 352.36 (4) day services, including:

- 353.1 (i) structured day services as defined under the brain injury waiver plan;
 353.2 (ii) day training and habilitation services under sections 252.40 to 252.46, and as
 353.3 defined under the developmental disability waiver plan; and
 353.4 (iii) prevocational services as defined under the brain injury and community
 353.5 alternatives for disabled individuals waiver plans; and
 353.6 (5) supported employment as defined under the brain injury, developmental
 353.7 disability, and community alternatives for disabled individuals waiver plans.

353.8 **Subd. 2. Relationship to other standards governing home and community-based**
 353.9 **services.** (a) A license holder governed by this chapter is also subject to the licensure
 353.10 requirements under chapter 245A.

353.11 (b) A license holder concurrently providing child foster care services licensed
 353.12 according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed
 353.13 under this chapter is exempt from section 245D.04 as it applies to the person. A corporate
 353.14 or family child foster care site controlled by a license holder and providing services
 353.15 governed by this chapter is exempt from compliance with section 245D.04. This exemption
 353.16 applies to foster care homes where at least one resident is receiving residential supports
 353.17 and services licensed according to this chapter. This chapter does not apply to corporate or
 353.18 family child foster care homes that do not provide services licensed under this chapter.

353.19 (c) A family adult foster care site controlled by a license holder and providing
 353.20 services governed by this chapter is exempt from compliance with Minnesota Rules,
 353.21 parts 9555.6185; 9555.6225; 9555.6245; 9555.6255; and 9555.6265. These exemptions
 353.22 apply to family adult foster care homes where at least one resident is receiving residential
 353.23 supports and services licensed according to this chapter. This chapter does not apply to
 353.24 family adult foster care homes that do not provide services licensed under this chapter.

353.25 (d) A license holder providing services licensed according to this chapter in a
 353.26 supervised living facility is exempt from compliance with sections 245D.04; 245D.05,
 353.27 subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).

353.28 (e) A license holder providing residential services to persons in an ICF/DD is exempt
 353.29 from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision
 353.30 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09,
 353.31 subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

353.32 (e) (f) A license holder concurrently providing home care homemaker services
 353.33 registered licensed according to sections 144A.43 to 144A.49 to the same person receiving
 353.34 home management services licensed under this chapter and registered according to chapter
 353.35 144A is exempt from compliance with section 245D.04 as it applies to the person.

354.1 ~~(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt~~
354.2 ~~from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557,~~
354.3 ~~subdivision 14, paragraph (b).~~

354.4 ~~(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing~~
354.5 ~~structured day, prevocational, or supported employment services under this chapter~~
354.6 ~~and day training and habilitation or supported employment services licensed under~~
354.7 ~~chapter 245B within the same program is exempt from compliance with this chapter~~
354.8 ~~when the license holder notifies the commissioner in writing that the requirements under~~
354.9 ~~chapter 245B will be met for all persons receiving these services from the program. For~~
354.10 ~~the purposes of this paragraph, if the license holder has obtained approval from the~~
354.11 ~~commissioner for an alternative inspection status according to section 245B.031, that~~
354.12 ~~approval will apply to all persons receiving services in the program.~~

354.13 ~~(g) Nothing in this chapter prohibits a license holder from concurrently serving~~
354.14 ~~persons without disabilities or people who are or are not age 65 and older, provided this~~
354.15 ~~chapter's standards are met as well as other relevant standards.~~

354.16 ~~(h) The documentation required under sections 245D.07 and 245D.071 must meet~~
354.17 ~~the individual program plan requirements identified in section 256B.092 or successor~~
354.18 ~~provisions.~~

354.19 Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met,
354.20 the commissioner may grant a variance to any of the requirements in this chapter, except
354.21 sections 245D.04, and 245D.10, subdivision 4, paragraph (b) 245D.06, subdivision 4,
354.22 paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and
354.23 information rights of persons.

354.24 Subd. 4. **License holders with multiple 245D licenses.** ~~(a) When a person changes~~
354.25 ~~service from one license to a different license held by the same license holder, the license~~
354.26 ~~holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).~~

354.27 ~~(b) When a staff person begins providing direct service under one or more licenses~~
354.28 ~~held by the same license holder, other than the license for which staff orientation was~~
354.29 ~~initially provided according to section 245D.09, subdivision 4, the license holder is~~
354.30 ~~exempt from those staff orientation requirements, except the staff person must review each~~
354.31 ~~person's service plan and medication administration procedures in accordance with section~~
354.32 ~~245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.~~

354.33 Subd. 5. **Program certification.** An applicant or a license holder may apply for
354.34 program certification as identified in section 245D.33.

354.35 **EFFECTIVE DATE.** This section is effective January 1, 2014.

355.1 Sec. 24. Minnesota Statutes 2012, section 245D.04, is amended to read:

355.2 **245D.04 SERVICE RECIPIENT RIGHTS.**

355.3 Subdivision 1. **License holder responsibility for individual rights of persons**
 355.4 **served by the program.** The license holder must:

355.5 (1) provide each person or each person's legal representative with a written notice
 355.6 that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of
 355.7 those rights within five working days of service initiation and annually thereafter;

355.8 (2) make reasonable accommodations to provide this information in other formats
 355.9 or languages as needed to facilitate understanding of the rights by the person and the
 355.10 person's legal representative, if any;

355.11 (3) maintain documentation of the person's or the person's legal representative's
 355.12 receipt of a copy and an explanation of the rights; and

355.13 (4) ensure the exercise and protection of the person's rights in the services provided
 355.14 by the license holder and as authorized in the coordinated service and support plan.

355.15 Subd. 2. **Service-related rights.** A person's service-related rights include the right to:

355.16 (1) participate in the development and evaluation of the services provided to the
 355.17 person;

355.18 (2) have services and supports identified in the coordinated service and support plan
 355.19 and the coordinated service and support plan addendum provided in a manner that respects
 355.20 and takes into consideration the person's preferences according to the requirements in
 355.21 sections 245D.07 and 245D.071;

355.22 (3) refuse or terminate services and be informed of the consequences of refusing
 355.23 or terminating services;

355.24 (4) know, in advance, limits to the services available from the license holder,
 355.25 including the license holder's knowledge, skill, and ability to meet the person's service
 355.26 and support needs;

355.27 (5) know conditions and terms governing the provision of services, including the
 355.28 license holder's admission criteria and policies and procedures related to temporary
 355.29 service suspension and service termination;

355.30 (6) a coordinated transfer to ensure continuity of care when there will be a change
 355.31 in the provider;

355.32 (7) know what the charges are for services, regardless of who will be paying for the
 355.33 services, and be notified of changes in those charges;

355.34 ~~(7)~~ (8) know, in advance, whether services are covered by insurance, government
 355.35 funding, or other sources, and be told of any charges the person or other private party
 355.36 may have to pay; and

356.1 ~~(8)~~ (9) receive services from an individual who is competent and trained, who has
356.2 professional certification or licensure, as required, and who meets additional qualifications
356.3 identified in the person's coordinated service and support plan; ~~or coordinated service and~~
356.4 support plan addendum.

356.5 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include
356.6 the right to:

356.7 (1) have personal, financial, service, health, and medical information kept private,
356.8 and be advised of disclosure of this information by the license holder;

356.9 (2) access records and recorded information about the person in accordance with
356.10 applicable state and federal law, regulation, or rule;

356.11 (3) be free from maltreatment;

356.12 (4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except
356.13 for emergency use of manual restraint to protect the person from imminent danger to self
356.14 or others according to the requirements in section 245D.06;

356.15 (5) receive services in a clean and safe environment when the license holder is the
356.16 owner, lessor, or tenant of the service site;

356.17 (6) be treated with courtesy and respect and receive respectful treatment of the
356.18 person's property;

356.19 (7) reasonable observance of cultural and ethnic practice and religion;

356.20 (8) be free from bias and harassment regarding race, gender, age, disability,
356.21 spirituality, and sexual orientation;

356.22 (9) be informed of and use the license holder's grievance policy and procedures,
356.23 including knowing how to contact persons responsible for addressing problems and to
356.24 appeal under section 256.045;

356.25 (10) know the name, telephone number, and the Web site, e-mail, and street
356.26 addresses of protection and advocacy services, including the appropriate state-appointed
356.27 ombudsman, and a brief description of how to file a complaint with these offices;

356.28 (11) assert these rights personally, or have them asserted by the person's family,
356.29 authorized representative, or legal representative, without retaliation;

356.30 (12) give or withhold written informed consent to participate in any research or
356.31 experimental treatment;

356.32 (13) associate with other persons of the person's choice;

356.33 (14) personal privacy; and

356.34 (15) engage in chosen activities.

357.1 (b) For a person residing in a residential site licensed according to chapter 245A,
357.2 or where the license holder is the owner, lessor, or tenant of the residential service site,
357.3 protection-related rights also include the right to:

357.4 (1) have daily, private access to and use of a non-coin-operated telephone for local
357.5 calls and long-distance calls made collect or paid for by the person;

357.6 (2) receive and send, without interference, uncensored, unopened mail or electronic
357.7 correspondence or communication; ~~and~~

357.8 (3) have use of and free access to common areas in the residence; and

357.9 (4) privacy for visits with the person's spouse, next of kin, legal counsel, religious
357.10 advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including
357.11 privacy in the person's bedroom.

357.12 (c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a),
357.13 clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure
357.14 the health, safety, and well-being of the person. Any restriction of those rights must be
357.15 documented in the person's coordinated service and support plan for the person and or
357.16 coordinated service and support plan addendum. The restriction must be implemented
357.17 in the least restrictive alternative manner necessary to protect the person and provide
357.18 support to reduce or eliminate the need for the restriction in the most integrated setting
357.19 and inclusive manner. The documentation must include the following information:

357.20 (1) the justification for the restriction based on an assessment of the person's
357.21 vulnerability related to exercising the right without restriction;

357.22 (2) the objective measures set as conditions for ending the restriction;

357.23 (3) a schedule for reviewing the need for the restriction based on the conditions for
357.24 ending the restriction to occur, ~~at a minimum, every three months for persons who do not~~
357.25 ~~have a legal representative and annually for persons who do have a legal representative~~
357.26 semiannually from the date of initial approval, at a minimum, or more frequently if
357.27 requested by the person, the person's legal representative, if any, and case manager; and

357.28 (4) signed and dated approval for the restriction from the person, or the person's
357.29 legal representative, if any. A restriction may be implemented only when the required
357.30 approval has been obtained. Approval may be withdrawn at any time. If approval is
357.31 withdrawn, the right must be immediately and fully restored.

357.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

357.33 Sec. 25. Minnesota Statutes 2012, section 245D.05, is amended to read:

357.34 **245D.05 HEALTH SERVICES.**

358.1 Subdivision 1. **Health needs.** (a) The license holder is responsible for ~~providing~~
 358.2 meeting health services service needs assigned in the coordinated service and support plan
 358.3 ~~and~~ or the coordinated service and support plan addendum, consistent with the person's
 358.4 health needs. The license holder is responsible for promptly notifying ~~the person or~~
 358.5 the person's legal representative, if any, and the case manager of changes in a person's
 358.6 physical and mental health needs affecting ~~assigned health services~~ service needs assigned
 358.7 to the license holder in the coordinated service and support plan or the coordinated service
 358.8 and support plan addendum, when discovered by the license holder, unless the license
 358.9 holder has reason to know the change has already been reported. The license holder
 358.10 must document when the notice is provided.

358.11 (b) ~~When assigned in the service plan,~~ If responsibility for meeting the person's
 358.12 health service needs has been assigned to the license holder in the coordinated service and
 358.13 support plan or the coordinated service and support plan addendum, the license holder ~~is~~
 358.14 ~~required to~~ must maintain documentation on how the person's health needs will be met,
 358.15 including a description of the procedures the license holder will follow in order to:

358.16 (1) provide medication ~~administration,~~ assistance or medication assistance, or
 358.17 ~~medication management~~ administration according to this chapter;

358.18 (2) monitor health conditions according to written instructions from ~~the person's~~
 358.19 ~~physician~~ or a licensed health professional;

358.20 (3) assist with or coordinate medical, dental, and other health service appointments; or

358.21 (4) use medical equipment, devices, or adaptive aides or technology safely and
 358.22 correctly according to written instructions from ~~the person's physician~~ or a licensed
 358.23 health professional.

358.24 **Subd. 1a. Medication setup.** For the purposes of this subdivision, "medication
 358.25 setup" means the arranging of medications according to instructions from the pharmacy,
 358.26 the prescriber, or a licensed nurse, for later administration when the license holder
 358.27 is assigned responsibility for medication assistance or medication administration in
 358.28 the coordinated service and support plan or the coordinated service and support plan
 358.29 addendum. A prescription label or the prescriber's written or electronically recorded order
 358.30 for the prescription is sufficient to constitute written instructions from the prescriber. The
 358.31 license holder must document in the person's medication administration record: dates
 358.32 of setup, name of medication, quantity of dose, times to be administered, and route of
 358.33 administration at time of setup; and, when the person will be away from home, to whom
 358.34 the medications were given.

358.35 **Subd. 1b. Medication assistance.** If responsibility for medication assistance
 358.36 is assigned to the license holder in the coordinated service and support plan or the

359.1 coordinated service and support plan addendum, the license holder must ensure that
 359.2 the requirements of subdivision 2, paragraph (b), have been met when staff provides
 359.3 medication assistance to enable a person to self-administer medication or treatment when
 359.4 the person is capable of directing the person's own care, or when the person's legal
 359.5 representative is present and able to direct care for the person. For the purposes of this
 359.6 subdivision, "medication assistance" means any of the following:

359.7 (1) bringing to the person and opening a container of previously set up medications,
 359.8 emptying the container into the person's hand, or opening and giving the medications in
 359.9 the original container to the person;

359.10 (2) bringing to the person liquids or food to accompany the medication; or

359.11 (3) providing reminders to take regularly scheduled medication or perform regularly
 359.12 scheduled treatments and exercises.

359.13 **Subd. 2. Medication administration.** (a) If responsibility for medication
 359.14 administration is assigned to the license holder in the coordinated service and support plan
 359.15 or the coordinated service and support plan addendum, the license holder must implement
 359.16 the following medication administration procedures to ensure a person takes medications
 359.17 and treatments as prescribed:

359.18 (1) checking the person's medication record;

359.19 (2) preparing the medication as necessary;

359.20 (3) administering the medication or treatment to the person;

359.21 (4) documenting the administration of the medication or treatment or the reason for
 359.22 not administering the medication or treatment; and

359.23 (5) reporting to the prescriber or a nurse any concerns about the medication or
 359.24 treatment, including side effects, effectiveness, or a pattern of the person refusing to
 359.25 take the medication or treatment as prescribed. Adverse reactions must be immediately
 359.26 reported to the prescriber or a nurse.

359.27 (b)(1) The license holder must ensure that the following criteria requirements in
 359.28 clauses (2) to (4) have been met before staff that is not a licensed health professional
 359.29 administers administering medication or treatment.

359.30 (+) (2) The license holder must obtain written authorization has been obtained from
 359.31 the person or the person's legal representative to administer medication or treatment
 359.32 orders; and must obtain reauthorization annually as needed. If the person or the person's
 359.33 legal representative refuses to authorize the license holder to administer medication, the
 359.34 medication must not be administered. The refusal to authorize medication administration
 359.35 must be reported to the prescriber as expeditiously as possible.

360.1 ~~(2)~~ (3) The staff person ~~has completed~~ responsible for administering the medication
360.2 or treatment must complete medication administration training according to section
360.3 245D.09, subdivision 4, ~~paragraph 4a, paragraphs (a) and (c), clause (2); and, as applicable~~
360.4 to the person, paragraph (d).

360.5 ~~(3) The medication or treatment will be administered under administration~~
360.6 ~~procedures established for the person in consultation with a licensed health professional.~~
360.7 ~~written instruction from the person's physician may constitute the medication~~
360.8 ~~administration procedures. A prescription label or the prescriber's order for the~~
360.9 ~~prescription is sufficient to constitute written instructions from the prescriber. A licensed~~
360.10 ~~health professional may delegate medication administration procedures.~~

360.11 (4) For a license holder providing intensive support services, the medication or
360.12 treatment must be administered according to the license holder's medication administration
360.13 policy and procedures as required under section 245D.11, subdivision 2, clause (3).

360.14 ~~(b)~~ (c) The license holder must ensure the following information is documented in
360.15 the person's medication administration record:

360.16 (1) the information on the current prescription label or the prescriber's current written
360.17 or electronically recorded order or prescription that includes ~~directions for the person's~~
360.18 name, description of the medication or treatment to be provided, and the frequency and
360.19 other information needed to safely and correctly administering administer the medication
360.20 or treatment to ensure effectiveness;

360.21 (2) information on any ~~discomforts~~, risks; or other side effects that are reasonable to
360.22 expect, and any contraindications to its use. This information must be readily available
360.23 to all staff administering the medication;

360.24 (3) the possible consequences if the medication or treatment is not taken or
360.25 administered as directed;

360.26 (4) instruction ~~from the prescriber~~ on when and to whom to report the following:

360.27 (i) if ~~the~~ a dose of medication or treatment is not administered or treatment is not
360.28 performed as prescribed, whether by error by the staff or the person or by refusal by
360.29 the person; and

360.30 (ii) the occurrence of possible adverse reactions to the medication or treatment;

360.31 (5) notation of any occurrence of a dose of medication not being administered or
360.32 treatment not performed as prescribed, whether by error by the staff or the person or by
360.33 refusal by the person, or of adverse reactions, and when and to whom the report was
360.34 made; and

360.35 (6) notation of when a medication or treatment is started, administered, changed, or
360.36 discontinued.

361.1 ~~(e) The license holder must ensure that the information maintained in the medication~~
361.2 ~~administration record is current and is regularly reviewed with the person or the person's~~
361.3 ~~legal representative and the staff administering the medication to identify medication~~
361.4 ~~administration issues or errors. At a minimum, the review must be conducted every three~~
361.5 ~~months or more often if requested by the person or the person's legal representative.~~
361.6 ~~Based on the review, the license holder must develop and implement a plan to correct~~
361.7 ~~medication administration issues or errors. If issues or concerns are identified related to~~
361.8 ~~the medication itself, the license holder must report those as required under subdivision 4.~~

361.9 ~~Subd. 3. **Medication assistance.** The license holder must ensure that the~~
361.10 ~~requirements of subdivision 2, paragraph (a), have been met when staff provides assistance~~
361.11 ~~to enable a person to self-administer medication when the person is capable of directing~~
361.12 ~~the person's own care, or when the person's legal representative is present and able to~~
361.13 ~~direct care for the person.~~

361.14 ~~Subd. 4. **Reviewing and reporting medication and treatment issues.** The~~
361.15 ~~following medication administration issues must be reported to the person or the person's~~
361.16 ~~legal representative and case manager as they occur or following timelines established~~
361.17 ~~in the person's service plan or as requested in writing by the person or the person's legal~~
361.18 ~~representative, or the case manager: (a) When assigned responsibility for medication~~
361.19 ~~administration, the license holder must ensure that the information maintained in~~
361.20 ~~the medication administration record is current and is regularly reviewed to identify~~
361.21 ~~medication administration errors. At a minimum, the review must be conducted every~~
361.22 ~~three months, or more frequently as directed in the coordinated service and support plan~~
361.23 ~~or coordinated service and support plan addendum or as requested by the person or the~~
361.24 ~~person's legal representative. Based on the review, the license holder must develop and~~
361.25 ~~implement a plan to correct patterns of medication administration errors when identified.~~

361.26 ~~(b) If assigned responsibility for medication assistance or medication administration,~~
361.27 ~~the license holder must report the following to the person's legal representative and case~~
361.28 ~~manager as they occur or as otherwise directed in the coordinated service and support plan~~
361.29 ~~or the coordinated service and support plan addendum:~~

361.30 ~~(1) any reports made to the person's physician or prescriber required under~~
361.31 ~~subdivision 2, paragraph ~~(b)~~ (c), clause (4);~~

361.32 ~~(2) a person's refusal or failure to take or receive medication or treatment as~~
361.33 ~~prescribed; or~~

361.34 ~~(3) concerns about a person's self-administration of medication or treatment.~~

362.1 Subd. 5. **Injectable medications.** Injectable medications may be administered
362.2 according to a prescriber's order and written instructions when one of the following
362.3 conditions has been met:

362.4 (1) a registered nurse or licensed practical nurse will administer the subcutaneous or
362.5 intramuscular injection;

362.6 (2) a supervising registered nurse with a physician's order has delegated the
362.7 administration of subcutaneous injectable medication to an unlicensed staff member
362.8 and has provided the necessary training; or

362.9 (3) there is an agreement signed by the license holder, the prescriber, and the
362.10 person or the person's legal representative specifying what subcutaneous injections may
362.11 be given, when, how, and that the prescriber must retain responsibility for the license
362.12 holder's giving the injections. A copy of the agreement must be placed in the person's
362.13 service recipient record.

362.14 Only licensed health professionals are allowed to administer psychotropic
362.15 medications by injection.

362.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

362.17 Sec. 26. **[245D.051] PSYCHOTROPIC MEDICATION USE AND**
362.18 **MONITORING.**

362.19 **Subdivision 1. Conditions for psychotropic medication administration.** (a)
362.20 When a person is prescribed a psychotropic medication and the license holder is assigned
362.21 responsibility for administration of the medication in the person's coordinated service
362.22 and support plan or the coordinated service and support plan addendum, the license
362.23 holder must ensure that the requirements in paragraphs (b) to (d) and section 245D.05,
362.24 subdivision 2, are met.

362.25 (b) Use of the medication must be included in the person's coordinated service and
362.26 support plan or in the coordinated service and support plan addendum and based on a
362.27 prescriber's current written or electronically recorded prescription.

362.28 (c) The license holder must develop, implement, and maintain the following
362.29 documentation in the person's coordinated service and support plan addendum according
362.30 to the requirements in sections 245D.07 and 245D.071:

362.31 (1) a description of the target symptoms that the psychotropic medication is to
362.32 alleviate; and

362.33 (2) documentation methods the license holder will use to monitor and measure
362.34 changes in the target symptoms that are to be alleviated by the psychotropic medication if
362.35 required by the prescriber. The license holder must collect and report on medication and

363.1 symptom-related data as instructed by the prescriber. The license holder must provide
363.2 the monitoring data to the expanded support team for review every three months, or as
363.3 otherwise requested by the person or the person's legal representative.

363.4 For the purposes of this section, "target symptom" refers to any perceptible
363.5 diagnostic criteria for a person's diagnosed mental disorder as defined by the Diagnostic
363.6 and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or
363.7 successive editions that has been identified for alleviation.

363.8 Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the
363.9 person's legal representative refuses to authorize the administration of a psychotropic
363.10 medication as ordered by the prescriber, the license holder must follow the requirement
363.11 in section 245D.05, subdivision 2, paragraph (b), clause (2). After reporting the refusal
363.12 to the prescriber, the license holder must follow any directives or orders given by the
363.13 prescriber. A court order must be obtained to override the refusal. Refusal to authorize
363.14 administration of a specific psychotropic medication is not grounds for service termination
363.15 and does not constitute an emergency. A decision to terminate services must be reached in
363.16 compliance with section 245D.10, subdivision 3.

363.17 **EFFECTIVE DATE.** This section is effective January 1, 2014.

363.18 Sec. 27. Minnesota Statutes 2012, section 245D.06, is amended to read:

363.19 **245D.06 PROTECTION STANDARDS.**

363.20 Subdivision 1. **Incident response and reporting.** (a) The license holder must
363.21 respond to all incidents under section 245D.02, subdivision 11, that occur while providing
363.22 services to protect the health and safety of and minimize risk of harm to the person.

363.23 (b) The license holder must maintain information about and report incidents to the
363.24 person's legal representative or designated emergency contact and case manager within 24
363.25 hours of an incident occurring while services are being provided, or within 24 hours of
363.26 discovery or receipt of information that an incident occurred, unless the license holder
363.27 has reason to know that the incident has already been reported, or as otherwise directed
363.28 in a person's coordinated service and support plan or coordinated service and support
363.29 plan addendum. An incident of suspected or alleged maltreatment must be reported as
363.30 required under paragraph (d), and an incident of serious injury or death must be reported
363.31 as required under paragraph (e).

363.32 (c) When the incident involves more than one person, the license holder must not
363.33 disclose personally identifiable information about any other person when making the report
363.34 to each person and case manager unless the license holder has the consent of the person.

364.1 (d) Within 24 hours of reporting maltreatment as required under section 626.556
364.2 or 626.557, the license holder must inform the case manager of the report unless there is
364.3 reason to believe that the case manager is involved in the suspected maltreatment. The
364.4 license holder must disclose the nature of the activity or occurrence reported and the
364.5 agency that received the report.

364.6 (e) The license holder must report the death or serious injury of the person to the legal
364.7 representative, if any, and case manager, as required in paragraph (b) and to the Department
364.8 of Human Services Licensing Division, and the Office of Ombudsman for Mental Health
364.9 and Developmental Disabilities as required under section 245.94, subdivision 2a, within
364.10 24 hours of the death, or receipt of information that the death occurred, unless the license
364.11 holder has reason to know that the death has already been reported.

364.12 (f) When a death or serious injury occurs in a facility certified as an intermediate
364.13 care facility for persons with developmental disabilities, the death or serious injury must
364.14 be reported to the Department of Health, Office of Health Facility Complaints, and the
364.15 Office of Ombudsman for Mental Health and Developmental Disabilities, as required
364.16 under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to
364.17 know that the death has already been reported.

364.18 (f) (g) The license holder must conduct an internal review of incident reports of
364.19 deaths and serious injuries that occurred while services were being provided and that
364.20 were not reported by the program as alleged or suspected maltreatment, for identification
364.21 of incident patterns, and implementation of corrective action as necessary to reduce
364.22 occurrences. The review must include an evaluation of whether related policies and
364.23 procedures were followed, whether the policies and procedures were adequate, whether
364.24 there is a need for additional staff training, whether the reported event is similar to past
364.25 events with the persons or the services involved, and whether there is a need for corrective
364.26 action by the license holder to protect the health and safety of persons receiving services.
364.27 Based on the results of this review, the license holder must develop, document, and
364.28 implement a corrective action plan designed to correct current lapses and prevent future
364.29 lapses in performance by staff or the license holder, if any.

364.30 (h) The license holder must verbally report the emergency use of manual restraint of
364.31 a person as required in paragraph (b), within 24 hours of the occurrence. The license holder
364.32 must ensure the written report and internal review of all incident reports of the emergency
364.33 use of manual restraints are completed according to the requirements in section 245D.061.

364.34 Subd. 2. **Environment and safety.** The license holder must:

364.35 (1) ensure the following when the license holder is the owner, lessor, or tenant
364.36 of the service site:

- 365.1 (i) the service site is a safe and hazard-free environment;
- 365.2 (ii) ~~doors are locked or~~ that toxic substances or dangerous items normally accessible
- 365.3 are inaccessible to persons served by the program ~~are stored in locked cabinets, drawers, or~~
- 365.4 ~~containers~~ only to protect the safety of a person receiving services and not as a substitute
- 365.5 for staff supervision or interactions with a person who is receiving services. ~~If doors are~~
- 365.6 ~~locked or~~ toxic substances or dangerous items normally accessible to persons served by the
- 365.7 ~~program are stored in locked cabinets, drawers, or containers~~ are made inaccessible, the
- 365.8 license holder must justify and document how this determination was made in consultation
- 365.9 ~~with the person or person's legal representative, and how access will otherwise be provided~~
- 365.10 ~~to the person and all other affected persons receiving services; and~~ document an assessment
- 365.11 of the physical plant, its environment, and its population identifying the risk factors which
- 365.12 require toxic substances or dangerous items to be inaccessible and a statement of specific
- 365.13 measures to be taken to minimize the safety risk to persons receiving services;
- 365.14 (iii) doors are locked from the inside to prevent a person from exiting only when
- 365.15 necessary to protect the safety of a person receiving services and not as a substitute for
- 365.16 staff supervision or interactions with the person. If doors are locked from the inside, the
- 365.17 license holder must document an assessment of the physical plant, the environment and
- 365.18 the population served, identifying the risk factors which require the use of locked doors,
- 365.19 and a statement of specific measures to be taken to minimize the safety risk to persons
- 365.20 receiving services at the service site; and
- 365.21 ~~(iii)~~ (iv) a staff person is available on at the service site who is trained in basic first
- 365.22 aid and, when required in a person's coordinated service and support plan or coordinated
- 365.23 service and support plan addendum, cardiopulmonary resuscitation, "CPR," whenever
- 365.24 persons are present and staff are required to be at the site to provide direct service. The
- 365.25 CPR training must include in-person instruction, hands-on practice, and an observed skills
- 365.26 assessment under the direct supervision of a CPR instructor;
- 365.27 (2) maintain equipment, vehicles, supplies, and materials owned or leased by the
- 365.28 license holder in good condition when used to provide services;
- 365.29 (3) follow procedures to ensure safe transportation, handling, and transfers of the
- 365.30 person and any equipment used by the person, when the license holder is responsible for
- 365.31 transportation of a person or a person's equipment;
- 365.32 (4) be prepared for emergencies and follow emergency response procedures to
- 365.33 ensure the person's safety in an emergency; and
- 365.34 (5) follow universal precautions and sanitary practices, including hand washing, for
- 365.35 infection prevention and control, and to prevent communicable diseases.

366.1 Subd. 3. ~~Compliance with fire and safety codes.~~ When services are provided at a
366.2 ~~service site licensed according to chapter 245A or where the license holder is the owner,~~
366.3 ~~lessor, or tenant of the service site, the license holder must document compliance with~~
366.4 ~~applicable building codes, fire and safety codes, health rules, and zoning ordinances, or~~
366.5 ~~document that an appropriate waiver has been granted.~~

366.6 Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person
366.7 with the safekeeping of funds or other property according to section 245A.04, subdivision
366.8 13, the license holder must have obtain written authorization to do so from the person or
366.9 the person's legal representative and the case manager. Authorization must be obtained
366.10 within five working days of service initiation and renewed annually thereafter. At the time
366.11 initial authorization is obtained, the license holder must survey, document, and implement
366.12 the preferences of the person or the person's legal representative and the case manager
366.13 for frequency of receiving a statement that itemizes receipts and disbursements of funds
366.14 or other property. The license holder must document changes to these preferences when
366.15 they are requested.

366.16 (b) A license holder or staff person may not accept powers-of-attorney from a
366.17 person receiving services from the license holder for any purpose, ~~and may not accept an~~
366.18 ~~appointment as guardian or conservator of a person receiving services from the license~~
366.19 ~~holder.~~ This does not apply to license holders that are Minnesota counties or other
366.20 units of government or to staff persons employed by license holders who were acting
366.21 as ~~power-of-attorney, guardian, or conservator~~ attorney-in-fact for specific individuals
366.22 prior to April 23, 2012 implementation of this chapter. The license holder must maintain
366.23 documentation of the power-of-attorney, ~~guardianship, or conservatorship~~ in the service
366.24 recipient record.

366.25 (c) Upon the transfer or death of a person, any funds or other property of the person
366.26 must be surrendered to the person or the person's legal representative, or given to the
366.27 executor or administrator of the estate in exchange for an itemized receipt.

366.28 Subd. 5. **Prohibitions Prohibited procedures.** (a) The license holder is prohibited
366.29 from using ~~psychotropic medication~~ chemical restraints, mechanical restraints, manual
366.30 restraints, time out, seclusion, or any other aversive or deprivation procedure, as a
366.31 substitute for adequate staffing, for a behavioral or therapeutic program to reduce or
366.32 eliminate behavior, as punishment, or for staff convenience, ~~or for any reason other than~~
366.33 ~~as prescribed.~~

366.34 (b) ~~The license holder is prohibited from using restraints or seclusion under any~~
366.35 ~~circumstance, unless the commissioner has approved a variance request from the license~~
366.36 ~~holder that allows for the emergency use of restraints and seclusion according to terms~~

367.1 ~~and conditions approved in the variance. Applicants and license holders who have~~
367.2 ~~reason to believe they may be serving an individual who will need emergency use of~~
367.3 ~~restraints or seclusion may request a variance on the application or reapplication, and~~
367.4 ~~the commissioner shall automatically review the request for a variance as part of the~~
367.5 ~~application or reapplication process. License holders may also request the variance any~~
367.6 ~~time after issuance of a license. In the event a license holder uses restraint or seclusion for~~
367.7 ~~any reason without first obtaining a variance as required, the license holder must report~~
367.8 ~~the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the~~
367.9 ~~occurrence and request the required variance.~~

367.10 Subd. 6. **Restricted procedures.** The following procedures are allowed when the
367.11 procedures are implemented in compliance with the standards governing their use as
367.12 identified in clauses (1) to (3). Allowed but restricted procedures include:

367.13 (1) permitted actions and procedures subject to the requirements in subdivision 7;

367.14 (2) procedures identified in a positive support transition plan subject to the
367.15 requirements in subdivision 8; or

367.16 (3) emergency use of manual restraint subject to the requirements in section
367.17 245D.061.

367.18 For purposes of this chapter, this section supersedes the requirements identified in
367.19 Minnesota Rules, part 9525.2740.

367.20 Subd. 7. **Permitted actions and procedures.** (a) Use of the instructional techniques
367.21 and intervention procedures as identified in paragraphs (b) and (c), is permitted when used
367.22 on an intermittent or continuous basis. When used on a continuous basis, it must be
367.23 addressed in a person's coordinated service and support plan addendum as identified in
367.24 sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this
367.25 subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

367.26 (b) Physical contact or instructional techniques must use the least restrictive
367.27 alternative possible to meet the needs of the person and may be used:

367.28 (1) to calm or comfort a person by holding that person with no resistance from
367.29 that person;

367.30 (2) to protect a person known to be at risk or injury due to frequent falls as a result
367.31 of a medical condition;

367.32 (3) to facilitate the person's completion of a task or response when the person does
367.33 not resist or the person's resistance is minimal in intensity and duration; or

367.34 (4) to briefly block or redirect a person's limbs or body without holding the person
367.35 or limiting the person's movement to interrupt the person's behavior that may result in
367.36 injury to self or others.

368.1 (c) Restraint may be used as an intervention procedure to:

368.2 (1) allow a licensed health care professional to safely conduct a medical examination
368.3 or to provide medical treatment ordered by a licensed health care professional to a person
368.4 necessary to promote healing or recovery from an acute, meaning short-term, medical
368.5 condition;

368.6 (2) assist in the safe evacuation or redirection of a person in the event of an
368.7 emergency and the person is at imminent risk of harm.

368.8 Any use of manual restraint as allowed in this paragraph must comply with the restrictions
368.9 identified in section 245D.061, subdivision 3; or

368.10 (3) to position a person with physical disabilities in a manner specified in the
368.11 person's coordinated service and support plan addendum.

368.12 (d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment
368.13 ordered by a licensed health professional to treat a diagnosed medical condition do not in
368.14 and of themselves constitute the use of mechanical restraint.

368.15 Subd. 8. **Positive support transition plan.** License holders must develop a positive
368.16 support transition plan on the forms and in the manner prescribed by the commissioner for
368.17 a person who requires intervention in order to maintain safety when it is known that the
368.18 person's behavior poses an immediate risk of physical harm to self or others. The positive
368.19 support transition plan forms and instructions will supersede the requirements in Minnesota
368.20 Rules, parts 9525.2750; 9525.2760; and 9525.2780. The positive support transition plan
368.21 must phase out any existing plans for the emergency or programmatic use of aversive or
368.22 deprivation procedures prohibited under this chapter within the following timelines:

368.23 (1) for persons receiving services from the license holder before January 1, 2014,
368.24 the plan must be developed and implemented by February 1, 2014, and phased out no
368.25 later than December 31, 2014; and

368.26 (2) for persons admitted to the program on or after January 1, 2014, the plan must be
368.27 developed and implemented within 30 calendar days of service initiation and phased out
368.28 no later than 11 months from the date of plan implementation.

368.29 **EFFECTIVE DATE.** This section is effective January 1, 2014.

368.30 **Sec. 28. [245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

368.31 Subdivision 1. **Standards for emergency use of manual restraints.** The license
368.32 holder must ensure that emergency use of manual restraints complies with the requirements
368.33 of this chapter and the license holder's policy and procedures as required under subdivision

369.1 10. For the purposes of persons receiving services governed by this chapter, this section
369.2 supersedes the requirements identified in Minnesota Rules, part 9525.2770.

369.3 Subd. 2. **Conditions for emergency use of manual restraint.** Emergency use of
369.4 manual restraint must meet the following conditions:

369.5 (1) immediate intervention must be needed to protect the person or others from
369.6 imminent risk of physical harm; and

369.7 (2) the type of manual restraint used must be the least restrictive intervention to
369.8 eliminate the immediate risk of harm and effectively achieve safety. The manual restraint
369.9 must end when the threat of harm ends.

369.10 Subd. 3. **Restrictions when implementing emergency use of manual restraint.**

369.11 (a) Emergency use of manual restraint procedures must not:

369.12 (1) be implemented with a child in a manner that constitutes sexual abuse, neglect,
369.13 physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

369.14 (2) be implemented with an adult in a manner that constitutes abuse or neglect as
369.15 defined in section 626.5572, subdivisions 2 and 17;

369.16 (3) be implemented in a manner that violates a person's rights and protections
369.17 identified in section 245D.04;

369.18 (4) restrict a person's normal access to a nutritious diet, drinking water, adequate
369.19 ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping
369.20 conditions, or necessary clothing, or to any protection required by state licensing standards
369.21 and federal regulations governing the program;

369.22 (5) deny the person visitation or ordinary contact with legal counsel, a legal
369.23 representative, or next of kin;

369.24 (6) be used as a substitute for adequate staffing, for the convenience of staff, as
369.25 punishment, or as a consequence if the person refuses to participate in the treatment
369.26 or services provided by the program; or

369.27 (7) use prone restraint. For the purposes of this section, "prone restraint" means use
369.28 of manual restraint that places a person in a face-down position. This does not include
369.29 brief physical holding of a person who, during an emergency use of manual restraint, rolls
369.30 into a prone position, and the person is restored to a standing, sitting, or side-lying position
369.31 as quickly as possible. Applying back or chest pressure while a person is in the prone or
369.32 supine position or face-up is prohibited.

369.33 Subd. 4. **Monitoring emergency use of manual restraint.** The license holder shall
369.34 monitor a person's health and safety during an emergency use of a manual restraint. Staff
369.35 monitoring the procedure must not be the staff implementing the procedure when possible.

370.1 The license holder shall complete a monitoring form, approved by the commissioner, for
370.2 each incident involving the emergency use of a manual restraint.

370.3 Subd. 5. **Reporting emergency use of manual restraint incident.** (a) Within
370.4 three calendar days after an emergency use of a manual restraint, the staff person who
370.5 implemented the emergency use must report in writing to the designated coordinator the
370.6 following information about the emergency use:

370.7 (1) the staff and persons receiving services who were involved in the incident
370.8 leading up to the emergency use of manual restraint;

370.9 (2) a description of the physical and social environment, including who was present
370.10 before and during the incident leading up to the emergency use of manual restraint;

370.11 (3) a description of what less restrictive alternative measures were attempted to
370.12 de-escalate the incident and maintain safety before the manual restraint was implemented
370.13 that identifies when, how, and how long the alternative measures were attempted before
370.14 manual restraint was implemented;

370.15 (4) a description of the mental, physical, and emotional condition of the person who
370.16 was restrained, and other persons involved in the incident leading up to, during, and
370.17 following the manual restraint;

370.18 (5) whether there was any injury to the person who was restrained or other persons
370.19 involved in the incident, including staff, before or as a result of the use of manual restraint;

370.20 (6) whether there was a debriefing with the staff, and, if not contraindicated, with
370.21 the person who was restrained and other persons who were involved in or who witnessed
370.22 the restraint, following the incident and the outcome of the debriefing. If the debriefing
370.23 was not conducted at the time the incident report was made, the report should identify
370.24 whether a debriefing is planned; and

370.25 (7) a copy of the report must be maintained in the person's service recipient record.

370.26 (b) Each single incident of emergency use of manual restraint must be reported
370.27 separately. For the purposes of this subdivision, an incident of emergency use of manual
370.28 restraint is a single incident when the following conditions have been met:

370.29 (1) after implementing the manual restraint, staff attempt to release the person at the
370.30 moment staff believe the person's conduct no longer poses an imminent risk of physical
370.31 harm to self or others and less restrictive strategies can be implemented to maintain safety;

370.32 (2) upon the attempt to release the restraint, the person's behavior immediately
370.33 re-escalates; and

370.34 (3) staff must immediately reimplement the restraint in order to maintain safety.

370.35 Subd. 6. **Internal review of emergency use of manual restraint.** (a) Within five
370.36 working days of the emergency use of manual restraint, the license holder must complete

371.1 and document an internal review of each report of emergency use of manual restraint. The
371.2 review must include an evaluation of whether:

371.3 (1) the person's service and support strategies developed according to sections
371.4 245D.07 and 245D.071 need to be revised;

371.5 (2) related policies and procedures were followed;

371.6 (3) the policies and procedures were adequate;

371.7 (4) there is a need for additional staff training;

371.8 (5) the reported event is similar to past events with the persons, staff, or the services
371.9 involved; and

371.10 (6) there is a need for corrective action by the license holder to protect the health
371.11 and safety of persons.

371.12 (b) Based on the results of the internal review, the license holder must develop,
371.13 document, and implement a corrective action plan for the program designed to correct
371.14 current lapses and prevent future lapses in performance by individuals or the license
371.15 holder, if any. The corrective action plan, if any, must be implemented within 30 days of
371.16 the internal review being completed.

371.17 (c) The license holder must maintain a copy of the internal review and the corrective
371.18 action plan, if any, in the person's service recipient record.

371.19 Subd. 7. **Expanded support team review.** (a) Within five working days after the
371.20 completion of the internal review required in subdivision 8, the license holder must consult
371.21 with the expanded support team following the emergency use of manual restraint to:

371.22 (1) discuss the incident reported in subdivision 7, to define the antecedent or event
371.23 that gave rise to the behavior resulting in the manual restraint and identify the perceived
371.24 function the behavior served; and

371.25 (2) determine whether the person's coordinated service and support plan addendum
371.26 needs to be revised according to sections 245D.07 and 245D.071 to positively and
371.27 effectively help the person maintain stability and to reduce or eliminate future occurrences
371.28 requiring emergency use of manual restraint.

371.29 (b) The license holder must maintain a written summary of the expanded support
371.30 team's discussion and decisions required in paragraph (a) in the person's service recipient
371.31 record.

371.32 Subd. 8. **External review and reporting.** Within five working days of the expanded
371.33 support team review, the license holder must submit the following to the Department of
371.34 Human Services, and the Office of the Ombudsman for Mental Health and Developmental
371.35 Disabilities, as required under section 245.94, subdivision 2a:

371.36 (1) the report required under subdivision 7;

372.1 (2) the internal review and the corrective action plan required under subdivision 8; and
372.2 (3) the summary of the expanded support team review required under subdivision 9.

372.3 Subd. 9. **Emergency use of manual restraints policy and procedures.** The license
372.4 holder must develop, document, and implement a policy and procedures that promote
372.5 service recipient rights and protect health and safety during the emergency use of manual
372.6 restraints. The policy and procedures must comply with the requirements of this section
372.7 and must specify the following:

372.8 (1) a description of the positive support strategies and techniques staff must use to
372.9 attempt to de-escalate a person's behavior before it poses an imminent risk of physical
372.10 harm to self or others;

372.11 (2) a description of the types of manual restraints the license holder allows staff to
372.12 use on an emergency basis, if any. If the license holder will not allow the emergency use
372.13 of manual restraint, the policy and procedure must identify the alternative measures the
372.14 license holder will require staff to use when a person's conduct poses an imminent risk of
372.15 physical harm to self or others and less restrictive strategies would not achieve safety;

372.16 (3) instructions for safe and correct implementation of the allowed manual restraint
372.17 procedures;

372.18 (4) the training that staff must complete and the timelines for completion, before they
372.19 may implement an emergency use of manual restraint. In addition to the training on this
372.20 policy and procedure and the orientation and annual training required in section 245D.09,
372.21 subdivision 4, the training for emergency use of manual restraint must incorporate the
372.22 following subjects:

372.23 (i) alternatives to manual restraint procedures, including techniques to identify
372.24 events and environmental factors that may escalate conduct that poses an imminent risk of
372.25 physical harm to self or others;

372.26 (ii) de-escalation methods, positive support strategies, and how to avoid power
372.27 struggles;

372.28 (iii) simulated experiences of administering and receiving manual restraint
372.29 procedures allowed by the license holder on an emergency basis;

372.30 (iv) how to properly identify thresholds for implementing and ceasing restrictive
372.31 procedures;

372.32 (v) how to recognize, monitor, and respond to the person's physical signs of distress,
372.33 including positional asphyxia;

372.34 (vi) the physiological and psychological impact on the person and the staff when
372.35 restrictive procedures are used;

372.36 (vii) the communicative intent of behaviors; and

- 373.1 (viii) relationship building;
 373.2 (5) the procedures and forms to be used to monitor the emergency use of manual
 373.3 restraints, including what must be monitored and the frequency of monitoring per
 373.4 each incident of emergency use of manual restraint, and the person or position who is
 373.5 responsible for monitoring the use;
 373.6 (6) the instructions, forms, and timelines required for completing and submitting an
 373.7 incident report by the person or persons who implemented the manual restraint; and
 373.8 (7) the procedures and timelines for conducting the internal review and the expanded
 373.9 support team review, and the person or position responsible for completing the reviews
 373.10 and for ensuring that corrective action is taken or the person's coordinated service and
 373.11 support plan addendum is revised, when determined necessary.

373.12 **EFFECTIVE DATE.** This section is effective January 1, 2014.

373.13 Sec. 29. Minnesota Statutes 2012, section 245D.07, is amended to read:

373.14 **245D.07 SERVICE NEEDS PLANNING AND DELIVERY.**

373.15 Subdivision 1. **Provision of services.** The license holder must provide services as
 373.16 ~~specified assigned~~ in the coordinated service and support plan ~~and assigned to the license~~
 373.17 ~~holder.~~ The provision of services must comply with the requirements of this chapter and
 373.18 the federal waiver plans.

373.19 **Subd. 1a. Person-centered planning and service delivery.** (a) The license holder
 373.20 must provide services in response to the person's identified needs, interests, preferences,
 373.21 and desired outcomes as specified in the coordinated service and support plan and the
 373.22 coordinated service and support plan addendum, and in compliance with the requirements
 373.23 of this chapter. License holders providing intensive support services must also provide
 373.24 outcome-based services according to the requirements in section 245D.071.

373.25 (b) Services must be provided in a manner that supports the person's preferences,
 373.26 daily needs, and activities and accomplishment of the person's personal goals and service
 373.27 outcomes, consistent with the principles of:

373.28 (1) person-centered service planning and delivery that:

373.29 (i) identifies and supports what is important to the person as well as what is
 373.30 important for the person, including preferences for when, how, and by whom direct
 373.31 support service is provided;

373.32 (ii) uses that information to identify outcomes the person desires; and

373.33 (iii) respects each person's history, dignity, and cultural background;

373.34 (2) self-determination that supports and provides:

374.1 (i) opportunities for the development and exercise of functional and age-appropriate
 374.2 skills, decision making and choice, personal advocacy, and communication; and

374.3 (ii) the affirmation and protection of each person's civil and legal rights; and

374.4 (3) providing the most integrated setting and inclusive service delivery that supports,
 374.5 promotes, and allows:

374.6 (i) inclusion and participation in the person's community as desired by the person
 374.7 in a manner that enables the person to interact with nondisabled persons to the fullest
 374.8 extent possible and supports the person in developing and maintaining a role as a valued
 374.9 community member;

374.10 (ii) opportunities for self-sufficiency as well as developing and maintaining social
 374.11 relationships and natural supports; and

374.12 (iii) a balance between risk and opportunity, meaning the least restrictive supports or
 374.13 interventions necessary are provided in the most integrated settings in the most inclusive
 374.14 manner possible to support the person to engage in activities of the person's own choosing
 374.15 that may otherwise present a risk to the person's health, safety, or rights.

374.16 **Subd. 2. Service planning requirements for basic support services.** (a) License
 374.17 holders providing basic support services must meet the requirements of this subdivision.

374.18 (b) Within 15 days of service initiation the license holder must complete a
 374.19 preliminary coordinated service and support plan addendum based on the coordinated
 374.20 service and support plan.

374.21 (c) Within 60 days of service initiation the license holder must review and revise as
 374.22 needed the preliminary coordinated service and support plan addendum to document the
 374.23 services that will be provided including how, when, and by whom services will be provided,
 374.24 and the person responsible for overseeing the delivery and coordination of services.

374.25 (d) The license holder must participate in service planning and support team
 374.26 meetings related to for the person following stated timelines established in the person's
 374.27 coordinated service and support plan or as requested by the support team, the person, or
 374.28 the person's legal representative, the support team or the expanded support team.

374.29 **Subd. 3. Reports.** The license holder must provide written reports regarding the
 374.30 person's progress or status as requested by the person, the person's legal representative, the
 374.31 case manager, or the team.

374.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

374.33 **Sec. 30. [245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE**
 374.34 **SUPPORT SERVICES.**

375.1 Subdivision 1. **Requirements for intensive support services.** A license holder
375.2 providing intensive support services identified in section 245D.03, subdivision 1,
375.3 paragraph (c), must comply with the requirements in section 245D.07, subdivisions 1
375.4 and 3, and this section.

375.5 Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder
375.6 must develop, document, and implement an abuse prevention plan according to section
375.7 245A.65, subdivision 2.

375.8 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service
375.9 initiation the license holder must complete a preliminary coordinated service and support
375.10 plan addendum based on the coordinated service and support plan.

375.11 (b) Within 45 days of service initiation the license holder must meet with the person,
375.12 the person's legal representative, the case manager, and other members of the support team
375.13 or expanded support team to assess and determine the following based on the person's
375.14 coordinated service and support plan and the requirements in subdivision 4 and section
375.15 245D.07, subdivision 1a:

375.16 (1) the scope of the services to be provided to support the person's daily needs
375.17 and activities;

375.18 (2) the person's desired outcomes and the supports necessary to accomplish the
375.19 person's desired outcomes;

375.20 (3) the person's preferences for how services and supports are provided;

375.21 (4) whether the current service setting is the most integrated setting available and
375.22 appropriate for the person; and

375.23 (5) how services must be coordinated across other providers licensed under this
375.24 chapter serving the same person to ensure continuity of care for the person.

375.25 (c) Within the scope of services, the license holder must, at a minimum, assess
375.26 the following areas:

375.27 (1) the person's ability to self-manage health and medical needs to maintain or
375.28 improve physical, mental, and emotional well-being, including, when applicable, allergies,
375.29 seizures, choking, special dietary needs, chronic medical conditions, self-administration
375.30 of medication or treatment orders, preventative screening, and medical and dental
375.31 appointments;

375.32 (2) the person's ability to self-manage personal safety to avoid injury or accident in
375.33 the service setting, including, when applicable, risk of falling, mobility, regulating water
375.34 temperature, community survival skills, water safety skills, and sensory disabilities; and

375.35 (3) the person's ability to self-manage symptoms or behavior that may otherwise
375.36 result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to

376.1 (7), suspension or termination of services by the license holder, or other symptoms
376.2 or behaviors that may jeopardize the health and safety of the person or others. The
376.3 assessments must produce information about the person that is descriptive of the person's
376.4 overall strengths, functional skills and abilities, and behaviors or symptoms.

376.5 Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the
376.6 45-day meeting, the license holder must develop and document the service outcomes and
376.7 supports based on the assessments completed under subdivision 3 and the requirements
376.8 in section 245D.07, subdivision 1a. The outcomes and supports must be included in the
376.9 coordinated service and support plan addendum.

376.10 (b) The license holder must document the supports and methods to be implemented
376.11 to support the accomplishment of outcomes related to acquiring, retaining, or improving
376.12 skills. The documentation must include:

376.13 (1) the methods or actions that will be used to support the person and to accomplish
376.14 the service outcomes, including information about:

376.15 (i) any changes or modifications to the physical and social environments necessary
376.16 when the service supports are provided;

376.17 (ii) any equipment and materials required; and

376.18 (iii) techniques that are consistent with the person's communication mode and
376.19 learning style;

376.20 (2) the measurable and observable criteria for identifying when the desired outcome
376.21 has been achieved and how data will be collected;

376.22 (3) the projected starting date for implementing the supports and methods and
376.23 the date by which progress towards accomplishing the outcomes will be reviewed and
376.24 evaluated; and

376.25 (4) the names of the staff or position responsible for implementing the supports
376.26 and methods.

376.27 (c) Within 20 working days of the 45-day meeting, the license holder must obtain
376.28 dated signatures from the person or the person's legal representative and case manager
376.29 to document completion and approval of the assessment and coordinated service and
376.30 support plan addendum.

376.31 Subd. 5. **Progress reviews.** (a) The license holder must give the person or the
376.32 person's legal representative and case manager an opportunity to participate in the ongoing
376.33 review and development of the methods used to support the person and accomplish
376.34 outcomes identified in subdivisions 3 and 4. The license holder, in coordination with
376.35 the person's support team or expanded support team, must meet with the person, the
376.36 person's legal representative, and the case manager, and participate in progress review

377.1 meetings following stated timelines established in the person's coordinated service and
377.2 support plan or coordinated service and support plan addendum or within 30 days of a
377.3 written request by the person, the person's legal representative, or the case manager,
377.4 at a minimum of once per year.

377.5 (b) The license holder must summarize the person's progress toward achieving the
377.6 identified outcomes and make recommendations and identify the rationale for changing,
377.7 continuing, or discontinuing implementation of supports and methods identified in
377.8 subdivision 4 in a written report sent to the person or the person's legal representative
377.9 and case manager five working days prior to the review meeting, unless the person, the
377.10 person's legal representative, or the case manager requests to receive the report at the
377.11 time of the meeting.

377.12 (c) Within ten working days of the progress review meeting, the license holder
377.13 must obtain dated signatures from the person or the person's legal representative and
377.14 the case manager to document approval of any changes to the coordinated service and
377.15 support plan addendum.

377.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

377.17 Sec. 31. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND**
377.18 **OVERSIGHT.**

377.19 **Subdivision 1. Program coordination and evaluation.** (a) The license holder
377.20 is responsible for:

377.21 (1) coordination of service delivery and evaluation for each person served by the
377.22 program as identified in subdivision 2; and

377.23 (2) program management and oversight that includes evaluation of the program
377.24 quality and program improvement for services provided by the license holder as identified
377.25 in subdivision 3.

377.26 (b) The same person may perform the functions in paragraph (a) if the work and
377.27 education qualifications are met in subdivisions 2 and 3.

377.28 **Subd. 2. Coordination and evaluation of individual service delivery.** (a) Delivery
377.29 and evaluation of services provided by the license holder must be coordinated by a
377.30 designated staff person. The designated coordinator must provide supervision, support,
377.31 and evaluation of activities that include:

377.32 (1) oversight of the license holder's responsibilities assigned in the person's
377.33 coordinated service and support plan and the coordinated service and support plan
377.34 addendum;

378.1 (2) taking the action necessary to facilitate the accomplishment of the outcomes
378.2 according to the requirements in section 245D.07;

378.3 (3) instruction and assistance to direct support staff implementing the coordinated
378.4 service and support plan and the service outcomes, including direct observation of service
378.5 delivery sufficient to assess staff competency; and

378.6 (4) evaluation of the effectiveness of service delivery, methodologies, and progress on
378.7 the person's outcomes based on the measurable and observable criteria for identifying when
378.8 the desired outcome has been achieved according to the requirements in section 245D.07.

378.9 (b) The license holder must ensure that the designated coordinator is competent to
378.10 perform the required duties identified in paragraph (a) through education and training in
378.11 human services and disability-related fields, and work experience in providing direct care
378.12 services and supports to persons with disabilities. The designated coordinator must have
378.13 the skills and ability necessary to develop effective plans and to design and use data
378.14 systems to measure effectiveness of services and supports. The license holder must verify
378.15 and document competence according to the requirements in section 245D.09, subdivision

378.16 3. The designated coordinator must minimally have:

378.17 (1) a baccalaureate degree in a field related to human services, and one year of
378.18 full-time work experience providing direct care services to persons with disabilities or
378.19 persons age 65 and older;

378.20 (2) an associate degree in a field related to human services, and two years of
378.21 full-time work experience providing direct care services to persons with disabilities or
378.22 persons age 65 and older;

378.23 (3) a diploma in a field related to human services from an accredited postsecondary
378.24 institution and three years of full-time work experience providing direct care services to
378.25 persons with disabilities or persons age 65 and older; or

378.26 (4) a minimum of 50 hours of education and training related to human services
378.27 and disabilities; and

378.28 (5) four years of full-time work experience providing direct care services to persons
378.29 with disabilities or persons age 65 and older under the supervision of a staff person who
378.30 meets the qualifications identified in clauses (1) to (3).

378.31 Subd. 3. **Program management and oversight.** (a) The license holder must
378.32 designate a managerial staff person or persons to provide program management and
378.33 oversight of the services provided by the license holder. The designated manager is
378.34 responsible for the following:

378.35 (1) maintaining a current understanding of the licensing requirements sufficient to
378.36 ensure compliance throughout the program as identified in section 245A.04, subdivision

379.1 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21,
 379.2 paragraph (b);

379.3 (2) ensuring the duties of the designated coordinator are fulfilled according to the
 379.4 requirements in subdivision 2;

379.5 (3) ensuring the program implements corrective action identified as necessary
 379.6 by the program following review of incident and emergency reports according to the
 379.7 requirements in section 245D.11, subdivision 2, clause (7). An internal review of
 379.8 incident reports of alleged or suspected maltreatment must be conducted according to the
 379.9 requirements in section 245A.65, subdivision 1, paragraph (b);

379.10 (4) evaluation of satisfaction of persons served by the program, the person's legal
 379.11 representative, if any, and the case manager, with the service delivery and progress
 379.12 towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and
 379.13 ensuring and protecting each person's rights as identified in section 245D.04;

379.14 (5) ensuring staff competency requirements are met according to the requirements in
 379.15 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
 379.16 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

379.17 (6) ensuring corrective action is taken when ordered by the commissioner and that
 379.18 the terms and condition of the license and any variances are met; and

379.19 (7) evaluating the information identified in clauses (1) to (6) to develop, document,
 379.20 and implement ongoing program improvements.

379.21 (b) The designated manager must be competent to perform the duties as required and
 379.22 must minimally meet the education and training requirements identified in subdivision
 379.23 2, paragraph (b), and have a minimum of three years of supervisory level experience in
 379.24 a program providing direct support services to persons with disabilities or persons age
 379.25 65 and older.

379.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

379.27 Sec. 32. Minnesota Statutes 2012, section 245D.09, is amended to read:

379.28 **245D.09 STAFFING STANDARDS.**

379.29 Subdivision 1. **Staffing requirements.** The license holder must provide the level of
 379.30 direct service support staff sufficient supervision, assistance, and training necessary:

379.31 (1) to ensure the health, safety, and protection of rights of each person; and

379.32 (2) to be able to implement the responsibilities assigned to the license holder in each
 379.33 person's coordinated service and support plan or identified in the coordinated service and
 379.34 support plan addendum, according to the requirements of this chapter.

380.1 Subd. 2. **Supervision of staff having direct contact.** Except for a license holder
380.2 who is the sole direct ~~service~~ support staff, the license holder must provide adequate
380.3 supervision of staff providing direct ~~service~~ support to ensure the health, safety, and
380.4 protection of rights of each person and implementation of the responsibilities assigned to
380.5 the license holder in each person's ~~service plan~~ coordinated service and support plan or
380.6 coordinated service and support plan addendum.

380.7 Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff is
380.8 providing direct support, or staff who have responsibilities related to supervising or
380.9 managing the provision of direct support service, are competent as demonstrated through
380.10 skills and knowledge training, experience, and education to meet the person's needs
380.11 and additional requirements as written in the coordinated service and support plan or
380.12 coordinated service and support plan addendum, or when otherwise required by the case
380.13 manager or the federal waiver plan. The license holder must verify and maintain evidence
380.14 of staff competency, including documentation of:

380.15 (1) education and experience qualifications relevant to the job responsibilities
380.16 assigned to the staff and the needs of the general population of persons served by the
380.17 program, including a valid degree and transcript, or a current license, registration, or
380.18 certification, when a degree or licensure, registration, or certification is required by this
380.19 chapter or in the coordinated service and support plan or coordinated service and support
380.20 plan addendum;

380.21 (2) ~~completion of required~~ demonstrated competency in the orientation and training
380.22 areas required under this chapter, including and when applicable, completion of continuing
380.23 education required to maintain professional licensure, registration, or certification
380.24 requirements. Competency in these areas is determined by the license holder through
380.25 knowledge testing and observed skill assessment conducted by the trainer or instructor; and

380.26 (3) except for a license holder who is the sole direct ~~service~~ support staff, periodic
380.27 performance evaluations completed by the license holder of the direct ~~service~~ support staff
380.28 person's ability to perform the job functions based on direct observation.

380.29 (b) Staff under 18 years of age may not perform overnight duties or administer
380.30 medication.

380.31 Subd. 4. **Orientation to program requirements.** (a) Except for a license holder
380.32 who does not supervise any direct ~~service~~ support staff, within ~~90 days of hiring direct~~
380.33 ~~service staff~~ 60 days of hire, unless stated otherwise, the license holder must provide
380.34 and ensure completion of 30 hours of orientation for direct support staff that combines
380.35 supervised on-the-job training with review of and instruction ~~on~~ in the following areas:

380.36 (1) the job description and how to complete specific job functions, including:

381.1 (i) responding to and reporting incidents as required under section 245D.06,
381.2 subdivision 1; and

381.3 (ii) following safety practices established by the license holder and as required in
381.4 section 245D.06, subdivision 2;

381.5 (2) the license holder's current policies and procedures required under this chapter,
381.6 including their location and access, and staff responsibilities related to implementation
381.7 of those policies and procedures;

381.8 (3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the
381.9 federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff
381.10 responsibilities related to complying with data privacy practices;

381.11 (4) the service recipient rights ~~under section 245D.04~~, and staff responsibilities
381.12 related to ensuring the exercise and protection of those rights according to the requirements
381.13 in section 245D.04;

381.14 (5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment
381.15 reporting and service planning for children and vulnerable adults, and staff responsibilities
381.16 related to protecting persons from maltreatment and reporting maltreatment. This
381.17 orientation must be provided within 72 hours of first providing direct contact services and
381.18 annually thereafter according to section 245A.65, subdivision 3;

381.19 (6) ~~what constitutes use of restraints, seclusion, and psychotropic medications,~~
381.20 ~~and staff responsibilities related to the prohibitions of their use~~ the principles of
381.21 person-centered service planning and delivery as identified in section 245D.07, subdivision
381.22 1a, and how they apply to direct support service provided by the staff person; and

381.23 (7) other topics as determined necessary in the person's coordinated service and
381.24 support plan by the case manager or other areas identified by the license holder.

381.25 (b) ~~License holders who provide direct service themselves must complete the~~
381.26 ~~orientation required in paragraph (a), clauses (3) to (7).~~

381.27 Subd. 4a. Orientation to individual service recipient needs. (e) (a) Before
381.28 providing having unsupervised direct service to contact with a person served by the
381.29 program, or for whom the staff person has not previously provided direct service support,
381.30 or any time the plans or procedures identified in ~~clauses (1) and (2)~~ paragraphs (b) to
381.31 (f) are revised, the staff person must review and receive instruction on the following
381.32 as it relates requirements in paragraphs (b) to (f) as they relate to the staff person's job
381.33 functions for that person.

381.34 (b) Training and competency evaluations must include the following:

382.1 (1) appropriate and safe techniques in personal hygiene and grooming, including
 382.2 hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of
 382.3 daily living (ADLs) as defined under section 256B.0659, subdivision 1;

382.4 (2) an understanding of what constitutes a healthy diet according to data from the
 382.5 Centers for Disease Control and Prevention and the skills necessary to prepare that diet;

382.6 (3) skills necessary to provide appropriate support in instrumental activities of daily
 382.7 living (IADLs) as defined under section 256B.0659, subdivision 1; and

382.8 (4) demonstrated competence in providing first aid.

382.9 ~~(1) (c) The staff person must review and receive instruction on the person's~~
 382.10 ~~coordinated service and support plan or coordinated service and support plan addendum as~~
 382.11 ~~it relates to the responsibilities assigned to the license holder, and when applicable, the~~
 382.12 ~~person's individual abuse prevention plan according to section 245A.65, to achieve and~~
 382.13 ~~demonstrate an understanding of the person as a unique individual, and how to implement~~
 382.14 ~~those plans; and.~~

382.15 ~~(2) (d) The staff person must review and receive instruction on medication~~
 382.16 ~~administration procedures established for the person when medication administration is~~
 382.17 ~~assigned to the license holder according to section 245D.05, subdivision 1, paragraph~~
 382.18 ~~(b). Unlicensed staff may administer medications only after successful completion of a~~
 382.19 ~~medication administration training, from a training curriculum developed by a registered~~
 382.20 ~~nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse~~
 382.21 ~~practitioner, physician's assistant, or physician incorporating. The training curriculum~~
 382.22 ~~must incorporate an observed skill assessment conducted by the trainer to ensure staff~~
 382.23 ~~demonstrate the ability to safely and correctly follow medication procedures.~~

382.24 Medication administration must be taught by a registered nurse, clinical nurse
 382.25 specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of
 382.26 service initiation or any time thereafter, the person has or develops a health care condition
 382.27 that affects the service options available to the person because the condition requires:

382.28 ~~(i) (1) specialized or intensive medical or nursing supervision; and~~

382.29 ~~(ii) (2) nonmedical service providers to adapt their services to accommodate the~~
 382.30 ~~health and safety needs of the person; and.~~

382.31 ~~(iii) necessary training in order to meet the health service needs of the person as~~
 382.32 ~~determined by the person's physician.~~

382.33 (e) The staff person must review and receive instruction on the safe and correct
 382.34 operation of medical equipment used by the person to sustain life, including but not
 382.35 limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided
 382.36 by a licensed health care professional or a manufacturer's representative and incorporate

383.1 an observed skill assessment to ensure staff demonstrate the ability to safely and correctly
383.2 operate the equipment according to the treatment orders and the manufacturer's instructions.

383.3 (f) The staff person must review and receive instruction on what constitutes use of
383.4 restraints, time out, and seclusion, including chemical restraint, and staff responsibilities
383.5 related to the prohibitions of their use according to the requirements in section 245D.06,
383.6 subdivision 5, why such procedures are not effective for reducing or eliminating symptoms
383.7 or undesired behavior and why they are not safe, and the safe and correct use of manual
383.8 restraint on an emergency basis according to the requirements in section 245D.061.

383.9 (g) In the event of an emergency service initiation, the license holder must ensure
383.10 the training required in this subdivision occurs within 72 hours of the direct support staff
383.11 person first having unsupervised contact with the person receiving services. The license
383.12 holder must document the reason for the unplanned or emergency service initiation and
383.13 maintain the documentation in the person's service recipient record.

383.14 (h) License holders who provide direct support services themselves must complete
383.15 the orientation required in subdivision 4, clauses (3) to (7).

383.16 Subd. 5. **Annual training.** ~~(a)~~ A license holder must provide annual training
383.17 to direct service support staff on the topics identified in subdivision 4, ~~paragraph (a),~~
383.18 clauses (3) to (6) (7), and subdivision 4a. A license holder must provide a minimum of 24
383.19 hours of annual training to direct service staff with fewer than five years of documented
383.20 experience and 12 hours of annual training to direct service staff with five or more years
383.21 of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a)
383.22 to (h). Training on relevant topics received from sources other than the license holder
383.23 may count toward training requirements.

383.24 ~~(b) A license holder providing behavioral programming, specialist services, personal~~
383.25 ~~support, 24-hour emergency assistance, night supervision, independent living skills,~~
383.26 ~~structured day, prevocational, or supported employment services must provide a minimum~~
383.27 ~~of eight hours of annual training to direct service staff that addresses:~~

383.28 ~~(1) topics related to the general health, safety, and service needs of the population~~
383.29 ~~served by the license holder; and~~

383.30 ~~(2) other areas identified by the license holder or in the person's current service plan.~~

383.31 ~~Training on relevant topics received from sources other than the license holder~~
383.32 ~~may count toward training requirements.~~

383.33 ~~(c) When the license holder is the owner, lessor, or tenant of the service site and~~
383.34 ~~whenever a person receiving services is present at the site, the license holder must have~~
383.35 ~~a staff person available on site who is trained in basic first aid and, when required in a~~
383.36 ~~person's service plan, cardiopulmonary resuscitation.~~

384.1 Subd. 5a. **Alternative sources of training.** Orientation or training received by the
384.2 staff person from sources other than the license holder in the same subjects as identified
384.3 in subdivision 4 may count toward the orientation and annual training requirements if
384.4 received in the 12-month period before the staff person's date of hire. The license holder
384.5 must maintain documentation of the training received from other sources and of each staff
384.6 person's competency in the required area according to the requirements in subdivision 3.

384.7 Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a
384.8 subcontractor or temporary staff to perform services licensed under this chapter on the
384.9 license holder's behalf, the license holder must ensure that the subcontractor or temporary
384.10 staff meets and maintains compliance with all requirements under this chapter that apply
384.11 to the services to be provided, including training, orientation, and supervision necessary
384.12 to fulfill their responsibilities. The license holder must ensure that a background study
384.13 has been completed according to the requirements in sections 245C.03, subdivision 1,
384.14 and 245C.04. Subcontractors and temporary staff hired by the license holder must meet
384.15 the Minnesota licensing requirements applicable to the disciplines in which they are
384.16 providing services. The license holder must maintain documentation that the applicable
384.17 requirements have been met.

384.18 Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide
384.19 direct support services to persons served by the program receive the training, orientation,
384.20 and supervision necessary to fulfill their responsibilities. The license holder must ensure
384.21 that a background study has been completed according to the requirements in sections
384.22 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation
384.23 that the applicable requirements have been met.

384.24 Subd. 8. **Staff orientation and training plan.** The license holder must develop
384.25 a staff orientation and training plan documenting when and how compliance with
384.26 subdivisions 4, 4a, and 5 will be met.

384.27 **EFFECTIVE DATE.** This section is effective January 1, 2014.

384.28 Sec. 33. **[245D.091] INTERVENTION SERVICES.**

384.29 Subdivision 1. **Licensure requirements.** An individual meeting the staff
384.30 qualification requirements of this section who is an employee of a program licensed
384.31 according to this chapter and providing behavioral support services, specialist services,
384.32 or crisis respite services is not required to hold a separate license under this chapter.
384.33 An individual meeting the staff qualifications of this section who is not providing these
384.34 services as an employee of a program licensed according to this chapter must obtain a
384.35 license according to this chapter.

385.1 Subd. 2. Behavior professional qualifications. A behavior professional, as defined
385.2 in the brain injury and community alternatives for disabled individuals waiver plans or
385.3 successor plans, must have competencies in areas related to:

385.4 (1) ethical considerations;
385.5 (2) functional assessment;
385.6 (3) functional analysis;
385.7 (4) measurement of behavior and interpretation of data;
385.8 (5) selecting intervention outcomes and strategies;
385.9 (6) behavior reduction and elimination strategies that promote least restrictive
385.10 approved alternatives;

385.11 (7) data collection;
385.12 (8) staff and caregiver training;
385.13 (9) support plan monitoring;
385.14 (10) co-occurring mental disorders or neuro-cognitive disorder;
385.15 (11) demonstrated expertise with populations being served; and
385.16 (12) must be a:

385.17 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the
385.18 Board of Psychology competencies in the above identified areas;

385.19 (ii) clinical social worker licensed as an independent clinical social worker under
385.20 chapter 148D, or a person with a master's degree in social work from an accredited college
385.21 or university, with at least 4,000 hours of post-master's supervised experience in the
385.22 delivery of clinical services in the areas identified in clauses (1) to (11);

385.23 (iii) physician licensed under chapter 147 and certified by the American Board
385.24 of Psychiatry and Neurology or eligible for board certification in psychiatry with
385.25 competencies in the areas identified in clauses (1) to (11);

385.26 (iv) licensed professional clinical counselor licensed under sections 148B.29 to
385.27 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery
385.28 of clinical services who has demonstrated competencies in the areas identified in clauses
385.29 (1) to (11);

385.30 (v) person with a master's degree from an accredited college or university in one
385.31 of the behavioral sciences or related fields, with at least 4,000 hours of post-master's
385.32 supervised experience in the delivery of clinical services with demonstrated competencies
385.33 in the areas identified in clauses (1) to (11); or

385.34 (vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is
385.35 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
385.36 mental health nursing by a national nurse certification organization, or who has a master's

386.1 degree in nursing or one of the behavioral sciences or related fields from an accredited
386.2 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
386.3 experience in the delivery of clinical services.

386.4 Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in
386.5 the brain injury and community alternatives for disabled individuals waiver plans or
386.6 successor plans, must:

386.7 (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services
386.8 discipline; or

386.9 (2) meet the qualifications of a mental health practitioner as defined in section
386.10 245.462, subdivision 17.

386.11 (b) In addition, a behavior analyst must:

386.12 (1) have four years of supervised experience working with individuals who exhibit
386.13 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;

386.14 (2) have received ten hours of instruction in functional assessment and functional
386.15 analysis;

386.16 (3) have received 20 hours of instruction in the understanding of the function of
386.17 behavior;

386.18 (4) have received ten hours of instruction on design of positive practices behavior
386.19 support strategies;

386.20 (5) have received 20 hours of instruction on the use of behavior reduction approved
386.21 strategies used only in combination with behavior positive practices strategies;

386.22 (6) be determined by a behavior professional to have the training and prerequisite
386.23 skills required to provide positive practice strategies as well as behavior reduction

386.24 approved and permitted intervention to the person who receives behavioral support; and

386.25 (7) be under the direct supervision of a behavior professional.

386.26 Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined
386.27 in the brain injury and community alternatives for disabled individuals waiver plans or
386.28 successor plans, must meet the following qualifications:

386.29 (1) have an associate's degree in a social services discipline; or

386.30 (2) have two years of supervised experience working with individuals who exhibit
386.31 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.

386.32 (b) In addition, a behavior specialist must:

386.33 (1) have received a minimum of four hours of training in functional assessment;

386.34 (2) have received 20 hours of instruction in the understanding of the function of
386.35 behavior;

387.1 (3) have received ten hours of instruction on design of positive practices behavioral
387.2 support strategies;

387.3 (4) be determined by a behavior professional to have the training and prerequisite
387.4 skills required to provide positive practices strategies as well as behavior reduction
387.5 approved intervention to the person who receives behavioral support; and

387.6 (5) be under the direct supervision of a behavior professional.

387.7 Subd. 5. **Specialist services qualifications.** An individual providing specialist
387.8 services, as defined in the developmental disabilities waiver plan or successor plan, must
387.9 have:

387.10 (1) the specific experience and skills required of the specialist to meet the needs of
387.11 the person identified by the person's service planning team; and

387.12 (2) the qualifications of the specialist identified in the person's coordinated service
387.13 and support plan.

387.14 **EFFECTIVE DATE.** This section is effective January 1, 2014.

387.15 Sec. 34. **[245D.095] RECORD REQUIREMENTS.**

387.16 Subdivision 1. **Record-keeping systems.** The license holder must ensure that the
387.17 content and format of service recipient, personnel, and program records are uniform and
387.18 legible according to the requirements of this chapter.

387.19 Subd. 2. **Admission and discharge register.** The license holder must keep a written
387.20 or electronic register, listing in chronological order the dates and names of all persons
387.21 served by the program who have been admitted, discharged, or transferred, including
387.22 service terminations initiated by the license holder and deaths.

387.23 Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of
387.24 current services provided to each person on the premises where the services are provided
387.25 or coordinated. When the services are provided in a licensed facility, the records must
387.26 be maintained at the facility, otherwise the records must be maintained at the license
387.27 holder's program office. The license holder must protect service recipient records against
387.28 loss, tampering, or unauthorized disclosure according to the requirements in sections
387.29 13.01 to 13.10 and 13.46.

387.30 (b) The license holder must maintain the following information for each person:

387.31 (1) an admission form signed by the person or the person's legal representative
387.32 that includes:

387.33 (i) identifying information, including the person's name, date of birth, address,
387.34 and telephone number; and

388.1 (ii) the name, address, and telephone number of the person's legal representative, if
388.2 any, and a primary emergency contact, the case manager, and family members or others as
388.3 identified by the person or case manager;

388.4 (2) service information, including service initiation information, verification of the
388.5 person's eligibility for services, documentation verifying that services have been provided
388.6 as identified in the coordinated service and support plan or coordinated service and support
388.7 plan addendum according to paragraph (a), and date of admission or readmission;

388.8 (3) health information, including medical history, special dietary needs, and
388.9 allergies, and when the license holder is assigned responsibility for meeting the person's
388.10 health service needs according to section 245D.05:

388.11 (i) current orders for medication, treatments, or medical equipment and a signed
388.12 authorization from the person or the person's legal representative to administer or assist in
388.13 administering the medication or treatments, if applicable;

388.14 (ii) a signed statement authorizing the license holder to act in a medical emergency
388.15 when the person's legal representative, if any, cannot be reached or is delayed in arriving;

388.16 (iii) medication administration procedures;

388.17 (iv) a medication administration record documenting the implementation of the
388.18 medication administration procedures, and the medication administration record reviews,
388.19 including any agreements for administration of injectable medications by the license
388.20 holder according to the requirements in section 245D.05; and

388.21 (v) a medical appointment schedule when the license holder is assigned
388.22 responsibility for assisting with medical appointments;

388.23 (4) the person's current coordinated service and support plan or that portion of the
388.24 plan assigned to the license holder;

388.25 (5) copies of the individual abuse prevention plan and assessments as required under
388.26 section 245D.071, subdivisions 2 and 3;

388.27 (6) a record of other service providers serving the person when the person's
388.28 coordinated service and support plan or coordinated service and support plan addendum
388.29 identifies the need for coordination between the service providers, that includes a contact
388.30 person and telephone numbers, services being provided, and names of staff responsible for
388.31 coordination;

388.32 (7) documentation of orientation to service recipient rights according to section
388.33 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to
388.34 section 245A.65, subdivision 1, paragraph (c);

388.35 (8) copies of authorizations to handle a person's funds, according to section 245D.06,
388.36 subdivision 4, paragraph (a);

- 389.1 (9) documentation of complaints received and grievance resolution;
389.2 (10) incident reports involving the person, required under section 245D.06,
389.3 subdivision 1;
389.4 (11) copies of written reports regarding the person's status when requested according
389.5 to section 245D.07, subdivision 3, progress review reports as required under section
389.6 245D.071, subdivision 5, progress or daily log notes that are recorded by the program,
389.7 and reports received from other agencies involved in providing services or care to the
389.8 person; and
389.9 (12) discharge summary, including service termination notice and related
389.10 documentation, when applicable.

389.11 Subd. 4. **Access to service recipient records.** The license holder must ensure that
389.12 the following people have access to the information in subdivision 1 in accordance with
389.13 applicable state and federal laws, regulations, or rules:

- 389.14 (1) the person, the person's legal representative, and anyone properly authorized
389.15 by the person;
389.16 (2) the person's case manager;
389.17 (3) staff providing services to the person unless the information is not relevant to
389.18 carrying out the coordinated service and support plan or coordinated service and support
389.19 plan addendum; and
389.20 (4) the county child or adult foster care licensur, when services are also licensed as
389.21 child or adult foster care.

389.22 Subd. 5. **Personnel records.** (a) The license holder must maintain a personnel
389.23 record of each employee to document and verify staff qualifications, orientation, and
389.24 training. The personnel record must include:

- 389.25 (1) the employee's date of hire, completed application, an acknowledgement signed
389.26 by the employee that job duties were reviewed with the employee and the employee
389.27 understands those duties, and documentation that the employee meets the position
389.28 requirements as determined by the license holder;
389.29 (2) documentation of staff qualifications, orientation, training, and performance
389.30 evaluations as required under section 245D.09, subdivisions 3 to 5, including the date
389.31 the training was completed, the number of hours per subject area, and the name of the
389.32 trainer or instructor; and
389.33 (3) a completed background study as required under chapter 245C.

389.34 (b) For employees hired after January 1, 2014, the license holder must maintain
389.35 documentation in the personnel record or elsewhere, sufficient to determine the date of the

390.1 employee's first supervised direct contact with a person served by the program, and the
390.2 date of first unsupervised direct contact with a person served by the program.

390.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

390.4 Sec. 35. Minnesota Statutes 2012, section 245D.10, is amended to read:

390.5 **245D.10 POLICIES AND PROCEDURES.**

390.6 Subdivision 1. **Policy and procedure requirements.** The A license holder
390.7 providing either basic or intensive supports and services must establish, enforce, and
390.8 maintain policies and procedures as required in this chapter, chapter 245A, and other
390.9 applicable state and federal laws and regulations governing the provision of home and
390.10 community-based services licensed according to this chapter.

390.11 Subd. 2. **Grievances.** The license holder must establish policies and procedures
390.12 that ~~provide~~ promote service recipient rights by providing a simple complaint process for
390.13 persons served by the program and their authorized representatives to bring a grievance that:

390.14 (1) provides staff assistance with the complaint process when requested, and the
390.15 addresses and telephone numbers of outside agencies to assist the person;

390.16 (2) allows the person to bring the complaint to the highest level of authority in the
390.17 program if the grievance cannot be resolved by other staff members, and that provides
390.18 the name, address, and telephone number of that person;

390.19 (3) requires the license holder to promptly respond to all complaints affecting a
390.20 person's health and safety. For all other complaints, the license holder must provide an
390.21 initial response within 14 calendar days of receipt of the complaint. All complaints must
390.22 be resolved within 30 calendar days of receipt or the license holder must document the
390.23 reason for the delay and a plan for resolution;

390.24 (4) requires a complaint review that includes an evaluation of whether:

390.25 (i) related policies and procedures were followed and adequate;

390.26 (ii) there is a need for additional staff training;

390.27 (iii) the complaint is similar to past complaints with the persons, staff, or services
390.28 involved; and

390.29 (iv) there is a need for corrective action by the license holder to protect the health
390.30 and safety of persons receiving services;

390.31 (5) based on the review in clause (4), requires the license holder to develop,
390.32 document, and implement a corrective action plan designed to correct current lapses and
390.33 prevent future lapses in performance by staff or the license holder, if any;

391.1 (6) provides a written summary of the complaint and a notice of the complaint
391.2 resolution to the person and case manager that:

391.3 (i) identifies the nature of the complaint and the date it was received;

391.4 (ii) includes the results of the complaint review;

391.5 (iii) identifies the complaint resolution, including any corrective action; and

391.6 (7) requires that the complaint summary and resolution notice be maintained in the
391.7 service recipient record.

391.8 Subd. 3. **Service suspension and service termination.** (a) The license holder must
391.9 establish policies and procedures for temporary service suspension and service termination
391.10 that promote continuity of care and service coordination with the person and the case
391.11 manager and with other licensed caregivers, if any, who also provide support to the person.

391.12 (b) The policy must include the following requirements:

391.13 (1) the license holder must notify the person or the person's legal representative and
391.14 case manager in writing of the intended termination or temporary service suspension, and
391.15 the person's right to seek a temporary order staying the termination of service according to
391.16 the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

391.17 (2) notice of the proposed termination of services, including those situations
391.18 that began with a temporary service suspension, must be given at least 60 days before
391.19 the proposed termination is to become effective when a license holder is providing
391.20 ~~independent living skills training, structured day, prevocational or supported employment~~
391.21 ~~services to the person~~ intensive supports and services identified in section 245D.03,
391.22 subdivision 1, paragraph (c), and 30 days prior to termination for all other services
391.23 licensed under this chapter;

391.24 (3) the license holder must provide information requested by the person or case
391.25 manager when services are temporarily suspended or upon notice of termination;

391.26 (4) prior to giving notice of service termination or temporary service suspension,
391.27 the license holder must document actions taken to minimize or eliminate the need for
391.28 service suspension or termination;

391.29 (5) during the temporary service suspension or service termination notice period,
391.30 the license holder will work with the appropriate county agency to develop reasonable
391.31 alternatives to protect the person and others;

391.32 (6) the license holder must maintain information about the service suspension or
391.33 termination, including the written termination notice, in the service recipient record; and

391.34 (7) the license holder must restrict temporary service suspension to situations in
391.35 which the person's ~~behavior causes immediate and serious danger to the health and safety~~

392.1 ~~of the person or others~~ conduct poses an imminent risk of physical harm to self or others
 392.2 and less restrictive or positive support strategies would not achieve safety.

392.3 Subd. 4. **Availability of current written policies and procedures.** (a) The license
 392.4 holder must review and update, as needed, the written policies and procedures required
 392.5 under this chapter.

392.6 (b)(1) The license holder must inform the person and case manager of the policies
 392.7 and procedures affecting a person's rights under section 245D.04, and provide copies of
 392.8 those policies and procedures, within five working days of service initiation.

392.9 (2) If a license holder only provides basic services and supports, this includes the:

392.10 (i) grievance policy and procedure required under subdivision 2; and

392.11 (ii) service suspension and termination policy and procedure required under
 392.12 subdivision 3.

392.13 (3) For all other license holders this includes the:

392.14 (i) policies and procedures in clause (2);

392.15 (ii) emergency use of manual restraints policy and procedure required under section
 392.16 245D.061, subdivision 10; and

392.17 (iii) data privacy requirements under section 245D.11, subdivision 3.

392.18 (c) The license holder must provide a written notice to all persons or their legal
 392.19 representatives and case managers at least 30 days before implementing any ~~revised~~
 392.20 ~~policies and procedures~~ procedural revisions to policies affecting a person's service-related
 392.21 or protection-related rights under section 245D.04 and maltreatment reporting policies and
 392.22 procedures. The notice must explain the revision that was made and include a copy of the
 392.23 revised policy and procedure. The license holder must document the ~~reason~~ reasonable
 392.24 cause for not providing the notice at least 30 days before implementing the revisions.

392.25 (d) Before implementing revisions to required policies and procedures, the license
 392.26 holder must inform all employees of the revisions and provide training on implementation
 392.27 of the revised policies and procedures.

392.28 (e) The license holder must annually notify all persons, or their legal representatives,
 392.29 and case managers of any procedural revisions to policies required under this chapter,
 392.30 other than those in paragraph (c). Upon request, the license holder must provide the
 392.31 person, or the person's legal representative, and case manager with copies of the revised
 392.32 policies and procedures.

392.33 **EFFECTIVE DATE.** This section is effective January 1, 2014.

392.34 Sec. 36. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT**
 392.35 **SERVICES.**

393.1 Subdivision 1. **Policy and procedure requirements.** A license holder providing
393.2 intensive support services as identified in section 245D.03, subdivision 1, paragraph (c),
393.3 must establish, enforce, and maintain policies and procedures as required in this section.

393.4 Subd. 2. **Health and safety.** The license holder must establish policies and
393.5 procedures that promote health and safety by ensuring:

393.6 (1) use of universal precautions and sanitary practices in compliance with section
393.7 245D.06, subdivision 2, clause (5);

393.8 (2) if the license holder operates a residential program, health service coordination
393.9 and care according to the requirements in section 245D.05, subdivision 1;

393.10 (3) safe medication assistance and administration according to the requirements
393.11 in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
393.12 consultation with a registered nurse, nurse practitioner, physician's assistant, or medical
393.13 doctor and require completion of medication administration training according to the
393.14 requirements in section 245D.09, subdivision 4a, paragraph (d). Medication assistance
393.15 and administration includes, but is not limited to:

393.16 (i) providing medication-related services for a person;

393.17 (ii) medication setup;

393.18 (iii) medication administration;

393.19 (iv) medication storage and security;

393.20 (v) medication documentation and charting;

393.21 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
393.22 handling and administration;

393.23 (vii) coordination of medication refills;

393.24 (viii) handling changes to prescriptions and implementation of those changes;

393.25 (ix) communicating with the pharmacy; and

393.26 (x) coordination and communication with prescriber;

393.27 (4) safe transportation, when the license holder is responsible for transportation of
393.28 persons, with provisions for handling emergency situations according to the requirements
393.29 in section 245D.06, subdivision 2, clauses (2) to (4);

393.30 (5) a plan for ensuring the safety of persons served by the program in emergencies as
393.31 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
393.32 to the license holder. A license holder with a community residential setting or a day service
393.33 facility license must ensure the policy and procedures comply with the requirements in
393.34 section 245D.22, subdivision 4;

394.1 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision
394.2 11; and reporting all incidents required to be reported according to section 245D.06,
394.3 subdivision 1. The plan must:

394.4 (i) provide the contact information of a source of emergency medical care and
394.5 transportation; and

394.6 (ii) require staff to first call 911 when the staff believes a medical emergency may be
394.7 life threatening, or to call the mental health crisis intervention team when the person is
394.8 experiencing a mental health crisis; and

394.9 (7) a procedure for the review of incidents and emergencies to identify trends or
394.10 patterns, and corrective action if needed. The license holder must establish and maintain
394.11 a record-keeping system for the incident and emergency reports. Each incident and
394.12 emergency report file must contain a written summary of the incident. The license holder
394.13 must conduct a review of incident reports for identification of incident patterns, and
394.14 implementation of corrective action as necessary to reduce occurrences. Each incident
394.15 report must include:

394.16 (i) the name of the person or persons involved in the incident. It is not necessary
394.17 to identify all persons affected by or involved in an emergency unless the emergency
394.18 resulted in an incident;

394.19 (ii) the date, time, and location of the incident or emergency;

394.20 (iii) a description of the incident or emergency;

394.21 (iv) a description of the response to the incident or emergency and whether a person's
394.22 coordinated service and support plan addendum or program policies and procedures were
394.23 implemented as applicable;

394.24 (v) the name of the staff person or persons who responded to the incident or
394.25 emergency; and

394.26 (vi) the determination of whether corrective action is necessary based on the results
394.27 of the review.

394.28 Subd. 3. **Data privacy.** The license holder must establish policies and procedures that
394.29 promote service recipient rights by ensuring data privacy according to the requirements in:

394.30 (1) the Minnesota Government Data Practices Act, section 13.46, and all other
394.31 applicable Minnesota laws and rules in handling all data related to the services provided;
394.32 and

394.33 (2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the
394.34 extent that the license holder performs a function or activity involving the use of protected
394.35 health information as defined under Code of Federal Regulations, title 45, section 164.501,
394.36 including, but not limited to, providing health care services; health care claims processing

395.1 or administration; data analysis, processing, or administration; utilization review; quality
395.2 assurance; billing; benefit management; practice management; repricing; or as otherwise
395.3 provided by Code of Federal Regulations, title 45, section 160.103. The license holder
395.4 must comply with the Health Insurance Portability and Accountability Act of 1996 and
395.5 its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164,
395.6 and all applicable requirements.

395.7 Subd. 4. **Admission criteria.** The license holder must establish policies and
395.8 procedures that promote continuity of care by ensuring that admission or service initiation
395.9 criteria:

395.10 (1) is consistent with the license holder's registration information identified in the
395.11 requirements in section 245D.031, subdivision 2, and with the service-related rights
395.12 identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

395.13 (2) identifies the criteria to be applied in determining whether the license holder
395.14 can develop services to meet the needs specified in the person's coordinated service and
395.15 support plan;

395.16 (3) requires a license holder providing services in a health care facility to comply
395.17 with the requirements in section 243.166, subdivision 4b, to provide notification to
395.18 residents when a registered predatory offender is admitted into the program or to a
395.19 potential admission when the facility was already serving a registered predatory offender.
395.20 For purposes of this clause, "health care facility" means a facility licensed by the
395.21 commissioner as a residential facility under chapter 245A to provide adult foster care or
395.22 residential services to persons with disabilities; and

395.23 (4) requires that when a person or the person's legal representative requests services
395.24 from the license holder, a refusal to admit the person must be based on an evaluation of
395.25 the person's assessed needs and the license holder's lack of capacity to meet the needs of
395.26 the person. The license holder must not refuse to admit a person based solely on the
395.27 type of residential services the person is receiving, or solely on the person's severity of
395.28 disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of
395.29 communication skills, physical disabilities, toilet habits, behavioral disorders, or past
395.30 failure to make progress. Documentation of the basis for refusal must be provided to the
395.31 person or the person's legal representative and case manager upon request.

395.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

395.33 Sec. 37. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND**
395.34 **APPLICATION PROCESS.**

396.1 Subdivision 1. **Community residential settings and day service facilities.** For
396.2 purposes of this section, "facility" means both a community residential setting and day
396.3 service facility and the physical plant.

396.4 Subd. 2. **Inspections and code compliance.** (a) Physical plants must comply with
396.5 applicable state and local fire, health, building, and zoning codes.

396.6 (b)(1) The facility must be inspected by a fire marshal or their delegate within
396.7 12 months before initial licensure to verify that it meets the applicable occupancy
396.8 requirements as defined in the State Fire Code and that the facility complies with the fire
396.9 safety standards for that occupancy code contained in the State Fire Code.

396.10 (2) The fire marshal inspection of a community residential setting must verify the
396.11 residence is a dwelling unit within a residential occupancy as defined in section 9.117 of
396.12 the State Fire Code. A home safety checklist, approved by the commissioner, must be
396.13 completed for a community residential setting by the license holder and the commissioner
396.14 before the satellite license is reissued.

396.15 (3) The facility shall be inspected according to the facility capacity specified on the
396.16 initial application form.

396.17 (4) If the commissioner has reasonable cause to believe that a potentially hazardous
396.18 condition may be present or the licensed capacity is increased, the commissioner shall
396.19 request a subsequent inspection and written report by a fire marshal to verify the absence
396.20 of hazard.

396.21 (5) Any condition cited by a fire marshal, building official, or health authority as
396.22 hazardous or creating an immediate danger of fire or threat to health and safety must be
396.23 corrected before a license is issued by the department, and for community residential
396.24 settings, before a license is reissued.

396.25 (c) The facility must maintain in a permanent file the reports of health, fire, and
396.26 other safety inspections.

396.27 (d) The facility's plumbing, ventilation, heating, cooling, lighting, and other
396.28 fixtures and equipment, including elevators or food service, if provided, must conform to
396.29 applicable health, sanitation, and safety codes and regulations.

396.30 **EFFECTIVE DATE.** This section is effective January 1, 2014.

396.31 **Sec. 38. [245D.22] FACILITY SANITATION AND HEALTH.**

396.32 Subdivision 1. **General maintenance.** The license holder must maintain the interior
396.33 and exterior of buildings, structures, or enclosures used by the facility, including walls,
396.34 floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a
396.35 sanitary and safe condition. The facility must be clean and free from accumulations of

397.1 dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must
397.2 correct building and equipment deterioration, safety hazards, and unsanitary conditions.

397.3 Subd. 2. **Hazards and toxic substances.** The license holder must ensure that
397.4 service sites owned or leased by the license holder are free from hazards that would
397.5 threaten the health or safety of a person receiving services by ensuring the requirements
397.6 in paragraphs (a) to (g) are met.

397.7 (a) Chemicals, detergents, and other hazardous or toxic substances must not be
397.8 stored with food products or in any way that poses a hazard to persons receiving services.

397.9 (b) The license holder must install handrails and nonslip surfaces on interior and
397.10 exterior runways, stairways, and ramps according to the applicable building code.

397.11 (c) If there are elevators in the facility, the license holder must have elevators
397.12 inspected each year. The date of the inspection, any repairs needed, and the date the
397.13 necessary repairs were made must be documented.

397.14 (d) The license holder must keep stairways, ramps, and corridors free of obstructions.

397.15 (e) Outside property must be free from debris and safety hazards. Exterior stairs and
397.16 walkways must be kept free of ice and snow.

397.17 (f) Heating, ventilation, air conditioning units, and other hot surfaces and moving
397.18 parts of machinery must be shielded or enclosed.

397.19 (g) Use of dangerous items or equipment by persons served by the program must be
397.20 allowed in accordance with the person's coordinated service and support plan addendum
397.21 or the program abuse prevention plan, if not addressed in the coordinated service and
397.22 support plan addendum.

397.23 Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in
397.24 the facility that are named in section 152.02, subdivision 3, must be stored in a locked
397.25 storage area permitting access only by persons and staff authorized to administer the
397.26 medication. This must be incorporated into the license holder's medication administration
397.27 policy and procedures required under section 245D.11, subdivision 2, clause (3).
397.28 Medications must be disposed of according to the Environmental Protection Agency
397.29 recommendations.

397.30 Subd. 4. **First aid must be available on site.** (a) A staff person trained in first
397.31 aid must be available on site and, when required in a person's coordinated service and
397.32 support plan or coordinated service and support plan addendum, be able to provide
397.33 cardiopulmonary resuscitation, whenever persons are present and staff are required to be
397.34 at the site to provide direct service. The CPR training must include in-person instruction,
397.35 hands-on practice, and an observed skills assessment under the direct supervision of a
397.36 CPR instructor.

398.1 (b) A facility must have first aid kits readily available for use by, and that meet
398.2 the needs of, persons receiving services and staff. At a minimum, the first aid kit must
398.3 be equipped with accessible first aid supplies including bandages, sterile compresses,
398.4 scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap,
398.5 adhesive tape, and first aid manual.

398.6 Subd. 5. **Emergencies.** (a) The license holder must have a written plan for
398.7 responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the
398.8 safety of persons served in the facility. The plan must include:

398.9 (1) procedures for emergency evacuation and emergency sheltering, including:

398.10 (i) how to report a fire or other emergency;

398.11 (ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive
398.12 procedures or equipment to assist with the safe evacuation of persons with physical or
398.13 sensory disabilities; and

398.14 (iii) instructions on closing off the fire area, using fire extinguishers, and activating
398.15 and responding to alarm systems;

398.16 (2) a floor plan that identifies:

398.17 (i) the location of fire extinguishers;

398.18 (ii) the location of audible or visual alarm systems, including but not limited to
398.19 manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and
398.20 sprinkler systems;

398.21 (iii) the location of exits, primary and secondary evacuation routes, and accessible
398.22 egress routes, if any; and

398.23 (iv) the location of emergency shelter within the facility;

398.24 (3) a site plan that identifies:

398.25 (i) designated assembly points outside the facility;

398.26 (ii) the locations of fire hydrants; and

398.27 (iii) the routes of fire department access;

398.28 (4) the responsibilities each staff person must assume in case of emergency;

398.29 (5) procedures for conducting quarterly drills each year and recording the date of
398.30 each drill in the file of emergency plans;

398.31 (6) procedures for relocation or service suspension when services are interrupted
398.32 for more than 24 hours;

398.33 (7) for a community residential setting with three or more dwelling units, a floor
398.34 plan that identifies the location of enclosed exit stairs; and

398.35 (8) an emergency escape plan for each resident.

398.36 (b) The license holder must:

- 399.1 (1) maintain a log of quarterly fire drills on file in the facility;
399.2 (2) provide an emergency response plan that is readily available to staff and persons
399.3 receiving services;
399.4 (3) inform each person of a designated area within the facility where the person
399.5 should go for emergency shelter during severe weather and the designated assembly points
399.6 outside the facility; and
399.7 (4) maintain emergency contact information for persons served at the facility that
399.8 can be readily accessed in an emergency.

399.9 Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable
399.10 radio or television set that do not require electricity and can be used if a power failure
399.11 occurs.

399.12 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated
399.13 telephone that is readily accessible. A list of emergency numbers must be posted in a
399.14 prominent location. When an area has a 911 number or a mental health crisis intervention
399.15 team number, both numbers must be posted and the emergency number listed must be
399.16 911. In areas of the state without a 911 number, the numbers listed must be those of the
399.17 local fire department, police department, emergency transportation, and poison control
399.18 center. The names and telephone numbers of each person's representative, physician, and
399.19 dentist must be readily available.

399.20 **EFFECTIVE DATE.** This section is effective January 1, 2014.

399.21 Sec. 39. **[245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE**
399.22 **LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

399.23 Subdivision 1. **Separate satellite license required for separate sites.** (a) A license
399.24 holder providing residential support services must obtain a separate satellite license for
399.25 each community residential setting located at separate addresses when the community
399.26 residential settings are to be operated by the same license holder. For purposes of this
399.27 chapter, a community residential setting is a satellite of the home and community-based
399.28 services license.

399.29 (b) Community residential settings are permitted single-family use homes. After a
399.30 license has been issued, the commissioner shall notify the local municipality where the
399.31 residence is located of the approved license.

399.32 Subd. 2. **Notification to local agency.** The license holder must notify the local
399.33 agency within 24 hours of the onset of changes in a residence resulting from construction,
399.34 remodeling, or damages requiring repairs that require a building permit or may affect a
399.35 licensing requirement in this chapter.

400.1 Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate
400.2 overnight supervision technology adult foster care license according to section 245A.11,
400.3 subdivision 7a, that converts to a community residential setting satellite license according
400.4 to this chapter, must retain that designation.

400.5 **EFFECTIVE DATE.** This section is effective January 1, 2014.

400.6 Sec. 40. **[245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL**
400.7 **PLANT AND ENVIRONMENT.**

400.8 Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling
400.9 unit in a residential occupancy.

400.10 Subd. 2. **Common area requirements.** The living area must be provided with an
400.11 adequate number of furnishings for the usual functions of daily living and social activities.
400.12 The dining area must be furnished to accommodate meals shared by all persons living in
400.13 the residence. These furnishings must be in good repair and functional to meet the daily
400.14 needs of the persons living in the residence.

400.15 Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in
400.16 writing, to sharing a bedroom with one another. No more than two people receiving
400.17 services may share one bedroom.

400.18 (b) A single occupancy bedroom must have at least 80 square feet of floor space with
400.19 a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
400.20 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and
400.21 other habitable rooms by floor to ceiling walls containing no openings except doorways
400.22 and must not serve as a corridor to another room used in daily living.

400.23 (c) A person's personal possessions and items for the person's own use are the only
400.24 items permitted to be stored in a person's bedroom.

400.25 (d) Unless otherwise documented through assessment as a safety concern for the
400.26 person, each person must be provided with the following furnishings:

400.27 (1) a separate bed of proper size and height for the convenience and comfort of the
400.28 person, with a clean mattress in good repair;

400.29 (2) clean bedding appropriate for the season for each person;

400.30 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
400.31 possessions and clothing; and

400.32 (4) a mirror for grooming.

400.33 (e) When possible, a person must be allowed to have items of furniture that the
400.34 person personally owns in the bedroom, unless doing so would interfere with safety
400.35 precautions, violate a building or fire code, or interfere with another person's use of the

401.1 bedroom. A person may choose not to have a cabinet, dresser, shelves, or a mirror in the
401.2 bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may
401.3 choose to use a mattress other than an innerspring mattress and may choose not to have
401.4 the mattress on a mattress frame or support. If a person chooses not to have a piece of
401.5 required furniture, the license holder must document this choice and is not required to
401.6 provide the item. If a person chooses to use a mattress other than an innerspring mattress
401.7 or chooses not to have a mattress frame or support, the license holder must document this
401.8 choice and allow the alternative desired by the person.

401.9 (f) A person must be allowed to bring personal possessions into the bedroom
401.10 and other designated storage space, if such space is available, in the residence. The
401.11 person must be allowed to accumulate possessions to the extent the residence is able to
401.12 accommodate them, unless doing so is contraindicated for the person's physical or mental
401.13 health, would interfere with safety precautions or another person's use of the bedroom, or
401.14 would violate a building or fire code. The license holder must allow for locked storage
401.15 of personal items. Any restriction on the possession or locked storage of personal items,
401.16 including requiring a person to use a lock provided by the license holder, must comply
401.17 with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if
401.18 and when the license holder opens the lock.

401.19 **EFFECTIVE DATE.** This section is effective January 1, 2014.

401.20 Sec. 41. **[245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND**
401.21 **WATER.**

401.22 Subdivision 1. **Water.** Potable water from privately owned wells must be tested
401.23 annually by a Department of Health-certified laboratory for coliform bacteria and nitrate
401.24 nitrogens to verify safety. The health authority may require retesting and corrective
401.25 measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in
401.26 the event of flooding or an incident which may put the well at risk of contamination. To
401.27 prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

401.28 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as
401.29 prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day
401.30 must be served or made available to persons, and nutritious snacks must be available
401.31 between meals.

401.32 Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to
401.33 prevent contamination, spoilage, or a threat to the health of a person.

401.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

402.1 Sec. 42. **[245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION**
402.2 **AND HEALTH.**

402.3 Subdivision 1. **Goods provided by the license holder.** Individual clean bed linens
402.4 appropriate for the season and the person's comfort, including towels and wash cloths,
402.5 must be available for each person. Usual or customary goods for the operation of a
402.6 residence which are communally used by all persons receiving services living in the
402.7 residence must be provided by the license holder, including household items for meal
402.8 preparation, cleaning supplies to maintain the cleanliness of the residence, window
402.9 coverings on windows for privacy, toilet paper, and hand soap.

402.10 Subd. 2. **Personal items.** Personal health and hygiene items must be stored in a
402.11 safe and sanitary manner.

402.12 Subd. 3. **Pets and service animals.** Pets and service animals housed within
402.13 the residence must be immunized and maintained in good health as required by local
402.14 ordinances and state law. The license holder must ensure that the person and the person's
402.15 representative are notified before admission of the presence of pets in the residence.

402.16 Subd. 4. **Smoking in the residence.** License holders must comply with the
402.17 requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when
402.18 smoking is permitted in the residence.

402.19 Subd. 5. **Weapons.** Weapons and ammunition must be stored separately in locked
402.20 areas that are inaccessible to a person receiving services. For purposes of this subdivision,
402.21 "weapons" means firearms and other instruments or devices designed for and capable of
402.22 producing bodily harm.

402.23 **EFFECTIVE DATE.** This section is effective January 1, 2014.

402.24 Sec. 43. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE**
402.25 **REQUIREMENTS AND APPLICATION PROCESS.**

402.26 Except for day service facilities on the same or adjoining lot, the license holder
402.27 providing day services must apply for a separate license for each facility-based service
402.28 site when the license holder is the owner, lessor, or tenant of the service site at which
402.29 persons receive day services and the license holder's employees who provide day services
402.30 are present for a cumulative total of more than 30 days within any 12-month period. For
402.31 purposes of this chapter, a day services facility license is a satellite license of the day
402.32 services program. A day services program may operate multiple licensed day service
402.33 facilities in one or more counties in the state. For the purposes of this section, "adjoining
402.34 lot" means day services facilities that are next door to or across the street from one another.

403.1 **EFFECTIVE DATE.** This section is effective January 1, 2014.

403.2 Sec. 44. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND**
403.3 **SPACE REQUIREMENTS.**

403.4 Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility
403.5 capacity of each day service facility must be determined by the amount of primary space
403.6 available, the scheduling of activities at other service sites, and the space requirements of
403.7 all persons receiving services at the facility, not just the licensed services. The facility
403.8 capacity must specify the maximum number of persons that may receive services on
403.9 site at any one time.

403.10 (b) When a facility is located in a multifunctional organization, the facility may
403.11 share common space with the multifunctional organization if the required available
403.12 primary space for use by persons receiving day services is maintained while the facility is
403.13 operating. The license holder must comply at all times with all applicable fire and safety
403.14 codes under section 245A.04, subdivision 2a, and adequate supervision requirements
403.15 under section 245D.31 for all persons receiving day services.

403.16 (c) A day services facility must have a minimum of 40 square feet of primary space
403.17 available for each person receiving services who is present at the site at any one time.

403.18 Primary space does not include:

403.19 (1) common areas, such as hallways, stairways, closets, utility areas, bathrooms,
403.20 and kitchens;

403.21 (2) floor areas beneath stationary equipment; or

403.22 (3) any space occupied by persons associated with the multifunctional organization
403.23 while persons receiving day services are using common space.

403.24 Subd. 2. **Individual personal articles.** Each person must be provided space in a
403.25 closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own
403.26 use while receiving services at the facility, unless doing so would interfere with safety
403.27 precautions, another person's work space, or violate a building or fire code.

403.28 **EFFECTIVE DATE.** This section is effective January 1, 2014.

403.29 Sec. 45. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY**
403.30 **REQUIREMENTS.**

403.31 Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service
403.32 sites owned or leased by the license holder for storing perishable foods and perishable
403.33 portions of bag lunches, whether the foods are supplied by the license holder or the

404.1 persons receiving services, the refrigeration must have a temperature of 40 degrees
404.2 Fahrenheit or less.

404.3 Subd. 2. **Drinking water.** Drinking water must be available to all persons
404.4 receiving services. If a person is unable to request or obtain drinking water, it must be
404.5 provided according to that person's individual needs. Drinking water must be provided in
404.6 single-service containers or from drinking fountains accessible to all persons.

404.7 Subd. 3. **Individuals who become ill during the day.** There must be an area in
404.8 which a person receiving services can rest if:

404.9 (1) the person becomes ill during the day;

404.10 (2) the person does not live in a licensed residential site;

404.11 (3) the person requires supervision; and

404.12 (4) there is not a caretaker immediately available. Supervision must be provided
404.13 until the caretaker arrives to bring the person home.

404.14 Subd. 4. **Safety procedures.** The license holder must establish general written
404.15 safety procedures that include criteria for selecting, training, and supervising persons who
404.16 work with hazardous machinery, tools, or substances. Safety procedures specific to each
404.17 person's activities must be explained and be available in writing to all staff members
404.18 and persons receiving services.

404.19 **EFFECTIVE DATE.** This section is effective January 1, 2014.

404.20 Sec. 46. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND**
404.21 **FACILITY COVERAGE.**

404.22 Subdivision 1. **Scope.** This section applies only to facility-based day services.

404.23 Subd. 2. **Factors.** (a) The number of direct support service staff members that a
404.24 license holder must have on duty at the facility at a given time to meet the minimum
404.25 staffing requirements established in this section varies according to:

404.26 (1) the number of persons who are enrolled and receiving direct support services
404.27 at that given time;

404.28 (2) the staff ratio requirement established under subdivision 3 for each person who
404.29 is present; and

404.30 (3) whether the conditions described in subdivision 8 exist and warrant additional
404.31 staffing beyond the number determined to be needed under subdivision 7.

404.32 (b) The commissioner must consider the factors in paragraph (a) in determining a
404.33 license holder's compliance with the staffing requirements and must further consider
404.34 whether the staff ratio requirement established under subdivision 3 for each person
404.35 receiving services accurately reflects the person's need for staff time.

405.1 Subd. 3. Staff ratio requirement for each person receiving services. The case
405.2 manager, in consultation with the interdisciplinary team, must determine at least once each
405.3 year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving
405.4 services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio
405.5 assigned each person and the documentation of how the ratio was arrived at must be kept
405.6 in each person's individual service plan. Documentation must include an assessment of the
405.7 person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard
405.8 assessment form required by the commissioner.

405.9 Subd. 4. Person requiring staff ratio of one to four. A person must be assigned a
405.10 staff ratio requirement of one to four if:

405.11 (1) on a daily basis the person requires total care and monitoring or constant
405.12 hand-over-hand physical guidance to successfully complete at least three of the following
405.13 activities: toileting, communicating basic needs, eating, ambulating; or is not capable of
405.14 taking appropriate action for self-preservation under emergency conditions; or

405.15 (2) the person engages in conduct that poses an imminent risk of physical harm to
405.16 self or others at a documented level of frequency, intensity, or duration requiring frequent
405.17 daily ongoing intervention and monitoring as established in the person's coordinated
405.18 service and support plan or coordinated service and support plan addendum.

405.19 Subd. 5. Person requiring staff ratio of one to eight. A person must be assigned a
405.20 staff ratio requirement of one to eight if:

405.21 (1) the person does not meet the requirements in subdivision 4; and

405.22 (2) on a daily basis the person requires verbal prompts or spot checks and minimal
405.23 or no physical assistance to successfully complete at least four of the following activities:
405.24 toileting, communicating basic needs, eating, ambulating, or taking appropriate action for
405.25 self-preservation under emergency conditions.

405.26 Subd. 6. Person requiring staff ratio of one to six. A person who does not have
405.27 any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio
405.28 requirement of one to six.

405.29 Subd. 7. Determining number of direct support service staff required. The
405.30 minimum number of direct support service staff members required at any one time to
405.31 meet the combined staff ratio requirements of the persons present at that time can be
405.32 determined by the following steps:

405.33 (1) assign to each person in attendance the three-digit decimal below that corresponds
405.34 to the staff ratio requirement assigned to that person. A staff ratio requirement of one to
405.35 four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio
405.36 requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

406.1 (2) add all of the three-digit decimals (one three-digit decimal for every person in
406.2 attendance) assigned in clause (1);

406.3 (3) when the sum in clause (2) falls between two whole numbers, round off the sum
406.4 to the larger of the two whole numbers; and

406.5 (4) the larger of the two whole numbers in clause (3) equals the number of direct
406.6 support service staff members needed to meet the staff ratio requirements of the persons
406.7 in attendance.

406.8 **Subd. 8. Staff to be included in calculating minimum staffing requirement.**

406.9 Only staff providing direct support must be counted as staff members in calculating
406.10 the staff-to-participant ratio. A volunteer may be counted as a direct support staff in
406.11 calculating the staff-to-participant ratio if the volunteer meets the same standards and
406.12 requirements as paid staff. No person receiving services must be counted as or be
406.13 substituted for a staff member in calculating the staff-to-participant ratio.

406.14 **Subd. 9. Conditions requiring additional direct support staff.** The license holder
406.15 must increase the number of direct support staff members present at any one time beyond
406.16 the number arrived at in subdivision 4 if necessary when any one or combination of the
406.17 following circumstances can be documented by the commissioner as existing:

406.18 (1) the health and safety needs of the persons receiving services cannot be met by
406.19 the number of staff members available under the staffing pattern in effect even though the
406.20 number has been accurately calculated under subdivision 7; or

406.21 (2) the person's conduct frequently presents an imminent risk of physical harm to
406.22 self or others.

406.23 **Subd. 10. Supervision requirements.** (a) At no time must one direct support
406.24 staff member be assigned responsibility for supervision and training of more than ten
406.25 persons receiving supervision and training, except as otherwise stated in each person's risk
406.26 management plan.

406.27 (b) In the temporary absence of the director or a supervisor, a direct support staff
406.28 member must be designated to supervise the center.

406.29 **Subd. 11. Multifunctional programs.** A multifunctional program may count other
406.30 employees of the organization besides direct support staff of the day service facility in
406.31 calculating the staff-to-participant ratio if the employee is assigned to the day services
406.32 facility for a specified amount of time, during which the employee is not assigned to
406.33 another organization or program.

406.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

406.35 **Sec. 47. [245D.32] ALTERNATIVE LICENSING INSPECTIONS.**

407.1 Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license
407.2 holder providing services licensed under this chapter, with a qualifying accreditation and
407.3 meeting the eligibility criteria in paragraphs (b) and (c), may request approval for an
407.4 alternative licensing inspection when all services provided under the license holder's
407.5 license are accredited. A license holder with a qualifying accreditation and meeting
407.6 the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative
407.7 licensing inspection for individual community residential settings or day services facilities
407.8 licensed under this chapter.

407.9 (b) In order to be eligible for an alternative licensing inspection, the program must
407.10 have had at least one inspection by the commissioner following issuance of the initial
407.11 license. For programs operating a day services facility, each facility must have had at least
407.12 one on-site inspection by the commissioner following issuance of the initial license.

407.13 (c) In order to be eligible for an alternative licensing inspection, the program must
407.14 have been in substantial and consistent compliance at the time of the last licensing
407.15 inspection and during the current licensing period. For purposes of this section,
407.16 "substantial and consistent compliance" means:

407.17 (1) the license holder's license was not made conditional, suspended, or revoked;

407.18 (2) there have been no substantiated allegations of maltreatment against the license
407.19 holder;

407.20 (3) there were no program deficiencies identified that would jeopardize the health,
407.21 safety, or rights of persons being served; and

407.22 (4) the license holder maintained substantial compliance with the other requirements
407.23 of chapters 245A and 245C and other applicable laws and rules.

407.24 (d) For the purposes of this section, the license holder's license includes services
407.25 licensed under this chapter that were previously licensed under chapter 245B until
407.26 December 31, 2013.

407.27 Subd. 2. **Qualifying accreditation.** The commissioner must accept a three-year
407.28 accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)
407.29 as a qualifying accreditation.

407.30 Subd. 3. **Request for approval of an alternative inspection status.** (a) A request
407.31 for an alternative inspection must be made on the forms and in the manner prescribed
407.32 by the commissioner. When submitting the request, the license holder must submit all
407.33 documentation issued by the accrediting body verifying that the license holder has obtained
407.34 and maintained the qualifying accreditation and has complied with recommendations
407.35 or requirements from the accrediting body during the period of accreditation. Based

408.1 on the request and the additional required materials, the commissioner may approve
408.2 an alternative inspection status.

408.3 (b) The commissioner must notify the license holder in writing that the request for
408.4 an alternative inspection status has been approved. Approval must be granted until the
408.5 end of the qualifying accreditation period.

408.6 (c) The license holder must submit a written request for approval to be renewed
408.7 one month before the end of the current approval period according to the requirements
408.8 in paragraph (a). If the license holder does not submit a request to renew approval as
408.9 required, the commissioner must conduct a licensing inspection.

408.10 Subd. 4. **Programs approved for alternative licensing inspection; deemed**
408.11 **compliance licensing requirements.** (a) A license holder approved for alternative
408.12 licensing inspection under this section is required to maintain compliance with all
408.13 licensing standards according to this chapter.

408.14 (b) A license holder approved for alternative licensing inspection under this section
408.15 must be deemed to be in compliance with all the requirements of this chapter, and the
408.16 commissioner must not perform routine licensing inspections.

408.17 (c) Upon receipt of a complaint regarding the services of a license holder approved
408.18 for alternative licensing inspection under this section, the commissioner must investigate
408.19 the complaint and may take any action as provided under section 245A.06 or 245A.07.

408.20 Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this
408.21 section changes the commissioner's responsibilities to investigate alleged or suspected
408.22 maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

408.23 Subd. 6. **Termination or denial of subsequent approval.** Following approval of
408.24 an alternative licensing inspection, the commissioner may terminate or deny subsequent
408.25 approval of an alternative licensing inspection if the commissioner determines that:

408.26 (1) the license holder has not maintained the qualifying accreditation;

408.27 (2) the commissioner has substantiated maltreatment for which the license holder or
408.28 facility is determined to be responsible during the qualifying accreditation period; or

408.29 (3) during the qualifying accreditation period, the license holder has been issued
408.30 an order for conditional license, fine, suspension, or license revocation that has not been
408.31 reversed upon appeal.

408.32 Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for
408.33 an alternative licensing inspection have not been met is final and not subject to appeal
408.34 under the provisions of chapter 14.

409.1 Subd. 8. Commissioner's programs. Home and community-based services licensed
409.2 under this chapter for which the commissioner is the license holder with a qualifying
409.3 accreditation are excluded from being approved for an alternative licensing inspection.

409.4 EFFECTIVE DATE. This section is effective January 1, 2014.

409.5 Sec. 48. [245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.

409.6 (a) The commissioner of human services shall issue a mental health certification
409.7 for services licensed under this chapter when a license holder is determined to have met
409.8 the requirements under paragraph (b). This certification is voluntary for license holders.
409.9 The certification shall be printed on the license and identified on the commissioner's
409.10 public Web site.

409.11 (b) The requirements for certification are:

409.12 (1) all staff have received at least seven hours of annual training covering all of
409.13 the following topics:

409.14 (i) mental health diagnoses;

409.15 (ii) mental health crisis response and de-escalation techniques;

409.16 (iii) recovery from mental illness;

409.17 (iv) treatment options, including evidence-based practices;

409.18 (v) medications and their side effects;

409.19 (vi) co-occurring substance abuse and health conditions; and

409.20 (vii) community resources;

409.21 (2) a mental health professional, as defined in section 245.462, subdivision 18, or a
409.22 mental health practitioner as defined in section 245.462, subdivision 17, is available
409.23 for consultation and assistance;

409.24 (3) there is a plan and protocol in place to address a mental health crisis; and

409.25 (4) each person's individual service and support plan identifies who is providing
409.26 clinical services and their contact information, and includes an individual crisis prevention
409.27 and management plan developed with the person.

409.28 (c) License holders seeking certification under this section must request this
409.29 certification on forms and in the manner prescribed by the commissioner.

409.30 (d) If the commissioner finds that the license holder has failed to comply with the
409.31 certification requirements under paragraph (b), the commissioner may issue a correction
409.32 order and an order of conditional license in accordance with section 245A.06 or may
409.33 issue a sanction in accordance with section 245A.07, including and up to removal of
409.34 the certification.

410.1 (e) A denial of the certification or the removal of the certification based on a
410.2 determination that the requirements under paragraph (b) have not been met is not subject to
410.3 appeal. A license holder that has been denied a certification or that has had a certification
410.4 removed may again request certification when the license holder is in compliance with the
410.5 requirements of paragraph (b).

410.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

410.7 Sec. 49. Minnesota Statutes 2012, section 256B.092, subdivision 1a, is amended to read:

410.8 Subd. 1a. **Case management services.** (a) Each recipient of a home and
410.9 community-based waiver shall be provided case management services by qualified
410.10 vendors as described in the federally approved waiver application.

410.11 (b) Case management service activities provided to or arranged for a person include:

410.12 (1) development of the coordinated service and support plan under subdivision 1b;

410.13 (2) informing the individual or the individual's legal guardian or conservator, or
410.14 parent if the person is a minor, of service options;

410.15 (3) consulting with relevant medical experts or service providers;

410.16 (4) assisting the person in the identification of potential providers;

410.17 (5) assisting the person to access services and assisting in appeals under section
410.18 256.045;

410.19 (6) coordination of services, if coordination is not provided by another service
410.20 provider;

410.21 (7) evaluation and monitoring of the services identified in the coordinated service
410.22 and support plan, which must incorporate at least one annual face-to-face visit by the case
410.23 manager with each person; and

410.24 (8) reviewing coordinated service and support plans and providing the lead agency
410.25 with recommendations for service authorization based upon the individual's needs
410.26 identified in the coordinated service and support plan.

410.27 (c) Case management service activities that are provided to the person with a
410.28 developmental disability shall be provided directly by county agencies or under contract.
410.29 Case management services must be provided by a public or private agency that is enrolled
410.30 as a medical assistance provider determined by the commissioner to meet all of the
410.31 requirements in the approved federal waiver plans. Case management services must not
410.32 be provided to a recipient by a private agency that has a financial interest in the provision
410.33 of any other services included in the recipient's coordinated service and support plan. For
410.34 purposes of this section, "private agency" means any agency that is not identified as a lead
410.35 agency under section 256B.0911, subdivision 1a, paragraph (e).

411.1 (d) Case managers are responsible for service provisions listed in paragraphs (a) and
 411.2 (b). Case managers shall collaborate with consumers, families, legal representatives, and
 411.3 relevant medical experts and service providers in the development and annual review of
 411.4 the coordinated service and support plan and habilitation plan.

411.5 (e) For persons who need a positive support transition plan as required in chapter
 411.6 245D, the case manager shall participate in the development and ongoing evaluation
 411.7 of the plan with the expanded support team. At least quarterly, the case manager, in
 411.8 consultation with the expanded support team, shall evaluate the effectiveness of the plan
 411.9 based on progress evaluation data submitted by the licensed provider to the case manager.
 411.10 The evaluation must identify whether the plan has been developed and implemented in a
 411.11 manner to achieve the following within the required timelines:

411.12 (1) phasing out the use of prohibited procedures;

411.13 (2) acquisition of skills needed to eliminate the prohibited procedures within the
 411.14 plan's timeline; and

411.15 (3) accomplishment of identified outcomes.

411.16 If adequate progress is not being made, the case manager shall consult with the person's
 411.17 expanded support team to identify needed modifications and whether additional
 411.18 professional support is required to provide consultation.

411.19 ~~(e)~~ (f) The Department of Human Services shall offer ongoing education in case
 411.20 management to case managers. Case managers shall receive no less than ten hours of case
 411.21 management education and disability-related training each year.

411.22 **EFFECTIVE DATE.** This section is effective January 1, 2014.

411.23 Sec. 50. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

411.24 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
 411.25 established a new service called residential support that is available on the community
 411.26 alternative care, community alternatives for disabled individuals, developmental
 411.27 disabilities, and brain injury waivers. Existing waiver service descriptions must be
 411.28 modified to the extent necessary to ensure there is no duplication between other services.
 411.29 Residential support services must be provided by vendors licensed as a community
 411.30 residential setting as defined in section 245A.11, subdivision 8, a foster care setting
 411.31 licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care
 411.32 setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

411.33 (b) Residential support services must meet the following criteria:

411.34 ~~(1) providers of residential support services must own or control the residential site;~~

412.1 ~~(2) the residential site must not be the primary residence of the license holder;~~

412.2 ~~(3) (1) the residential site must have a designated program supervisor person~~
 412.3 responsible for program management, oversight, development, and implementation of
 412.4 policies and procedures;

412.5 ~~(4) (2) the provider of residential support services must provide supervision, training,~~
 412.6 and assistance as described in the person's coordinated service and support plan; and

412.7 ~~(5) (3) the provider of residential support services must meet the requirements of~~
 412.8 licensure and additional requirements of the person's coordinated service and support plan.

412.9 (c) Providers of residential support services that meet the definition in paragraph (a)
 412.10 ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~
 412.11 must be licensed according to chapter 245D. Providers licensed to provide child foster care
 412.12 under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under
 412.13 Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section
 412.14 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

412.15 Sec. 51. Minnesota Statutes 2012, section 256B.49, subdivision 13, is amended to read:

412.16 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
 412.17 waiver shall be provided case management services by qualified vendors as described
 412.18 in the federally approved waiver application. The case management service activities
 412.19 provided must include:

412.20 (1) finalizing the written coordinated service and support plan within ten working
 412.21 days after the case manager receives the plan from the certified assessor;

412.22 (2) informing the recipient or the recipient's legal guardian or conservator of service
 412.23 options;

412.24 (3) assisting the recipient in the identification of potential service providers and
 412.25 available options for case management service and providers;

412.26 (4) assisting the recipient to access services and assisting with appeals under section
 412.27 256.045; and

412.28 (5) coordinating, evaluating, and monitoring of the services identified in the service
 412.29 plan.

412.30 (b) The case manager may delegate certain aspects of the case management service
 412.31 activities to another individual provided there is oversight by the case manager. The case
 412.32 manager may not delegate those aspects which require professional judgment including:

412.33 (1) finalizing the coordinated service and support plan;

412.34 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
 412.35 approved coordinated service and support plan; and

413.1 (3) adjustments to the coordinated service and support plan.

413.2 (c) Case management services must be provided by a public or private agency that is
413.3 enrolled as a medical assistance provider determined by the commissioner to meet all of
413.4 the requirements in the approved federal waiver plans. Case management services must
413.5 not be provided to a recipient by a private agency that has any financial interest in the
413.6 provision of any other services included in the recipient's coordinated service and support
413.7 plan. For purposes of this section, "private agency" means any agency that is not identified
413.8 as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

413.9 (d) For persons who need a positive support transition plan as required in chapter
413.10 245D, the case manager shall participate in the development and ongoing evaluation
413.11 of the plan with the expanded support team. At least quarterly, the case manager, in
413.12 consultation with the expanded support team, shall evaluate the effectiveness of the plan
413.13 based on progress evaluation data submitted by the licensed provider to the case manager.
413.14 The evaluation must identify whether the plan has been developed and implemented in a
413.15 manner to achieve the following within the required timelines:

413.16 (1) phasing out the use of prohibited procedures;

413.17 (2) acquisition of skills needed to eliminate the prohibited procedures within the
413.18 plan's timeline; and

413.19 (3) accomplishment of identified outcomes.

413.20 If adequate progress is not being made, the case manager shall consult with the person's
413.21 expanded support team to identify needed modifications and whether additional
413.22 professional support is required to provide consultation.

413.23 **EFFECTIVE DATE.** This section is effective January 1, 2014.

413.24 Sec. 52. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

413.25 Subdivision 1. **Provider qualifications.** (a) For the home and community-based
413.26 waivers providing services to seniors and individuals with disabilities under sections
413.27 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

413.28 (1) agreements with enrolled waiver service providers to ensure providers meet
413.29 Minnesota health care program requirements;

413.30 (2) regular reviews of provider qualifications, and including requests of proof of
413.31 documentation; and

413.32 (3) processes to gather the necessary information to determine provider qualifications.

413.33 (b) Beginning July 1, 2012, staff that provide direct contact, as defined in section
413.34 245C.02, subdivision 11, for services specified in the federally approved waiver plans

414.1 must meet the requirements of chapter 245C prior to providing waiver services and as
414.2 part of ongoing enrollment. Upon federal approval, this requirement must also apply to
414.3 consumer-directed community supports.

414.4 (c) Beginning January 1, 2014, service owners and managerial officials overseeing
414.5 the management or policies of services that provide direct contact as specified in the
414.6 federally approved waiver plans must meet the requirements of chapter 245C prior to
414.7 reenrollment or, for new providers, prior to initial enrollment if they have not already done
414.8 so as a part of service licensure requirements.

414.9 Sec. 53. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:

414.10 Subd. 7. **Applicant and license holder training.** An applicant or license holder
414.11 for the home and community-based waivers providing services to seniors and individuals
414.12 with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is
414.13 not enrolled as a Minnesota health care program home and community-based services
414.14 waiver provider at the time of application must ensure that at least one controlling
414.15 individual completes a onetime training on the requirements for providing home and
414.16 community-based services from a qualified source as determined by the commissioner,
414.17 before a provider is enrolled or license is issued. Within six months of enrollment, a
414.18 newly enrolled home and community-based waiver service provider must ensure that at
414.19 least one controlling individual has completed training on waiver and related program
414.20 billing. Exemptions to new waiver provider training requirements may be granted, as
414.21 determined by the commissioner.

414.22 Sec. 54. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
414.23 subdivision to read:

414.24 Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1,
414.25 2013, facilities and services to be licensed under chapter 245D shall submit data regarding
414.26 the use of emergency use of manual restraint as identified in section 245D.061 in a format
414.27 and at a frequency identified by the commissioner.

414.28 Sec. 55. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
414.29 subdivision to read:

414.30 Subd. 9. **Definitions.** (a) For the purposes of this section, the following terms
414.31 have the meanings given them.

415.1 (b) "Controlling individual" means a public body, governmental agency, business
415.2 entity, officer, owner, or managerial official whose responsibilities include the direction of
415.3 the management or policies of a program.

415.4 (c) "Managerial official" means an individual who has decision-making authority
415.5 related to the operation of the program and responsibility for the ongoing management of
415.6 or direction of the policies, services, or employees of the program.

415.7 (d) "Owner" means an individual who has direct or indirect ownership interest in
415.8 a corporation or partnership, or business association enrolling with the Department of
415.9 Human Services as a provider of waiver services.

415.10 Sec. 56. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
415.11 subdivision to read:

415.12 Subd. 10. **Enrollment requirements.** All home and community-based waiver
415.13 providers must provide, at the time of enrollment and within 30 days of a request, in a
415.14 format determined by the commissioner, information and documentation that includes, but
415.15 is not limited to, the following:

415.16 (1) proof of surety bond coverage in the amount of \$50,000 or ten percent of the
415.17 provider's payments from Medicaid in the previous calendar year, whichever is greater;

415.18 (2) proof of fidelity bond coverage in the amount of \$20,000; and

415.19 (3) proof of liability insurance.

415.20 Sec. 57. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:

415.21 **Subd. 9a. Evaluation and referral of reports made to common entry point unit.**

415.22 The common entry point must screen the reports of alleged or suspected maltreatment for
415.23 immediate risk and make all necessary referrals as follows:

415.24 (1) if the common entry point determines that there is an immediate need for
415.25 adult protective services, the common entry point agency shall immediately notify the
415.26 appropriate county agency;

415.27 (2) if the report contains suspected criminal activity against a vulnerable adult, the
415.28 common entry point shall immediately notify the appropriate law enforcement agency;

415.29 (3) the common entry point shall refer all reports of alleged or suspected
415.30 maltreatment to the appropriate lead investigative agency as soon as possible, but in any
415.31 event no longer than two working days; and

415.32 ~~(4) if the report involves services licensed by the Department of Human Services~~
415.33 ~~and subject to chapter 245D, the common entry point shall refer the report to the county as~~

416.1 ~~the lead agency according to clause (3), but shall also notify the Department of Human~~
416.2 ~~Services of the report; and~~

416.3 ~~(5)~~ (4) if the report contains information about a suspicious death, the common
416.4 entry point shall immediately notify the appropriate law enforcement agencies, the local
416.5 medical examiner, and the ombudsman for mental health and developmental disabilities
416.6 established under section 245.92. Law enforcement agencies shall coordinate with the
416.7 local medical examiner and the ombudsman as provided by law.

416.8 Sec. 58. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:

416.9 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
416.10 administrative agency responsible for investigating reports made under section 626.557.

416.11 (a) The Department of Health is the lead investigative agency for facilities or
416.12 services licensed or required to be licensed as hospitals, home care providers, nursing
416.13 homes, boarding care homes, hospice providers, residential facilities that are also federally
416.14 certified as intermediate care facilities that serve people with developmental disabilities,
416.15 or any other facility or service not listed in this subdivision that is licensed or required to
416.16 be licensed by the Department of Health for the care of vulnerable adults. "Home care
416.17 provider" has the meaning provided in section 144A.43, subdivision 4, and applies when
416.18 care or services are delivered in the vulnerable adult's home, whether a private home or a
416.19 housing with services establishment registered under chapter 144D, including those that
416.20 offer assisted living services under chapter 144G.

416.21 (b) ~~Except as provided under paragraph (c), for services licensed according to chapter~~
416.22 ~~245D,~~ The Department of Human Services is the lead investigative agency for facilities or
416.23 services licensed or required to be licensed as adult day care, adult foster care, community
416.24 residential settings, programs for people with ~~developmental~~ disabilities, family adult day
416.25 services, mental health programs, mental health clinics, chemical dependency programs,
416.26 the Minnesota sex offender program, or any other facility or service not listed in this
416.27 subdivision that is licensed or required to be licensed by the Department of Human Services.

416.28 (c) The county social service agency or its designee is the lead investigative agency
416.29 for all other reports, including, but not limited to, reports involving vulnerable adults
416.30 receiving services from a personal care provider organization under section 256B.0659;
416.31 ~~or receiving home and community-based services licensed by the Department of Human~~
416.32 ~~Services and subject to chapter 245D.~~

416.33 Sec. 59. **REPORT ON TRANSFER OF VULNERABLE ADULT**
416.34 **MALTREATMENT INVESTIGATION DUTIES.**

417.1 (a) The commissioner of human services shall provide a follow-up report on the
417.2 collection of fees and actual licensing and maltreatment investigation costs resulting from
417.3 the reform of the standards and oversight for home and community-based services as
417.4 adopted and funded by the 2013 legislature.

417.5 (b) The report must identify actual fees collected based on provider revenue,
417.6 distinguish the amount of fees collected based on non-medical assistance revenue, and
417.7 determine the impact of the non-medical assistance revenue on future licensing fees.

417.8 (c) The report must recommend how maltreatment investigations, when conducted
417.9 by the commissioner of human services, should be funded and at what amount. The
417.10 recommendation must identify whether maltreatment investigation costs should be
417.11 recovered through licensure fees, an appropriation from the general fund, provider
417.12 finances for substantiated maltreatment, licensing fee surcharges related to substantiated
417.13 maltreatment, or a combination of these sources.

417.14 (d) The report must contain a cost comparison between similar maltreatment
417.15 investigations completed by the Minnesota Department of Health and the Department of
417.16 Human Services, and describe the method of funding for the investigations conducted by
417.17 the Department of Health.

417.18 (e) The report must make recommendations for changes that the commissioner
417.19 determines are appropriate to reduce the costs of maltreatment investigations.

417.20 (f) The commissioner must submit the report with draft legislation proposing
417.21 alternative fees, if necessary, to the chairs and ranking minority members of the legislative
417.22 committees with jurisdiction over health and human services policy and finance by July
417.23 1, 2015.

417.24 **Sec. 60. INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
417.25 **AND COMMUNITY-BASED SERVICES.**

417.26 (a) The Department of Health Compliance Monitoring Division and the Department
417.27 of Human Services Licensing Division shall jointly develop an integrated licensing system
417.28 for providers of both home care services subject to licensure under Minnesota Statutes,
417.29 chapter 144A, and for home and community-based services subject to licensure under
417.30 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

417.31 (1) require only one license of any provider of services under Minnesota Statutes,
417.32 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

417.33 (2) promote quality services that recognize a person's individual needs and protect
417.34 the person's health, safety, rights, and well-being;

418.1 (3) promote provider accountability through application requirements, compliance
418.2 inspections, investigations, and enforcement actions;

418.3 (4) reference other applicable requirements in existing state and federal laws,
418.4 including the federal Affordable Care Act;

418.5 (5) establish internal procedures to facilitate ongoing communications between the
418.6 agencies and with providers and services recipients about the regulatory activities;

418.7 (6) create a link between the agency Web sites so that providers and the public can
418.8 access the same information regardless of which Web site is accessed initially; and

418.9 (7) collect data on identified outcome measures as necessary for the agencies to
418.10 report to the Centers for Medicare and Medicaid Services.

418.11 (b) The joint recommendations for legislative changes to implement the integrated
418.12 licensing system are due to the legislature by February 15, 2014.

418.13 (c) Before implementation of the integrated licensing system, providers licensed as
418.14 home care providers under Minnesota Statutes, chapter 144A, may also provide home
418.15 and community-based services subject to licensure under Minnesota Statutes, chapter
418.16 245D, without obtaining a home and community-based services license under Minnesota
418.17 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
418.18 apply to these providers:

418.19 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
418.20 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

418.21 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
418.22 enforced by the Department of Health under the enforcement authority set forth in
418.23 Minnesota Statutes, section 144A.475; and

418.24 (3) the Department of Health will provide information to the Department of Human
418.25 Services about each provider licensed under this section, including the provider's license
418.26 application, licensing documents, inspections, information about complaints received, and
418.27 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

418.28 **Sec. 61. REPEALER.**

418.29 (a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031;
418.30 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and
418.31 245B.08, are repealed effective January 1, 2014.

418.32 (b) Minnesota Statutes 2012, section 245D.08, is repealed.

419.1 **ARTICLE 9**

419.2 **WAIVER PROVIDER STANDARDS TECHNICAL CHANGES**

419.3 Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:

419.4 Subd. 5. **Specific purchases.** The solicitation process described in this chapter is
419.5 not required for acquisition of the following:

419.6 (1) merchandise for resale purchased under policies determined by the commissioner;

419.7 (2) farm and garden products which, as determined by the commissioner, may be
419.8 purchased at the prevailing market price on the date of sale;

419.9 (3) goods and services from the Minnesota correctional facilities;

419.10 (4) goods and services from rehabilitation facilities and extended employment
419.11 providers that are certified by the commissioner of employment and economic
419.12 development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01~~
419.13 ~~to 245B.08~~ chapter 245D;

419.14 (5) goods and services for use by a community-based facility operated by the
419.15 commissioner of human services;

419.16 (6) goods purchased at auction or when submitting a sealed bid at auction provided
419.17 that before authorizing such an action, the commissioner consult with the requesting
419.18 agency to determine a fair and reasonable value for the goods considering factors
419.19 including, but not limited to, costs associated with submitting a bid, travel, transportation,
419.20 and storage. This fair and reasonable value must represent the limit of the state's bid;

419.21 (7) utility services where no competition exists or where rates are fixed by law or
419.22 ordinance; and

419.23 (8) goods and services from Minnesota sex offender program facilities.

419.24 **EFFECTIVE DATE.** This section is effective January 1, 2014.

419.25 Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:

419.26 Subdivision 1. **Service contracts.** The commissioner of administration shall
419.27 ensure that a portion of all contracts for janitorial services; document imaging;
419.28 document shredding; and mailing, collating, and sorting services be awarded by the
419.29 state to rehabilitation programs and extended employment providers that are certified
419.30 by the commissioner of employment and economic development, and day ~~training and~~
419.31 ~~habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D. The
419.32 amount of each contract awarded under this section may exceed the estimated fair market
419.33 price as determined by the commissioner for the same goods and services by up to six
419.34 percent. The aggregate value of the contracts awarded to eligible providers under this

420.1 section in any given year must exceed 19 percent of the total value of all contracts for
420.2 janitorial services; document imaging; document shredding; and mailing, collating, and
420.3 sorting services entered into in the same year. For the 19 percent requirement to be
420.4 applicable in any given year, the contract amounts proposed by eligible providers must be
420.5 within six percent of the estimated fair market price for at least 19 percent of the contracts
420.6 awarded for the corresponding service area.

420.7 **EFFECTIVE DATE.** This section is effective January 1, 2014.

420.8 Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:

420.9 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing
420.10 with services establishment" or "establishment" means:

420.11 (1) an establishment providing sleeping accommodations to one or more adult
420.12 residents, at least 80 percent of which are 55 years of age or older, and offering or
420.13 providing, for a fee, one or more regularly scheduled health-related services or two or
420.14 more regularly scheduled supportive services, whether offered or provided directly by the
420.15 establishment or by another entity arranged for by the establishment; or

420.16 (2) an establishment that registers under section 144D.025.

420.17 (b) Housing with services establishment does not include:

420.18 (1) a nursing home licensed under chapter 144A;

420.19 (2) a hospital, certified boarding care home, or supervised living facility licensed
420.20 under sections 144.50 to 144.56;

420.21 (3) a board and lodging establishment licensed under chapter 157 and Minnesota
420.22 Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660,
420.23 or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;

420.24 (4) a board and lodging establishment which serves as a shelter for battered women
420.25 or other similar purpose;

420.26 (5) a family adult foster care home licensed by the Department of Human Services;

420.27 (6) private homes in which the residents are related by kinship, law, or affinity with
420.28 the providers of services;

420.29 (7) residential settings for persons with developmental disabilities in which the
420.30 services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable
420.31 successor rules or laws;

420.32 (8) a home-sharing arrangement such as when an elderly or disabled person or
420.33 single-parent family makes lodging in a private residence available to another person
420.34 in exchange for services or rent, or both;

421.1 (9) a duly organized condominium, cooperative, common interest community, or
421.2 owners' association of the foregoing where at least 80 percent of the units that comprise the
421.3 condominium, cooperative, or common interest community are occupied by individuals
421.4 who are the owners, members, or shareholders of the units; or

421.5 (10) services for persons with developmental disabilities that are provided under
421.6 a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until
421.7 January 1, 1998, or under chapter ~~245B~~ 245D.

421.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

421.9 Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:

421.10 Subdivision 1. **Applicability.** (a) The operating standards for special transportation
421.11 service adopted under this section do not apply to special transportation provided by:

421.12 (1) a common carrier operating on fixed routes and schedules;

421.13 (2) a volunteer driver using a private automobile;

421.14 (3) a school bus as defined in section 169.011, subdivision 71; or

421.15 (4) an emergency ambulance regulated under chapter 144.

421.16 (b) The operating standards adopted under this section only apply to providers
421.17 of special transportation service who receive grants or other financial assistance from
421.18 either the state or the federal government, or both, to provide or assist in providing that
421.19 service; except that the operating standards adopted under this section do not apply
421.20 to any nursing home licensed under section 144A.02, to any board and care facility
421.21 licensed under section 144.50, or to any day training and habilitation services, day care,
421.22 or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or
421.23 program provides transportation to nonresidents on a regular basis and the facility receives
421.24 reimbursement, other than per diem payments, for that service under rules promulgated
421.25 by the commissioner of human services.

421.26 (c) Notwithstanding paragraph (b), the operating standards adopted under this
421.27 section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that
421.28 provides transportation services to consumers or residents of other vendors licensed under
421.29 chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents
421.30 and the driver.

421.31 **EFFECTIVE DATE.** This section is effective January 1, 2014.

421.32 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:

422.1 Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the
422.2 meanings given them in this section.

422.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

422.4 Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:

422.5 Subd. 9. **License holder.** "License holder" means an individual, corporation,
422.6 partnership, voluntary association, or other organization that is legally responsible for the
422.7 operation of the program, has been granted a license by the commissioner under this chapter
422.8 or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

422.9 **EFFECTIVE DATE.** This section is effective January 1, 2014.

422.10 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

422.11 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
422.12 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
422.13 person receiving supported living services may provide licensed services to that person if:

422.14 (1) the person who receives supported living services received these services in a
422.15 residential site on July 1, 2005;

422.16 (2) the services under clause (1) were provided in a corporate foster care setting for
422.17 adults and were funded by the developmental disabilities home and community-based
422.18 services waiver defined in section 256B.092;

422.19 (3) the individual who is related obtains and maintains both a license under chapter
422.20 ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105
422.21 to 9555.6265; and

422.22 (4) the individual who is related is not the guardian of the person receiving supported
422.23 living services.

422.24 **EFFECTIVE DATE.** This section is effective January 1, 2014.

422.25 Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:

422.26 Subd. 13. **Funds and property; other requirements.** (a) A license holder must
422.27 ensure that persons served by the program retain the use and availability of personal funds
422.28 or property unless restrictions are justified in the person's individual plan. ~~This subdivision~~
422.29 ~~does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~

422.30 (b) The license holder must ensure separation of funds of persons served by the
422.31 program from funds of the license holder, the program, or program staff.

423.1 (c) Whenever the license holder assists a person served by the program with the
423.2 safekeeping of funds or other property, the license holder must:

423.3 (1) immediately document receipt and disbursement of the person's funds or other
423.4 property at the time of receipt or disbursement, including the person's signature, or the
423.5 signature of the conservator or payee; and

423.6 (2) return to the person upon the person's request, funds and property in the license
423.7 holder's possession subject to restrictions in the person's treatment plan, as soon as
423.8 possible, but no later than three working days after the date of request.

423.9 (d) License holders and program staff must not:

423.10 (1) borrow money from a person served by the program;

423.11 (2) purchase personal items from a person served by the program;

423.12 (3) sell merchandise or personal services to a person served by the program;

423.13 (4) require a person served by the program to purchase items for which the license
423.14 holder is eligible for reimbursement; or

423.15 (5) use funds of persons served by the program to purchase items for which the
423.16 facility is already receiving public or private payments.

423.17 **EFFECTIVE DATE.** This section is effective January 1, 2014.

423.18 Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:

423.19 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may
423.20 suspend or revoke a license, or impose a fine if:

423.21 (1) a license holder fails to comply fully with applicable laws or rules;

423.22 (2) a license holder, a controlling individual, or an individual living in the household
423.23 where the licensed services are provided or is otherwise subject to a background study has
423.24 a disqualification which has not been set aside under section 245C.22;

423.25 (3) a license holder knowingly withholds relevant information from or gives false
423.26 or misleading information to the commissioner in connection with an application for
423.27 a license, in connection with the background study status of an individual, during an
423.28 investigation, or regarding compliance with applicable laws or rules; or

423.29 (4) after July 1, 2012, and upon request by the commissioner, a license holder fails
423.30 to submit the information required of an applicant under section 245A.04, subdivision 1,
423.31 paragraph (f) or (g).

423.32 A license holder who has had a license suspended, revoked, or has been ordered
423.33 to pay a fine must be given notice of the action by certified mail or personal service. If
423.34 mailed, the notice must be mailed to the address shown on the application or the last

424.1 known address of the license holder. The notice must state the reasons the license was
424.2 suspended, revoked, or a fine was ordered.

424.3 (b) If the license was suspended or revoked, the notice must inform the license
424.4 holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
424.5 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
424.6 a license. The appeal of an order suspending or revoking a license must be made in writing
424.7 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
424.8 the commissioner within ten calendar days after the license holder receives notice that the
424.9 license has been suspended or revoked. If a request is made by personal service, it must be
424.10 received by the commissioner within ten calendar days after the license holder received
424.11 the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits
424.12 a timely appeal of an order suspending or revoking a license, the license holder may
424.13 continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs
424.14 (g) and (h), until the commissioner issues a final order on the suspension or revocation.

424.15 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the
424.16 license holder of the responsibility for payment of fines and the right to a contested case
424.17 hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal
424.18 of an order to pay a fine must be made in writing by certified mail or personal service. If
424.19 mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
424.20 days after the license holder receives notice that the fine has been ordered. If a request is
424.21 made by personal service, it must be received by the commissioner within ten calendar
424.22 days after the license holder received the order.

424.23 (2) The license holder shall pay the fines assessed on or before the payment date
424.24 specified. If the license holder fails to fully comply with the order, the commissioner
424.25 may issue a second fine or suspend the license until the license holder complies. If the
424.26 license holder receives state funds, the state, county, or municipal agencies or departments
424.27 responsible for administering the funds shall withhold payments and recover any payments
424.28 made while the license is suspended for failure to pay a fine. A timely appeal shall stay
424.29 payment of the fine until the commissioner issues a final order.

424.30 (3) A license holder shall promptly notify the commissioner of human services,
424.31 in writing, when a violation specified in the order to forfeit a fine is corrected. If upon
424.32 reinspection the commissioner determines that a violation has not been corrected as
424.33 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
424.34 commissioner shall notify the license holder by certified mail or personal service that a
424.35 second fine has been assessed. The license holder may appeal the second fine as provided
424.36 under this subdivision.

425.1 (4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for
425.2 each determination of maltreatment of a child under section 626.556 or the maltreatment
425.3 of a vulnerable adult under section 626.557 for which the license holder is determined
425.4 responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i),
425.5 or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit \$200 for each
425.6 occurrence of a violation of law or rule governing matters of health, safety, or supervision,
425.7 including but not limited to the provision of adequate staff-to-child or adult ratios, and
425.8 failure to comply with background study requirements under chapter 245C; and the license
425.9 holder shall forfeit \$100 for each occurrence of a violation of law or rule other than
425.10 those subject to a \$1,000 or \$200 fine above. For purposes of this section, "occurrence"
425.11 means each violation identified in the commissioner's fine order. Fines assessed against a
425.12 license holder that holds a license to provide ~~the residential-based habilitation home and~~
425.13 community-based services, as defined under identified in section 245B.02, subdivision
425.14 20 245D.03, subdivision 1, and a community residential setting or day services facility
425.15 license to provide foster care under chapter 245D where the services are provided, may be
425.16 assessed against both licenses for the same occurrence, but the combined amount of the
425.17 fines shall not exceed the amount specified in this clause for that occurrence.

425.18 (5) When a fine has been assessed, the license holder may not avoid payment by
425.19 closing, selling, or otherwise transferring the licensed program to a third party. In such an
425.20 event, the license holder will be personally liable for payment. In the case of a corporation,
425.21 each controlling individual is personally and jointly liable for payment.

425.22 (d) Except for background study violations involving the failure to comply with an
425.23 order to immediately remove an individual or an order to provide continuous, direct
425.24 supervision, the commissioner shall not issue a fine under paragraph (c) relating to a
425.25 background study violation to a license holder who self-corrects a background study
425.26 violation before the commissioner discovers the violation. A license holder who has
425.27 previously exercised the provisions of this paragraph to avoid a fine for a background
425.28 study violation may not avoid a fine for a subsequent background study violation unless at
425.29 least 365 days have passed since the license holder self-corrected the earlier background
425.30 study violation.

425.31 **EFFECTIVE DATE.** This section is effective January 1, 2014.

425.32 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to
425.33 read:

425.34 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance
425.35 services provided by an individual who is qualified to provide the services according to

426.1 subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a
426.2 plan, and supervised by a qualified professional.

426.3 "Qualified professional" means a mental health professional as defined in section
426.4 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
426.5 or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker
426.6 as defined in sections 148E.010 and 148E.055, or a qualified ~~developmental disabilities~~
426.7 ~~specialist under section 245B.07, subdivision 4~~ designated coordinator under section
426.8 245D.081, subdivision 2. The qualified professional shall perform the duties required in
426.9 section 256B.0659.

426.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

426.11 Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

426.12 Subd. 2. **Contract provisions.** (a) The service contract with each intermediate
426.13 care facility must include provisions for:

426.14 (1) modifying payments when significant changes occur in the needs of the
426.15 consumers;

426.16 (2) appropriate and necessary statistical information required by the commissioner;

426.17 (3) annual aggregate facility financial information; and

426.18 (4) additional requirements for intermediate care facilities not meeting the standards
426.19 set forth in the service contract.

426.20 (b) The commissioner of human services and the commissioner of health, in
426.21 consultation with representatives from counties, advocacy organizations, and the provider
426.22 community, shall review ~~the consolidated standards under chapter 245B and the home and~~
426.23 community-based services standards under chapter 245D and the supervised living facility
426.24 rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota
426.25 Rules, chapter 4665, may be waived by the commissioner of health for intermediate care
426.26 facilities in order to enable facilities to implement the performance measures in their
426.27 contract and provide quality services to residents without a duplication of or increase in
426.28 regulatory requirements.

426.29 **EFFECTIVE DATE.** This section is effective January 1, 2014.

426.30 Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:

426.31 Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered
426.32 into through action of their governing bodies, may jointly or cooperatively exercise
426.33 any power common to the contracting parties or any similar powers, including those

427.1 which are the same except for the territorial limits within which they may be exercised.
427.2 The agreement may provide for the exercise of such powers by one or more of the
427.3 participating governmental units on behalf of the other participating units. The term
427.4 "governmental unit" as used in this section includes every city, county, town, school
427.5 district, independent nonprofit firefighting corporation, other political subdivision of
427.6 this or another state, another state, federally recognized Indian tribe, the University
427.7 of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under
427.8 sections 144.50 to 144.56, rehabilitation facilities and extended employment providers
427.9 that are certified by the commissioner of employment and economic development, ~~day~~
427.10 ~~training and habilitation services licensed under sections 245B.01 to 245B.08, day and~~
427.11 ~~supported employment services licensed under chapter 245D,~~ and any agency of the state
427.12 of Minnesota or the United States, and includes any instrumentality of a governmental
427.13 unit. For the purpose of this section, an instrumentality of a governmental unit means an
427.14 instrumentality having independent policy-making and appropriating authority.

427.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

427.16 Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:

427.17 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
427.18 given them unless the specific content indicates otherwise:

427.19 (a) "Family assessment" means a comprehensive assessment of child safety, risk
427.20 of subsequent child maltreatment, and family strengths and needs that is applied to a
427.21 child maltreatment report that does not allege substantial child endangerment. Family
427.22 assessment does not include a determination as to whether child maltreatment occurred
427.23 but does determine the need for services to address the safety of family members and the
427.24 risk of subsequent maltreatment.

427.25 (b) "Investigation" means fact gathering related to the current safety of a child
427.26 and the risk of subsequent maltreatment that determines whether child maltreatment
427.27 occurred and whether child protective services are needed. An investigation must be used
427.28 when reports involve substantial child endangerment, and for reports of maltreatment in
427.29 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
427.30 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
427.31 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
427.32 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

427.33 (c) "Substantial child endangerment" means a person responsible for a child's care,
427.34 and in the case of sexual abuse includes a person who has a significant relationship to the
427.35 child as defined in section 609.341, or a person in a position of authority as defined in

428.1 section 609.341, who by act or omission commits or attempts to commit an act against a
428.2 child under their care that constitutes any of the following:

428.3 (1) egregious harm as defined in section 260C.007, subdivision 14;

428.4 (2) sexual abuse as defined in paragraph (d);

428.5 (3) abandonment under section 260C.301, subdivision 2;

428.6 (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the
428.7 child's physical or mental health, including a growth delay, which may be referred to as
428.8 failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

428.9 (5) murder in the first, second, or third degree under section 609.185, 609.19, or
428.10 609.195;

428.11 (6) manslaughter in the first or second degree under section 609.20 or 609.205;

428.12 (7) assault in the first, second, or third degree under section 609.221, 609.222, or
428.13 609.223;

428.14 (8) solicitation, inducement, and promotion of prostitution under section 609.322;

428.15 (9) criminal sexual conduct under sections 609.342 to 609.3451;

428.16 (10) solicitation of children to engage in sexual conduct under section 609.352;

428.17 (11) malicious punishment or neglect or endangerment of a child under section
428.18 609.377 or 609.378;

428.19 (12) use of a minor in sexual performance under section 617.246; or

428.20 (13) parental behavior, status, or condition which mandates that the county attorney
428.21 file a termination of parental rights petition under section 260C.301, subdivision 3,
428.22 paragraph (a).

428.23 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
428.24 child's care, by a person who has a significant relationship to the child, as defined in
428.25 section 609.341, or by a person in a position of authority, as defined in section 609.341,
428.26 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
428.27 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),
428.28 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
428.29 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
428.30 abuse also includes any act which involves a minor which constitutes a violation of
428.31 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
428.32 threatened sexual abuse which includes the status of a parent or household member
428.33 who has committed a violation which requires registration as an offender under section
428.34 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section
428.35 243.166, subdivision 1b, paragraph (a) or (b).

429.1 (e) "Person responsible for the child's care" means (1) an individual functioning
429.2 within the family unit and having responsibilities for the care of the child such as a
429.3 parent, guardian, or other person having similar care responsibilities, or (2) an individual
429.4 functioning outside the family unit and having responsibilities for the care of the child
429.5 such as a teacher, school administrator, other school employees or agents, or other lawful
429.6 custodian of a child having either full-time or short-term care responsibilities including,
429.7 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
429.8 and coaching.

429.9 (f) "Neglect" means the commission or omission of any of the acts specified under
429.10 clauses (1) to (9), other than by accidental means:

429.11 (1) failure by a person responsible for a child's care to supply a child with necessary
429.12 food, clothing, shelter, health, medical, or other care required for the child's physical or
429.13 mental health when reasonably able to do so;

429.14 (2) failure to protect a child from conditions or actions that seriously endanger the
429.15 child's physical or mental health when reasonably able to do so, including a growth delay,
429.16 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
429.17 is due to parental neglect;

429.18 (3) failure to provide for necessary supervision or child care arrangements
429.19 appropriate for a child after considering factors as the child's age, mental ability, physical
429.20 condition, length of absence, or environment, when the child is unable to care for the
429.21 child's own basic needs or safety, or the basic needs or safety of another child in their care;

429.22 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
429.23 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
429.24 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

429.25 (5) nothing in this section shall be construed to mean that a child is neglected solely
429.26 because the child's parent, guardian, or other person responsible for the child's care in
429.27 good faith selects and depends upon spiritual means or prayer for treatment or care of
429.28 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,
429.29 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
429.30 if a lack of medical care may cause serious danger to the child's health. This section does
429.31 not impose upon persons, not otherwise legally responsible for providing a child with
429.32 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

429.33 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
429.34 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
429.35 symptoms in the child at birth, results of a toxicology test performed on the mother at
429.36 delivery or the child at birth, medical effects or developmental delays during the child's

430.1 first year of life that medically indicate prenatal exposure to a controlled substance, or the
430.2 presence of a fetal alcohol spectrum disorder;

430.3 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

430.4 (8) chronic and severe use of alcohol or a controlled substance by a parent or
430.5 person responsible for the care of the child that adversely affects the child's basic needs
430.6 and safety; or

430.7 (9) emotional harm from a pattern of behavior which contributes to impaired
430.8 emotional functioning of the child which may be demonstrated by a substantial and
430.9 observable effect in the child's behavior, emotional response, or cognition that is not
430.10 within the normal range for the child's age and stage of development, with due regard to
430.11 the child's culture.

430.12 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,
430.13 inflicted by a person responsible for the child's care on a child other than by accidental
430.14 means, or any physical or mental injury that cannot reasonably be explained by the child's
430.15 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
430.16 that have not been authorized under section 121A.67 or 245.825.

430.17 Abuse does not include reasonable and moderate physical discipline of a child
430.18 administered by a parent or legal guardian which does not result in an injury. Abuse does
430.19 not include the use of reasonable force by a teacher, principal, or school employee as
430.20 allowed by section 121A.582. Actions which are not reasonable and moderate include,
430.21 but are not limited to, any of the following that are done in anger or without regard to the
430.22 safety of the child:

430.23 (1) throwing, kicking, burning, biting, or cutting a child;

430.24 (2) striking a child with a closed fist;

430.25 (3) shaking a child under age three;

430.26 (4) striking or other actions which result in any nonaccidental injury to a child
430.27 under 18 months of age;

430.28 (5) unreasonable interference with a child's breathing;

430.29 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

430.30 (7) striking a child under age one on the face or head;

430.31 (8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
430.32 substances which were not prescribed for the child by a practitioner, in order to control or
430.33 punish the child; or other substances that substantially affect the child's behavior, motor
430.34 coordination, or judgment or that results in sickness or internal injury, or subjects the
430.35 child to medical procedures that would be unnecessary if the child were not exposed
430.36 to the substances;

431.1 (9) unreasonable physical confinement or restraint not permitted under section
431.2 609.379, including but not limited to tying, caging, or chaining; or

431.3 (10) in a school facility or school zone, an act by a person responsible for the child's
431.4 care that is a violation under section 121A.58.

431.5 (h) "Report" means any report received by the local welfare agency, police
431.6 department, county sheriff, or agency responsible for assessing or investigating
431.7 maltreatment pursuant to this section.

431.8 (i) "Facility" means:

431.9 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
431.10 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
431.11 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;

431.12 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
431.13 124D.10; or

431.14 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
431.15 subdivision 16, and 256B.0625, subdivision 19a.

431.16 (j) "Operator" means an operator or agency as defined in section 245A.02.

431.17 (k) "Commissioner" means the commissioner of human services.

431.18 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
431.19 not limited to employee assistance counseling and the provision of guardian ad litem and
431.20 parenting time expeditor services.

431.21 (m) "Mental injury" means an injury to the psychological capacity or emotional
431.22 stability of a child as evidenced by an observable or substantial impairment in the child's
431.23 ability to function within a normal range of performance and behavior with due regard to
431.24 the child's culture.

431.25 (n) "Threatened injury" means a statement, overt act, condition, or status that
431.26 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
431.27 injury includes, but is not limited to, exposing a child to a person responsible for the
431.28 child's care, as defined in paragraph (e), clause (1), who has:

431.29 (1) subjected a child to, or failed to protect a child from, an overt act or condition
431.30 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
431.31 similar law of another jurisdiction;

431.32 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
431.33 (4), or a similar law of another jurisdiction;

431.34 (3) committed an act that has resulted in an involuntary termination of parental rights
431.35 under section 260C.301, or a similar law of another jurisdiction; or

432.1 (4) committed an act that has resulted in the involuntary transfer of permanent
432.2 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section
432.3 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a
432.4 similar law of another jurisdiction.

432.5 A child is the subject of a report of threatened injury when the responsible social
432.6 services agency receives birth match data under paragraph (o) from the Department of
432.7 Human Services.

432.8 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a
432.9 birth record or recognition of parentage identifying a child who is subject to threatened
432.10 injury under paragraph (n), the Department of Human Services shall send the data to the
432.11 responsible social services agency. The data is known as "birth match" data. Unless the
432.12 responsible social services agency has already begun an investigation or assessment of the
432.13 report due to the birth of the child or execution of the recognition of parentage and the
432.14 parent's previous history with child protection, the agency shall accept the birth match
432.15 data as a report under this section. The agency may use either a family assessment or
432.16 investigation to determine whether the child is safe. All of the provisions of this section
432.17 apply. If the child is determined to be safe, the agency shall consult with the county
432.18 attorney to determine the appropriateness of filing a petition alleging the child is in need
432.19 of protection or services under section 260C.007, subdivision 6, clause (16), in order to
432.20 deliver needed services. If the child is determined not to be safe, the agency and the county
432.21 attorney shall take appropriate action as required under section 260C.301, subdivision 3.

432.22 (p) Persons who conduct assessments or investigations under this section shall take
432.23 into account accepted child-rearing practices of the culture in which a child participates
432.24 and accepted teacher discipline practices, which are not injurious to the child's health,
432.25 welfare, and safety.

432.26 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected
432.27 occurrence or event which:

432.28 (1) is not likely to occur and could not have been prevented by exercise of due
432.29 care; and

432.30 (2) if occurring while a child is receiving services from a facility, happens when the
432.31 facility and the employee or person providing services in the facility are in compliance
432.32 with the laws and rules relevant to the occurrence or event.

432.33 (r) "Nonmaltreatment mistake" means:

432.34 (1) at the time of the incident, the individual was performing duties identified in the
432.35 center's child care program plan required under Minnesota Rules, part 9503.0045;

433.1 (2) the individual has not been determined responsible for a similar incident that
433.2 resulted in a finding of maltreatment for at least seven years;

433.3 (3) the individual has not been determined to have committed a similar
433.4 nonmaltreatment mistake under this paragraph for at least four years;

433.5 (4) any injury to a child resulting from the incident, if treated, is treated only with
433.6 remedies that are available over the counter, whether ordered by a medical professional or
433.7 not; and

433.8 (5) except for the period when the incident occurred, the facility and the individual
433.9 providing services were both in compliance with all licensing requirements relevant to the
433.10 incident.

433.11 This definition only applies to child care centers licensed under Minnesota
433.12 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of
433.13 substantiated maltreatment by the individual, the commissioner of human services shall
433.14 determine that a nonmaltreatment mistake was made by the individual.

433.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

433.16 Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:

433.17 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
433.18 to believe a child is being neglected or physically or sexually abused, as defined in
433.19 subdivision 2, or has been neglected or physically or sexually abused within the preceding
433.20 three years, shall immediately report the information to the local welfare agency, agency
433.21 responsible for assessing or investigating the report, police department, or the county
433.22 sheriff if the person is:

433.23 (1) a professional or professional's delegate who is engaged in the practice of
433.24 the healing arts, social services, hospital administration, psychological or psychiatric
433.25 treatment, child care, education, correctional supervision, probation and correctional
433.26 services, or law enforcement; or

433.27 (2) employed as a member of the clergy and received the information while
433.28 engaged in ministerial duties, provided that a member of the clergy is not required by
433.29 this subdivision to report information that is otherwise privileged under section 595.02,
433.30 subdivision 1, paragraph (c).

433.31 The police department or the county sheriff, upon receiving a report, shall
433.32 immediately notify the local welfare agency or agency responsible for assessing or
433.33 investigating the report, orally and in writing. The local welfare agency, or agency
433.34 responsible for assessing or investigating the report, upon receiving a report, shall
433.35 immediately notify the local police department or the county sheriff orally and in writing.

434.1 The county sheriff and the head of every local welfare agency, agency responsible
434.2 for assessing or investigating reports, and police department shall each designate a
434.3 person within their agency, department, or office who is responsible for ensuring that
434.4 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
434.5 this subdivision shall be construed to require more than one report from any institution,
434.6 facility, school, or agency.

434.7 (b) Any person may voluntarily report to the local welfare agency, agency responsible
434.8 for assessing or investigating the report, police department, or the county sheriff if the
434.9 person knows, has reason to believe, or suspects a child is being or has been neglected or
434.10 subjected to physical or sexual abuse. The police department or the county sheriff, upon
434.11 receiving a report, shall immediately notify the local welfare agency or agency responsible
434.12 for assessing or investigating the report, orally and in writing. The local welfare agency or
434.13 agency responsible for assessing or investigating the report, upon receiving a report, shall
434.14 immediately notify the local police department or the county sheriff orally and in writing.

434.15 (c) A person mandated to report physical or sexual child abuse or neglect occurring
434.16 within a licensed facility shall report the information to the agency responsible for
434.17 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or
434.18 chapter ~~245B~~ 245D; or a nonlicensed personal care provider organization as defined in
434.19 sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections
434.20 agency receiving a report may request the local welfare agency to provide assistance
434.21 pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees
434.22 perform work within a school facility, upon receiving a complaint of alleged maltreatment,
434.23 shall provide information about the circumstances of the alleged maltreatment to the
434.24 commissioner of education. Section 13.03, subdivision 4, applies to data received by the
434.25 commissioner of education from a licensing entity.

434.26 (d) Any person mandated to report shall receive a summary of the disposition of
434.27 any report made by that reporter, including whether the case has been opened for child
434.28 protection or other services, or if a referral has been made to a community organization,
434.29 unless release would be detrimental to the best interests of the child. Any person who is
434.30 not mandated to report shall, upon request to the local welfare agency, receive a concise
434.31 summary of the disposition of any report made by that reporter, unless release would be
434.32 detrimental to the best interests of the child.

434.33 (e) For purposes of this section, "immediately" means as soon as possible but in
434.34 no event longer than 24 hours.

434.35 **EFFECTIVE DATE.** This section is effective January 1, 2014.

435.1 Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

435.2 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is
435.3 received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while
435.4 in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
435.5 sanitarium, or other facility or institution required to be licensed according to sections
435.6 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ 245D, or a school as
435.7 defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed
435.8 personal care provider organization as defined in section 256B.04, subdivision 16, and
435.9 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing
435.10 or investigating the report or local welfare agency investigating the report shall provide
435.11 the following information to the parent, guardian, or legal custodian of a child alleged to
435.12 have been neglected, physically abused, sexually abused, or the victim of maltreatment
435.13 of a child in the facility: the name of the facility; the fact that a report alleging neglect,
435.14 physical abuse, sexual abuse, or maltreatment of a child in the facility has been received;
435.15 the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child
435.16 in the facility; that the agency is conducting an assessment or investigation; any protective
435.17 or corrective measures being taken pending the outcome of the investigation; and that a
435.18 written memorandum will be provided when the investigation is completed.

435.19 (b) The commissioner of the agency responsible for assessing or investigating the
435.20 report or local welfare agency may also provide the information in paragraph (a) to the
435.21 parent, guardian, or legal custodian of any other child in the facility if the investigative
435.22 agency knows or has reason to believe the alleged neglect, physical abuse, sexual
435.23 abuse, or maltreatment of a child in the facility has occurred. In determining whether
435.24 to exercise this authority, the commissioner of the agency responsible for assessing
435.25 or investigating the report or local welfare agency shall consider the seriousness of the
435.26 alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the
435.27 number of children allegedly neglected, physically abused, sexually abused, or victims of
435.28 maltreatment of a child in the facility; the number of alleged perpetrators; and the length
435.29 of the investigation. The facility shall be notified whenever this discretion is exercised.

435.30 (c) When the commissioner of the agency responsible for assessing or investigating
435.31 the report or local welfare agency has completed its investigation, every parent, guardian,
435.32 or legal custodian previously notified of the investigation by the commissioner or
435.33 local welfare agency shall be provided with the following information in a written
435.34 memorandum: the name of the facility investigated; the nature of the alleged neglect,
435.35 physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's
435.36 name; a summary of the investigation findings; a statement whether maltreatment was

436.1 found; and the protective or corrective measures that are being or will be taken. The
436.2 memorandum shall be written in a manner that protects the identity of the reporter and
436.3 the child and shall not contain the name, or to the extent possible, reveal the identity of
436.4 the alleged perpetrator or of those interviewed during the investigation. If maltreatment
436.5 is determined to exist, the commissioner or local welfare agency shall also provide the
436.6 written memorandum to the parent, guardian, or legal custodian of each child in the facility
436.7 who had contact with the individual responsible for the maltreatment. When the facility is
436.8 the responsible party for maltreatment, the commissioner or local welfare agency shall also
436.9 provide the written memorandum to the parent, guardian, or legal custodian of each child
436.10 who received services in the population of the facility where the maltreatment occurred.
436.11 This notification must be provided to the parent, guardian, or legal custodian of each child
436.12 receiving services from the time the maltreatment occurred until either the individual
436.13 responsible for maltreatment is no longer in contact with a child or children in the facility
436.14 or the conclusion of the investigation. In the case of maltreatment within a school facility,
436.15 as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner
436.16 of education need not provide notification to parents, guardians, or legal custodians of
436.17 each child in the facility, but shall, within ten days after the investigation is completed,
436.18 provide written notification to the parent, guardian, or legal custodian of any student
436.19 alleged to have been maltreated. The commissioner of education may notify the parent,
436.20 guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

436.21 **EFFECTIVE DATE.** This section is effective January 1, 2014.

436.22 Sec. 16. **REPEALER.**

436.23 Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective
436.24 January 1, 2014.

436.25 **ARTICLE 10**

436.26 **HEALTH-RELATED LICENSING BOARDS**

436.27 Section 1. Minnesota Statutes 2012, section 148B.17, subdivision 2, is amended to read:

436.28 Subd. 2. **Licensure and application fees.** Nonrefundable licensure and application
436.29 fees ~~charged~~ established by the board ~~are as follows~~ shall not exceed the following amounts:

436.30 (1) application fee for national examination is ~~\$220~~ \$110;

436.31 (2) application fee for Licensed Marriage and Family Therapist (LMFT) state
436.32 examination is \$110;

436.33 (3) initial LMFT license fee is prorated, but cannot exceed \$125;

- 437.1 (4) annual renewal fee for LMFT license is \$125;
- 437.2 (5) late fee for ~~initial Licensed Associate Marriage and Family Therapist LAMFT~~
- 437.3 LMFT license renewal is \$50;
- 437.4 (6) application fee for LMFT licensure by reciprocity is ~~\$340~~ \$220;
- 437.5 (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT)
- 437.6 license is \$75;
- 437.7 (8) annual renewal fee for LAMFT license is \$75;
- 437.8 (9) late fee for LAMFT renewal is ~~\$50~~ \$25;
- 437.9 (10) fee for reinstatement of license is \$150; and
- 437.10 (11) fee for emeritus status is \$125.

437.11 Sec. 2. Minnesota Statutes 2012, section 151.19, subdivision 1, is amended to read:

437.12 Subdivision 1. **Pharmacy registration licensure requirements.** ~~The board shall~~

437.13 ~~require and provide for the annual registration of every pharmacy now or hereafter doing~~

437.14 ~~business within this state. Upon the payment of any applicable fee specified in section~~

437.15 ~~151.065, the board shall issue a registration certificate in such form as it may prescribe to~~

437.16 ~~such persons as may be qualified by law to conduct a pharmacy. Such certificate shall~~

437.17 ~~be displayed in a conspicuous place in the pharmacy for which it is issued and expire on~~

437.18 ~~the 30th day of June following the date of issue. It shall be unlawful for any person to~~

437.19 ~~conduct a pharmacy unless such certificate has been issued to the person by the board. (a)~~

437.20 No person shall operate a pharmacy without first obtaining a license from the board and

437.21 paying any applicable fee specified in section 151.065. The license shall be displayed in a

437.22 conspicuous place in the pharmacy for which it is issued and expires on June 30 following

437.23 the date of issue. It is unlawful for any person to operate a pharmacy unless the license

437.24 has been issued to the person by the board.

437.25 (b) Application for a pharmacy license under this section shall be made in a manner

437.26 specified by the board.

437.27 (c) No license shall be issued or renewed for a pharmacy located within the state

437.28 unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and

437.29 state law and according to rules adopted by the board. No license shall be issued for a

437.30 pharmacy located outside of the state unless the applicant agrees to operate the pharmacy

437.31 in a manner prescribed by federal law and, when dispensing medications for residents of

437.32 this state, the laws of this state, and Minnesota Rules.

437.33 (d) No license shall be issued or renewed for a pharmacy that is required to be

437.34 licensed or registered by the state in which it is physically located unless the applicant

437.35 supplies the board with proof of such licensure or registration.

438.1 (e) The board shall require a separate license for each pharmacy located within
438.2 the state and for each pharmacy located outside of the state at which any portion of the
438.3 dispensing process occurs for drugs dispensed to residents of this state.

438.4 (f) The board shall not issue an initial or renewed license for a pharmacy unless the
438.5 pharmacy passes an inspection conducted by an authorized representative of the board. In
438.6 the case of a pharmacy located outside of the state, the board may require the applicant to
438.7 pay the cost of the inspection, in addition to the license fee in section 151.065, unless the
438.8 applicant furnishes the board with a report, issued by the appropriate regulatory agency of
438.9 the state in which the facility is located, of an inspection that has occurred within the 24
438.10 months immediately preceding receipt of the license application by the board. The board
438.11 may deny licensure unless the applicant submits documentation satisfactory to the board
438.12 that any deficiencies noted in an inspection report have been corrected.

438.13 (g) The board shall not issue an initial or renewed license for a pharmacy located
438.14 outside of the state unless the applicant discloses and certifies:

438.15 (1) the location, names, and titles of all principal corporate officers and all
438.16 pharmacists who are involved in dispensing drugs to residents of this state;

438.17 (2) that it maintains its records of drugs dispensed to residents of this state so that the
438.18 records are readily retrievable from the records of other drugs dispensed;

438.19 (3) that it agrees to cooperate with, and provide information to, the board concerning
438.20 matters related to dispensing drugs to residents of this state;

438.21 (4) that, during its regular hours of operation, but no less than six days per week, for
438.22 a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate
438.23 communication between patients in this state and a pharmacist at the pharmacy who has
438.24 access to the patients' records; the toll-free number must be disclosed on the label affixed
438.25 to each container of drugs dispensed to residents of this state; and

438.26 (5) that, upon request of a resident of a long-term care facility located in this
438.27 state, the resident's authorized representative, or a contract pharmacy or licensed health
438.28 care facility acting on behalf of the resident, the pharmacy will dispense medications
438.29 prescribed for the resident in unit-dose packaging or, alternatively, comply with section
438.30 151.415, subdivision 5.

438.31 Sec. 3. Minnesota Statutes 2012, section 151.19, subdivision 3, is amended to read:

438.32 Subd. 3. **Sale of federally restricted medical gases.** ~~The board shall require and~~
438.33 ~~provide for the annual registration of every person or establishment not licensed as a~~
438.34 ~~pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted~~
438.35 ~~medical gases. Upon the payment of any applicable fee specified in section 151.065, the~~

439.1 ~~board shall issue a registration certificate in such form as it may prescribe to those persons~~
439.2 ~~or places that may be qualified to sell or distribute federally restricted medical gases. The~~
439.3 ~~certificate shall be displayed in a conspicuous place in the business for which it is issued~~
439.4 ~~and expire on the date set by the board. It is unlawful for a person to sell or distribute~~
439.5 ~~federally restricted medical gases unless a certificate has been issued to that person by the~~
439.6 ~~board.~~ (a) A person or establishment not licensed as a pharmacy or a practitioner shall not
439.7 engage in the retail sale or distribution of federally restricted medical gases without first
439.8 obtaining a registration from the board and paying the applicable fee specified in section
439.9 151.065. The registration shall be displayed in a conspicuous place in the business for
439.10 which it is issued and expires on the date set by the board. It is unlawful for a person to
439.11 sell or distribute federally restricted medical gases unless a certificate has been issued to
439.12 that person by the board.

439.13 (b) Application for a medical gas distributor registration under this section shall be
439.14 made in a manner specified by the board.

439.15 (c) No registration shall be issued or renewed for a medical gas distributor located
439.16 within the state unless the applicant agrees to operate in a manner prescribed by federal
439.17 and state law and according to the rules adopted by the board. No license shall be issued
439.18 for a medical gas distributor located outside of the state unless the applicant agrees to
439.19 operate in a manner prescribed by federal law and, when distributing medical gases for
439.20 residents of this state, the laws of this state and Minnesota Rules.

439.21 (d) No registration shall be issued or renewed for a medical gas distributor that is
439.22 required to be licensed or registered by the state in which it is physically located unless the
439.23 applicant supplies the board with proof of the licensure or registration. The board may, by
439.24 rule, establish standards for the registration of a medical gas distributor that is not required
439.25 to be licensed or registered by the state in which it is physically located.

439.26 (e) The board shall require a separate registration for each medical gas distributor
439.27 located within the state and for each facility located outside of the state from which
439.28 medical gases are distributed to residents of this state.

439.29 (f) The board shall not issue an initial or renewed registration for a medical gas
439.30 distributor unless the medical gas distributor passes an inspection conducted by an
439.31 authorized representative of the board. In the case of a medical gas distributor located
439.32 outside of the state, the board may require the applicant to pay the cost of the inspection,
439.33 in addition to the license fee in section 151.065, unless the applicant furnishes the board
439.34 with a report, issued by the appropriate regulatory agency of the state in which the facility
439.35 is located, of an inspection that has occurred within the 24 months immediately preceding
439.36 receipt of the license application by the board. The board may deny licensure unless the

440.1 applicant submits documentation satisfactory to the board that any deficiencies noted in
440.2 an inspection report have been corrected.

440.3 Sec. 4. **[151.252] LICENSING OF DRUG MANUFACTURERS; FEES;**
440.4 **PROHIBITIONS.**

440.5 Subdivision 1. Requirements. (a) No person shall act as a drug manufacturer
440.6 without first obtaining a license from the board and paying any applicable fee specified
440.7 in section 151.065.

440.8 (b) Application for a drug manufacturer license under this section shall be made in a
440.9 manner specified by the board.

440.10 (c) No license shall be issued or renewed for a drug manufacturer unless the
440.11 applicant agrees to operate in a manner prescribed by federal and state law and according
440.12 to Minnesota Rules.

440.13 (d) No license shall be issued or renewed for a drug manufacturer that is required
440.14 to be registered pursuant to United State Code, title 21, section 360, unless the applicant
440.15 supplies the board with proof of registration. The board may establish by rule the
440.16 standards for licensure of drug manufacturers that are not required to be registered under
440.17 United States Code, title 21, section 360.

440.18 (e) No license shall be issued or renewed for a drug manufacturer that is required to
440.19 be licensed or registered by the state in which it is physically located unless the applicant
440.20 supplies the board with proof of licensure or registration. The board may establish, by
440.21 rule, standards for the licensure of a drug manufacturer that is not required to be licensed
440.22 or registered by the state in which it is physically located.

440.23 (f) The board shall require a separate license for each facility located within the state
440.24 at which drug manufacturing occurs and for each facility located outside of the state at
440.25 which drugs that are shipped into the state are manufactured.

440.26 (g) The board shall not issue an initial or renewed license for a drug manufacturing
440.27 facility unless the facility passes an inspection conducted by an authorized representative
440.28 of the board. In the case of a drug manufacturing facility located outside of the state, the
440.29 board may require the applicant to pay the cost of the inspection, in addition to the license
440.30 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
440.31 appropriate regulatory agency of the state in which the facility is located or by the United
440.32 States Food and Drug Administration, of an inspection that has occurred within the 24
440.33 months immediately preceding receipt of the license application by the board. The board
440.34 may deny licensure unless the applicant submits documentation satisfactory to the board
440.35 that any deficiencies noted in an inspection report have been corrected.

441.1 Subd. 2. **Prohibition.** It is unlawful for any person engaged in drug manufacturing
441.2 to sell legend drugs to anyone located in this state except as provided in this chapter.

441.3 Subd. 3. **Payment to practitioner; reporting.** Unless prohibited by United States
441.4 Code, title 42, section 1320a-7h, a drug manufacturer shall file with the board an annual
441.5 report, in a form and on the date prescribed by the board, identifying all payments,
441.6 honoraria, reimbursement, or other compensation authorized under section 151.461,
441.7 clauses (4) and (5), paid to practitioners in Minnesota during the preceding calendar year.
441.8 The report shall identify the nature and value of any payments totaling \$100 or more to a
441.9 particular practitioner during the year, and shall identify the practitioner. Reports filed
441.10 under this subdivision are public data.

441.11 Sec. 5. Minnesota Statutes 2012, section 151.37, subdivision 4, is amended to read:

441.12 Subd. 4. **Research.** (a) Any qualified person may use legend drugs in the course
441.13 of a bona fide research project, but cannot administer or dispense such drugs to human
441.14 beings unless such drugs are prescribed, dispensed, and administered by a person lawfully
441.15 authorized to do so.

441.16 (b) Drugs may be dispensed or distributed by a pharmacy licensed by the board for
441.17 use by, or administration to, patients enrolled in a bona fide research study that is being
441.18 conducted pursuant to either an investigational new drug application approved by the
441.19 United States Food and Drug Administration or that has been approved by an institutional
441.20 review board. For the purposes of this subdivision only:

441.21 (1) a prescription drug order is not required for a pharmacy to dispense a research
441.22 drug, unless the study protocol requires the pharmacy to receive such an order;

441.23 (2) notwithstanding the prescription labeling requirements found in this chapter or
441.24 the rules promulgated by the board, a research drug may be labeled as required by the
441.25 study protocol; and

441.26 (3) dispensing and distribution of research drugs by pharmacies shall not be
441.27 considered compounding, manufacturing, or wholesaling under this chapter.

441.28 (c) An entity that is under contract to a federal agency for the purpose of distributing
441.29 drugs for bona fide research studies is exempt from the drug wholesaler licensing
441.30 requirements of this chapter. Any other entity is exempt from the drug wholesaler
441.31 licensing requirements of this chapter if the board finds that the entity is licensed or
441.32 registered according to the laws of the state in which it is physically located and it is
441.33 distributing drugs for use by, or administration to, patients enrolled in a bona fide research
441.34 study that is being conducted pursuant to either an investigational new drug application

442.1 approved by the United States Food and Drug Administration or that has been approved
442.2 by an institutional review board.

442.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

442.4 Sec. 6. Minnesota Statutes 2012, section 151.47, subdivision 1, is amended to read:

442.5 Subdivision 1. **Requirements.** (a) All wholesale drug distributors are subject to the
442.6 requirements ~~in paragraphs (a) to (f)~~ of this subdivision.

442.7 ~~(a)~~ (b) No person or distribution outlet shall act as a wholesale drug distributor
442.8 without first obtaining a license from the board and paying any applicable fee specified
442.9 in section 151.065.

442.10 (c) Application for a wholesale drug distributor license under this section shall be
442.11 made in a manner specified by the board.

442.12 ~~(b)~~ (d) No license shall be issued or renewed for a wholesale drug distributor to
442.13 operate unless the applicant agrees to operate in a manner prescribed by federal and state
442.14 law and according to the rules adopted by the board.

442.15 ~~(e) The board may require a separate license for each facility directly or indirectly~~
442.16 ~~owned or operated by the same business entity within the state, or for a parent entity~~
442.17 ~~with divisions, subsidiaries, or affiliate companies within the state, when operations~~
442.18 ~~are conducted at more than one location and joint ownership and control exists among~~
442.19 ~~all the entities.~~

442.20 (e) No license may be issued or renewed for a drug wholesale distributor that is
442.21 required to be licensed or registered by the state in which it is physically located unless
442.22 the applicant supplies the board with proof of licensure or registration. The board may
442.23 establish, by rule, standards for the licensure of a drug wholesale distributor that is not
442.24 required to be licensed or registered by the state in which it is physically located.

442.25 (f) The board shall require a separate license for each drug wholesale distributor
442.26 facility located within the state and for each drug wholesale distributor facility located
442.27 outside of the state from which drugs are shipped into the state or to which drugs are
442.28 reverse distributed.

442.29 (g) The board shall not issue an initial or renewed license for a drug wholesale
442.30 distributor facility unless the facility passes an inspection conducted by an authorized
442.31 representative of the board, or is accredited by an accreditation program approved by the
442.32 board. In the case of a drug wholesale distributor facility located outside of the state, the
442.33 board may require the applicant to pay the cost of the inspection, in addition to the license
442.34 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
442.35 appropriate regulatory agency of the state in which the facility is located, of an inspection

443.1 that has occurred within the 24 months immediately preceding receipt of the license
443.2 application by the board, or furnishes the board with proof of current accreditation. The
443.3 board may deny licensure unless the applicant submits documentation satisfactory to the
443.4 board that any deficiencies noted in an inspection report have been corrected.

443.5 ~~(d)~~ (h) As a condition for receiving and retaining a wholesale drug distributor license
443.6 issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has
443.7 and will continuously maintain:

443.8 (1) adequate storage conditions and facilities;

443.9 (2) minimum liability and other insurance as may be required under any applicable
443.10 federal or state law;

443.11 (3) a viable security system that includes an after hours central alarm, or comparable
443.12 entry detection capability; restricted access to the premises; comprehensive employment
443.13 applicant screening; and safeguards against all forms of employee theft;

443.14 (4) a system of records describing all wholesale drug distributor activities set forth
443.15 in section 151.44 for at least the most recent two-year period, which shall be reasonably
443.16 accessible as defined by board regulations in any inspection authorized by the board;

443.17 (5) principals and persons, including officers, directors, primary shareholders,
443.18 and key management executives, who must at all times demonstrate and maintain their
443.19 capability of conducting business in conformity with sound financial practices as well
443.20 as state and federal law;

443.21 (6) complete, updated information, to be provided to the board as a condition for
443.22 obtaining and retaining a license, about each wholesale drug distributor to be licensed,
443.23 including all pertinent corporate licensee information, if applicable, or other ownership,
443.24 principal, key personnel, and facilities information found to be necessary by the board;

443.25 (7) written policies and procedures that assure reasonable wholesale drug distributor
443.26 preparation for, protection against, and handling of any facility security or operation
443.27 problems, including, but not limited to, those caused by natural disaster or government
443.28 emergency, inventory inaccuracies or product shipping and receiving, outdated product
443.29 or other unauthorized product control, appropriate disposition of returned goods, and
443.30 product recalls;

443.31 (8) sufficient inspection procedures for all incoming and outgoing product
443.32 shipments; and

443.33 (9) operations in compliance with all federal requirements applicable to wholesale
443.34 drug distribution.

443.35 ~~(e)~~ (i) An agent or employee of any licensed wholesale drug distributor need not
443.36 seek licensure under this section.

444.1 ~~(f) A wholesale drug distributor shall file with the board an annual report, in a~~
444.2 ~~form and on the date prescribed by the board, identifying all payments, honoraria,~~
444.3 ~~reimbursement or other compensation authorized under section 151.461, clauses (3) to~~
444.4 ~~(5), paid to practitioners in Minnesota during the preceding calendar year. The report~~
444.5 ~~shall identify the nature and value of any payments totaling \$100 or more, to a particular~~
444.6 ~~practitioner during the year, and shall identify the practitioner. Reports filed under this~~
444.7 ~~provision are public data.~~

444.8 Sec. 7. Minnesota Statutes 2012, section 151.47, is amended by adding a subdivision
444.9 to read:

444.10 Subd. 3. **Prohibition.** It is unlawful for any person engaged in wholesale drug
444.11 distribution to sell drugs to a person located within the state or to receive drugs in reverse
444.12 distribution from a person located within the state except as provided in this chapter.

444.13 Sec. 8. Minnesota Statutes 2012, section 151.49, is amended to read:

444.14 **151.49 LICENSE RENEWAL APPLICATION PROCEDURES.**

444.15 Application blanks or notices for renewal of a license required by sections 151.42
444.16 to 151.51 shall be mailed or otherwise provided to each licensee on or before the first
444.17 day of the month prior to the month in which the license expires and, if application for
444.18 renewal of the license with the required fee and supporting documents is not made before
444.19 the expiration date, the existing license or renewal shall lapse and become null and void
444.20 upon the date of expiration.

444.21 Sec. 9. **[214.075] HEALTH-RELATED LICENSING BOARDS; CRIMINAL**
444.22 **BACKGROUND CHECKS.**

444.23 Subdivision 1. **Applications.** (a) By January 1, 2018, each health-related licensing
444.24 board, as defined in section 214.01, subdivision 2, shall require applicants for initial
444.25 licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse
444.26 in licensure, as defined by the individual health-related licensing boards, to submit to
444.27 a criminal history records check of state data completed by the Bureau of Criminal
444.28 Apprehension (BCA) and a national criminal history records check, including a search of
444.29 the records of the Federal Bureau of Investigation (FBI).

444.30 (b) An applicant must complete a criminal background check if more than one year
444.31 has elapsed since the applicant last submitted a background check to the board.

444.32 Subd. 2. **Investigations.** If a health-related licensing board has reasonable cause
444.33 to believe a licensee has been charged with or convicted of a crime in this or any other

445.1 jurisdiction, the health-related licensing board may require the licensee to submit to a
445.2 criminal history records check of state data completed by the BCA and a national criminal
445.3 history records check, including a search of the records of the FBI.

445.4 Subd. 3. **Consent form; fees; fingerprints.** (a) In order to effectuate the federal
445.5 and state level, fingerprint-based criminal background check, the applicant or licensee
445.6 must submit a completed criminal history records check consent form and a full set of
445.7 fingerprints to the respective health-related licensing board or a designee in the manner
445.8 and form specified by the board.

445.9 (b) The applicant or licensee is responsible for all fees associated with preparation of
445.10 the fingerprints, the criminal records check consent form, and the criminal background
445.11 check. The fees for the criminal records background check shall be set by the BCA and
445.12 the FBI and are not refundable. The fees shall be submitted to the respective health-related
445.13 licensing board by the applicant or licensee as prescribed by the respective board.

445.14 (c) All fees received by the health-related licensing boards under this subdivision
445.15 shall be deposited in a dedicated account in the special revenue fund and are appropriated
445.16 to the Board of Nursing Home Administrators for the administrative services unit to pay
445.17 for the criminal background checks conducted by the Bureau of Criminal Apprehension
445.18 and Federal Bureau of Investigation.

445.19 Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue
445.20 a license to any applicant who refuses to consent to a criminal background check or fails
445.21 to submit fingerprints within 90 days after submission of an application for licensure. Any
445.22 fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent
445.23 to the criminal background check or fails to submit the required fingerprints.

445.24 (b) The failure of a licensee to submit to a criminal background check as provided in
445.25 subdivision 3 is grounds for disciplinary action by the respective health licensing board.

445.26 Subd. 5. **Submission of fingerprints to the Bureau of Criminal Apprehension.**
445.27 The health-related licensing board or designee shall submit applicant or licensee
445.28 fingerprints to the BCA. The BCA shall perform a check for state criminal justice
445.29 information and shall forward the applicant's or licensee's fingerprints to the FBI to
445.30 perform a check for national criminal justice information regarding the applicant or
445.31 licensee. The BCA shall report to the board the results of the state and national criminal
445.32 justice information checks.

445.33 Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The
445.34 health-related licensing board may require an alternative method of criminal history
445.35 checks for an applicant or licensee who has submitted at least three sets of fingerprints in
445.36 accordance with this section that have been unreadable by the BCA or the FBI.

446.1 Subd. 7. **Opportunity to challenge accuracy of report.** Prior to taking disciplinary
446.2 action against an applicant or a licensee based on a criminal conviction, the health-related
446.3 licensing board shall provide the applicant or the licensee an opportunity to complete or
446.4 challenge the accuracy of the criminal history information reported to the board. The
446.5 applicant or licensee shall have 30 calendar days following notice from the board of
446.6 the intent to deny licensure or to take disciplinary action to request an opportunity to
446.7 correct or complete the record prior to the board taking disciplinary action based on the
446.8 information reported to the board. The board shall provide the applicant up to 180 days to
446.9 challenge the accuracy or completeness of the report with the agency responsible for the
446.10 record. This subdivision does not affect the right of the subject of the data to contest the
446.11 accuracy or completeness under section 13.04, subdivision 4.

446.12 Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in
446.13 collaboration with the commissioner of human services and the BCA, shall establish a
446.14 plan for completing criminal background checks of all licensees who were licensed before
446.15 the effective date requirement under subdivision 1. The plan must seek to minimize
446.16 duplication of requirements for background checks of licensed health professionals. The
446.17 plan for background checks of current licensees shall be developed no later than January
446.18 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI
446.19 in which any new crimes that an applicant or licensee commits after an initial background
446.20 check are flagged in the BCA's or FBI's database and reported back to the board. The plan
446.21 shall include recommendations for any necessary statutory changes.

446.22 Sec. 10. Minnesota Statutes 2012, section 214.12, is amended by adding a subdivision
446.23 to read:

446.24 Subd. 4. **Parental depression.** The health-related licensing boards that regulate
446.25 professions that serve caregivers at risk of depression, or their children, including
446.26 behavioral health and therapy, chiropractic, marriage and family therapy, medical practice,
446.27 nursing, psychology, and social work, shall provide educational materials to licensees on
446.28 the subject of parental depression and its potential effects on children if unaddressed,
446.29 including how to:

- 446.30 (1) screen mothers for depression;
446.31 (2) identify children who are affected by their mother's depression; and
446.32 (3) provide treatment or referral information on needed services.

446.33 Sec. 11. Minnesota Statutes 2012, section 214.40, subdivision 1, is amended to read:

447.1 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this
447.2 section.

447.3 (b) "Administrative services unit" means the administrative services unit for the
447.4 health-related licensing boards.

447.5 (c) "Charitable organization" means a charitable organization within the meaning of
447.6 section 501(c)(3) of the Internal Revenue Code that has as a purpose the sponsorship or
447.7 support of programs designed to improve the quality, awareness, and availability of health
447.8 care services and that serves as a funding mechanism for providing those services.

447.9 (d) "Health care facility or organization" means a health care facility licensed under
447.10 chapter 144 or 144A, or a charitable organization.

447.11 (e) "Health care provider" means a physician licensed under chapter 147, physician
447.12 assistant ~~registered~~ licensed and practicing under chapter 147A, nurse licensed and
447.13 registered to practice under chapter 148, ~~or~~ dentist or dental hygienist, or dental therapist
447.14 licensed under chapter 150A, or an advanced dental therapist licensed and certified under
447.15 chapter 150A.

447.16 (f) "Health care services" means health promotion, health monitoring, health
447.17 education, diagnosis, treatment, minor surgical procedures, the administration of local
447.18 anesthesia for the stitching of wounds, and primary dental services, including preventive,
447.19 diagnostic, restorative, and emergency treatment. Health care services do not include the
447.20 administration of general anesthesia or surgical procedures other than minor surgical
447.21 procedures.

447.22 (g) "Medical professional liability insurance" means medical malpractice insurance
447.23 as defined in section 62F.03.

447.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

447.25 Sec. 12. **INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO**
447.26 **CRIMINAL BACKGROUND CHECKS.**

447.27 (a) If the Department of Health is not reviewed by the Sunset Advisory Commission
447.28 according to the schedule in Minnesota Statutes, section 3D.21, the commissioner
447.29 of health, as the regulator for occupational therapy practitioners, speech-language
447.30 pathologists, audiologists, and hearing instrument dispensers, shall require applicants
447.31 for licensure or renewal to submit to a criminal history records check as required under
447.32 Minnesota Statutes, section 214.075, for other health-related licensed occupations
447.33 regulated by the health-related licensing boards.

448.1 (b) Any statutory changes necessary to include the commissioner of health to
448.2 Minnesota Statutes, section 214.075, shall be included in the plan required in Minnesota
448.3 Statutes, section 214.075, subdivision 8.

448.4 Sec. 13. **REPEALER.**

448.5 Minnesota Statutes 2012, sections 151.19, subdivision 2; 151.25; 151.45; 151.47,
448.6 subdivision 2; and 151.48, are repealed.

448.7 **ARTICLE 11**

448.8 **HOME CARE PROVIDERS**

448.9 Section 1. Minnesota Statutes 2012, section 13.381, subdivision 2, is amended to read:

448.10 Subd. 2. **Health occupations data. (a) Health-related licensees and registrants.**

448.11 The collection, analysis, reporting, and use of data on individuals licensed or registered by
448.12 the commissioner of health or health-related licensing boards are governed by sections
448.13 144.051, ~~subdivision 2~~ subdivisions 2 to 6, and 144.052.

448.14 (b) **Health services personnel.** Data collected by the commissioner of health for the
448.15 database on health services personnel are classified under section 144.1485.

448.16 Sec. 2. Minnesota Statutes 2012, section 13.381, subdivision 10, is amended to read:

448.17 Subd. 10. **Home care and hospice provider.** Data regarding a home care provider
448.18 under sections 144A.43 to 144A.47 are governed by section 144A.45. Data regarding
448.19 home care provider background studies are governed by section 144A.476, subdivision 1.
448.20 Data regarding a hospice provider under sections 144A.75 to 144A.755 are governed by
448.21 sections 144A.752 and 144A.754.

448.22 Sec. 3. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
448.23 to read:

448.24 Subd. 3. **Data classification; private data.** For providers regulated pursuant to
448.25 sections 144A.43 to 144A.482, the following data collected, created, or maintained by
448.26 the commissioner are classified as private data on individuals as defined in section 13.02,
448.27 subdivision 12:

448.28 (1) data submitted by or on behalf of applicants for licenses prior to issuance of
448.29 the license;

448.30 (2) the identity of complainants who have made reports concerning licensees or
448.31 applicants unless the complainant consents to the disclosure;

449.1 (3) the identity of individuals who provide information as part of surveys and
449.2 investigations;

449.3 (4) Social Security numbers; and

449.4 (5) health record data.

449.5 Sec. 4. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
449.6 to read:

449.7 Subd. 4. **Data classification; public data.** For providers regulated pursuant to
449.8 sections 144A.43 to 144A.482, the following data collected, created, or maintained by the
449.9 commissioner are classified as public data as defined in section 13.02, subdivision 15:

449.10 (1) all application data on licensees, license numbers, license status;

449.11 (2) licensing information about licenses previously held under this chapter;

449.12 (3) correction orders, including information about compliance with the order and
449.13 whether the fine was paid;

449.14 (4) final enforcement actions pursuant to chapter 14;

449.15 (5) orders for hearing, findings of fact and conclusions of law; and

449.16 (6) when the licensee and department agree to resolve the matter without a hearing,
449.17 the agreement and specific reasons for the agreement are public data.

449.18 Sec. 5. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
449.19 to read:

449.20 Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to
449.21 sections 144A.43 to 144A.482, the following data collected, created, or maintained by
449.22 the Department of Health are classified as confidential data on individuals as defined in
449.23 section 13.02, subdivision 3: active investigative data relating to the investigation of
449.24 potential violations of law by a licensee including data from the survey process before the
449.25 correction order is issued by the department.

449.26 Sec. 6. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
449.27 to read:

449.28 Subd. 6. **Release of private or confidential data.** For providers regulated pursuant
449.29 to sections 144A.43 to 144A.482, the department may release private or confidential data,
449.30 except Social Security numbers, to the appropriate state, federal, or local agency and law
449.31 enforcement office to enhance investigative or enforcement efforts or further a public
449.32 health protective process. Types of offices include Adult Protective Services, Office of the
449.33 Ombudsmen for Long-Term Care and Office of the Ombudsmen for Mental Health and

450.1 Developmental Disabilities, the health licensing boards, Department of Human Services,
450.2 county or city attorney's offices, police, and local or county public health offices.

450.3 Sec. 7. Minnesota Statutes 2012, section 144A.43, is amended to read:

450.4 **144A.43 DEFINITIONS.**

450.5 Subdivision 1. **Applicability.** The definitions in this section apply to sections
450.6 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.

450.7 Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall
450.8 be served and who is authorized to accept service of notices and orders on behalf of
450.9 the home care provider.

450.10 Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association,
450.11 corporation, unit of government, or other entity that applies for a temporary license,
450.12 license, or renewal of the applicant's home care provider license under section 144A.472.

450.13 Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

450.14 Subd. 1d. **Client record.** "Client record" means all records that document
450.15 information about the home care services provided to the client by the home care provider.

450.16 Subd. 1e. **Client representative.** "Client representative" means a person who,
450.17 because of the client's needs, makes decisions about the client's care on behalf of the
450.18 client. A client representative may be a guardian, health care agent, family member, or
450.19 other agent of the client. Nothing in this section expands or diminishes the rights of
450.20 persons to act on behalf of clients under other law.

450.21 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

450.22 Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given
450.23 in section 152.01, subdivision 4.

450.24 Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

450.25 Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken
450.26 by mouth that contains a dietary ingredient intended to supplement the diet. Dietary
450.27 ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and
450.28 substances such as enzymes, organ tissue, glandulars, or metabolites.

450.29 Subd. 2d. **Dietitian.** "Dietitian" is a person licensed under sections 148.621 to
450.30 148.633.

450.31 Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is
450.32 performed by a licensed dietitian or licensed nutritionist and includes the activities of
450.33 assessment, setting priorities and objectives, providing nutrition counseling, developing
450.34 and implementing nutrition care services, and evaluating and maintaining appropriate
450.35 standards of quality of nutrition care under sections 148.621 to 148.633.

451.1 Subd. 3. **Home care service.** "Home care service" means any of the following
 451.2 services ~~when delivered in a place of residence to~~ the home of a person whose illness,
 451.3 disability, or physical condition creates a need for the service:

451.4 ~~(1) nursing services, including the services of a home health aide;~~

451.5 ~~(2) personal care services not included under sections 148.171 to 148.285;~~

451.6 ~~(3) physical therapy;~~

451.7 ~~(4) speech therapy;~~

451.8 ~~(5) respiratory therapy;~~

451.9 ~~(6) occupational therapy;~~

451.10 ~~(7) nutritional services;~~

451.11 ~~(8) home management services when provided to a person who is unable to perform~~
 451.12 ~~these activities due to illness, disability, or physical condition. Home management~~
 451.13 ~~services include at least two of the following services: housekeeping, meal preparation,~~
 451.14 ~~and shopping;~~

451.15 ~~(9) medical social services;~~

451.16 ~~(10) the provision of medical supplies and equipment when accompanied by the~~
 451.17 ~~provision of a home care service; and~~

451.18 ~~(11) other similar medical services and health-related support services identified by~~
 451.19 ~~the commissioner in rule.~~

451.20 ~~"Home care service" does not include the following activities conducted by the~~
 451.21 ~~commissioner of health or a board of health as defined in section 145A.02, subdivision 2:~~
 451.22 ~~communicable disease investigations or testing; administering or monitoring a prescribed~~
 451.23 ~~therapy necessary to control or prevent a communicable disease; or the monitoring~~
 451.24 ~~of an individual's compliance with a health directive as defined in section 144.4172,~~
 451.25 ~~subdivision 6.~~

451.26 (1) assistive tasks provided by unlicensed personnel;

451.27 (2) services provided by a registered nurse or licensed practical nurse, physical
 451.28 therapist, respiratory therapist, occupational therapist, speech-language pathologist,
 451.29 dietitian or nutritionist, or social worker;

451.30 (3) medication and treatment management services; or

451.31 (4) the provision of durable medical equipment services when provided with any of
 451.32 the home care services listed in clauses (1) to (3).

451.33 Subd. 3a. **Hands-on assistance.** "Hands-on assistance" means physical help by
 451.34 another person without which the client is not able to perform the activity.

451.35 Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of
 451.36 residence.

452.1 Subd. 4. **Home care provider.** "Home care provider" means an individual,
452.2 organization, association, corporation, unit of government, or other entity that is regularly
452.3 engaged in the delivery of at least one home care service, directly or by contractual
452.4 arrangement, of home care services in a client's home for a fee and who has a valid current
452.5 temporary license or license issued under sections 144A.43 to 144A.482. ~~At least one~~
452.6 ~~home care service must be provided directly, although additional home care services may~~
452.7 ~~be provided by contractual arrangements.~~ "Home care provider" does not include:

452.8 (1) ~~any home care or nursing services conducted by and for the adherents of any~~
452.9 ~~recognized church or religious denomination for the purpose of providing care and~~
452.10 ~~services for those who depend upon spiritual means, through prayer alone, for healing;~~

452.11 (2) ~~an individual who only provides services to a relative;~~

452.12 (3) ~~an individual not connected with a home care provider who provides assistance~~
452.13 ~~with home management services or personal care needs if the assistance is provided~~
452.14 ~~primarily as a contribution and not as a business;~~

452.15 (4) ~~an individual not connected with a home care provider who shares housing with~~
452.16 ~~and provides primarily housekeeping or homemaking services to an elderly or disabled~~
452.17 ~~person in return for free or reduced-cost housing;~~

452.18 (5) ~~an individual or agency providing home-delivered meal services;~~

452.19 (6) ~~an agency providing senior companion services and other older American~~
452.20 ~~volunteer programs established under the Domestic Volunteer Service Act of 1973,~~
452.21 ~~Public Law 98-288;~~

452.22 (7) ~~an employee of a nursing home licensed under this chapter or an employee of a~~
452.23 ~~boarding care home licensed under sections 144.50 to 144.56 who responds to occasional~~
452.24 ~~emergency calls from individuals residing in a residential setting that is attached to or~~
452.25 ~~located on property contiguous to the nursing home or boarding care home;~~

452.26 (8) ~~a member of a professional corporation organized under chapter 319B that does~~
452.27 ~~not regularly offer or provide home care services as defined in subdivision 3;~~

452.28 (9) ~~the following organizations established to provide medical or surgical services~~
452.29 ~~that do not regularly offer or provide home care services as defined in subdivision 3:~~
452.30 ~~a business trust organized under sections 318.01 to 318.04, a nonprofit corporation~~
452.31 ~~organized under chapter 317A, a partnership organized under chapter 323, or any other~~
452.32 ~~entity determined by the commissioner;~~

452.33 (10) ~~an individual or agency that provides medical supplies or durable medical~~
452.34 ~~equipment, except when the provision of supplies or equipment is accompanied by a~~
452.35 ~~home care service;~~

452.36 (11) ~~an individual licensed under chapter 147; or~~

453.1 ~~(12) an individual who provides home care services to a person with a developmental~~
453.2 ~~disability who lives in a place of residence with a family, foster family, or primary caregiver.~~

453.3 ~~Subd. 5. **Medication reminder.** "Medication reminder" means providing a verbal~~
453.4 ~~or visual reminder to a client to take medication. This includes bringing the medication~~
453.5 ~~to the client and providing liquids or nutrition to accompany medication that a client is~~
453.6 ~~self-administering.~~

453.7 Subd. 6. **License.** "License" means a basic or comprehensive home care license
453.8 issued by the commissioner to a home care provider.

453.9 Subd. 7. **Licensed health professional.** "Licensed health professional" means a
453.10 person, other than a registered nurse or licensed practical nurse, who provides home care
453.11 services within the scope of practice of the person's health occupation license, registration,
453.12 or certification as regulated and who is licensed by the appropriate Minnesota state board
453.13 or agency.

453.14 Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under
453.15 this chapter.

453.16 Subd. 9. **Managerial official.** "Managerial official" means an administrator,
453.17 director, officer, trustee, or employee of a home care provider, however designated, who
453.18 has the authority to establish or control business policy.

453.19 Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug.
453.20 For purposes of this chapter only, medication includes dietary supplements.

453.21 Subd. 11. **Medication administration.** "Medication administration" means
453.22 performing a set of tasks to ensure a client takes medications, and includes the following:

453.23 (1) checking the client's medication record;

453.24 (2) preparing the medication as necessary;

453.25 (3) administering the medication to the client;

453.26 (4) documenting the administration or reason for not administering the medication;

453.27 and

453.28 (5) reporting to a nurse any concerns about the medication, the client, or the client's
453.29 refusal to take the medication.

453.30 Subd. 12. **Medication management.** "Medication management" means the
453.31 provision of any of the following medication-related services to a client:

453.32 (1) performing medication setup;

453.33 (2) administering medication;

453.34 (3) storing and securing medications;

453.35 (4) documenting medication activities;

454.1 (5) verifying and monitoring effectiveness of systems to ensure safe handling and
454.2 administration;

454.3 (6) coordinating refills;

454.4 (7) handling and implementing changes to prescriptions;

454.5 (8) communicating with the pharmacy about the client's medications; and

454.6 (9) coordinating and communicating with the prescriber.

454.7 Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a
454.8 nurse, pharmacy, or authorized prescriber for later administration by the client or by
454.9 comprehensive home care staff.

454.10 Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to
454.11 148.285.

454.12 Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is
454.13 licensed under sections 148.6401 to 148.6450.

454.14 Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is
454.15 not required by federal law to bear the symbol "Rx only."

454.16 Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who
454.17 has five percent or more equity interest in a limited partnership, a person who owns or
454.18 controls voting stock in a corporation in an amount equal to or greater than five percent of
454.19 the shares issued and outstanding, or a corporation that owns equity interest in a licensee
454.20 or applicant for a license.

454.21 Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01,
454.22 subdivision 3.

454.23 Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed
454.24 under sections 148.65 to 148.78.

454.25 Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.

454.26 Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections
454.27 148.235; 151.01, subdivision 23; and 151.37 to prescribe prescription drugs.

454.28 Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01,
454.29 subdivision 16.

454.30 Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned
454.31 to be completed at predetermined times or according to a predetermined routine.

454.32 Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder
454.33 to a client.

454.34 Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who
454.35 is licensed under chapter 147C.

455.1 Subd. 26. **Revenues.** "Revenues" means all money received by a licensee derived
455.2 from the provision of home care services, including fees for services and appropriations
455.3 of public money for home care services.

455.4 Subd. 27. **Service plan.** "Service plan" means the written plan between the client or
455.5 client's representative and the temporary licensee or licensee about the services that will
455.6 be provided to the client.

455.7 Subd. 28. **Social worker.** "Social worker" means a person who is licensed under
455.8 chapter 148D or 148E.

455.9 Subd. 29. **Speech-language pathologist.** "Speech-language pathologist" has the
455.10 meaning given in section 148.512.

455.11 Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another
455.12 person within arm's reach to minimize the risk of injury while performing daily activities
455.13 through physical intervention or cuing.

455.14 Subd. 31. **Substantial compliance.** "Substantial compliance" means complying
455.15 with the requirements in this chapter sufficiently to prevent unacceptable health or safety
455.16 risks to the home care client.

455.17 Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for
455.18 licensure for compliance with this chapter.

455.19 Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized
455.20 to conduct surveys of home care providers and applicants.

455.21 Subd. 34. **Temporary license.** "Temporary license" means the initial basic or
455.22 comprehensive home care license the department issues after approval of a complete
455.23 written application and before the department completes the temporary license survey and
455.24 determines that the temporary licensee is in substantial compliance.

455.25 Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision
455.26 of care, other than medications, ordered or prescribed by a licensed health professional
455.27 provided to a client to cure, rehabilitate, or ease symptoms.

455.28 Subd. 36. **Unit of government.** "Unit of government" means every city, county,
455.29 town, school district, other political subdivisions of the state, or agency of the state or
455.30 federal government, which includes any instrumentality of a unit of government.

455.31 Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not
455.32 otherwise licensed or certified by a governmental health board or agency who provide
455.33 home care services in the client's home.

455.34 Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

456.1 Sec. 8. Minnesota Statutes 2012, section 144A.44, is amended to read:

456.2 **144A.44 HOME CARE BILL OF RIGHTS.**

456.3 Subdivision 1. **Statement of rights.** A person who receives home care services
456.4 has these rights:

456.5 (1) the right to receive written information about rights ~~in advance of~~ before
456.6 ~~receiving care or during the initial evaluation visit before the initiation of treatment~~
456.7 services, including what to do if rights are violated;

456.8 (2) the right to receive care and services according to a suitable and up-to-date plan,
456.9 and subject to accepted health care, medical or nursing standards, to take an active part
456.10 ~~in creating and changing the plan~~ developing, modifying, and evaluating care the plan
456.11 and services;

456.12 (3) the right to be told ~~in advance of~~ before receiving care ~~about the services that will~~
456.13 ~~be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will
456.14 be providing the services, the frequency of visits proposed to be furnished, other choices
456.15 that are available for addressing home care needs, and ~~the consequences of these choices~~
456.16 including the potential consequences of refusing these services;

456.17 (4) the right to be told in advance of any ~~change~~ recommended changes by the
456.18 provider in the service plan of care and to take an active part in any ~~change~~ decisions
456.19 about changes to the service plan;

456.20 (5) the right to refuse services or treatment;

456.21 (6) the right to know, ~~in advance~~ before receiving services or during the initial
456.22 visit, any limits to the services available from a home care provider, ~~and the provider's~~
456.23 ~~grounds for a termination of services~~;

456.24 (7) ~~the right to know in advance of receiving care whether the services are covered~~
456.25 ~~by health insurance, medical assistance, or other health programs, the charges for services~~
456.26 ~~that will not be covered by Medicare, and the charges that the individual may have to pay~~;

456.27 (8) ~~(7)~~ the right to know be told before services are initiated what the provider
456.28 charges are for the services, no matter who will be paying the bill; to what extent payment
456.29 may be expected from health insurance, public programs, or other sources, if known; and
456.30 what charges the client may be responsible for paying;

456.31 (9) ~~(8)~~ the right to know that there may be other services available in the community,
456.32 including other home care services and providers, and to know where to ~~go for~~ find
456.33 information about these services;

456.34 (10) ~~(9)~~ the right to choose freely among available providers and to change providers
456.35 after services have begun, within the limits of health insurance, long-term care insurance,
456.36 medical assistance, or other health programs;

457.1 ~~(11)~~ (10) the right to have personal, financial, and medical information kept private,
 457.2 and to be advised of the provider's policies and procedures regarding disclosure of such
 457.3 information;

457.4 ~~(12)~~ (11) the right to ~~be allowed~~ access to the client's own records and written
 457.5 information from those records in accordance with sections 144.291 to 144.298;

457.6 ~~(13)~~ (12) the right to be served by people who are properly trained and competent
 457.7 to perform their duties;

457.8 ~~(14)~~ (13) the right to be treated with courtesy and respect, and to have the ~~patient's~~
 457.9 client's property treated with respect;

457.10 ~~(15)~~ (14) the right to be free from physical and verbal abuse, neglect, financial
 457.11 exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and
 457.12 the Maltreatment of Minors Act;

457.13 ~~(16)~~ (15) the right to reasonable, advance notice of changes in services or charges;
 457.14 ~~including;~~

457.15 (16) the right to know the provider's reason for termination of services;

457.16 (17) the right to at least ten days' advance notice of the termination of a service by a
 457.17 provider, except in cases where:

457.18 (i) ~~the recipient of services~~ client engages in conduct that significantly alters the
 457.19 ~~conditions of employment as specified in the employment contract between terms of~~
 457.20 the service plan with the home care provider ~~and the individual providing home care~~
 457.21 ~~services, or creates;~~

457.22 (ii) the client, person who lives with the client, or others create an abusive or unsafe
 457.23 work environment for the ~~individual~~ person providing home care services; or

457.24 (ii) ~~(iii)~~ an emergency ~~for the informal caregiver~~ or a significant change in the
 457.25 ~~recipient's~~ client's condition has resulted in service needs that exceed the current service
 457.26 ~~provider agreement~~ plan and that cannot be safely met by the home care provider;

457.27 ~~(17)~~ (18) the right to a coordinated transfer when there will be a change in the
 457.28 provider of services;

457.29 ~~(18)~~ (19) the right to ~~voice grievances regarding treatment or care that is~~ complain
 457.30 about services that are provided, or fails to be, furnished, or regarding fail to be provided,
 457.31 and the lack of courtesy or respect to the ~~patient~~ client or the ~~patient's~~ client's property;

457.32 ~~(19)~~ (20) the right to know how to contact an individual associated with the home
 457.33 care provider who is responsible for handling problems and to have the home care provider
 457.34 investigate and attempt to resolve the grievance or complaint;

457.35 ~~(20)~~ (21) the right to know the name and address of the state or county agency to
 457.36 contact for additional information or assistance; and

458.1 ~~(21)~~ (22) the right to assert these rights personally, or have them asserted by
 458.2 the patient's family or guardian when the patient has been judged incompetent, client's
 458.3 representative or by anyone on behalf of the client, without retaliation.

458.4 Subd. 2. **Interpretation and enforcement of rights.** These rights are established
 458.5 for the benefit of persons clients who receive home care services. "~~Home care services~~"
 458.6 ~~means home care services as defined in section 144A.43, subdivision 3, and unlicensed~~
 458.7 ~~personal care assistance services, including services covered by medical assistance under~~
 458.8 ~~section 256B.0625, subdivision 19a. All home care providers, including those exempted~~
 458.9 ~~under section 144A.471, must comply with this section. The commissioner shall enforce~~
 458.10 ~~this section and the home care bill of rights requirement against home care providers~~
 458.11 ~~exempt from licensure in the same manner as for licensees. A home care provider may~~
 458.12 ~~not request or require a person client to surrender any of these rights as a condition of~~
 458.13 ~~receiving services. A guardian or conservator or, when there is no guardian or conservator,~~
 458.14 ~~a designated person, may seek to enforce these rights. This statement of rights does not~~
 458.15 ~~replace or diminish other rights and liberties that may exist relative to persons clients~~
 458.16 ~~receiving home care services, persons providing home care services, or providers licensed~~
 458.17 ~~under Laws 1987, chapter 378. A copy of these rights must be provided to an individual~~
 458.18 ~~at the time home care services, including personal care assistance services, are initiated.~~
 458.19 ~~The copy shall also contain the address and phone number of the Office of Health Facility~~
 458.20 ~~Complaints and the Office of Ombudsman for Long-Term Care and a brief statement~~
 458.21 ~~describing how to file a complaint with these offices. Information about how to contact~~
 458.22 ~~the Office of Ombudsman for Long-Term Care shall be included in notices of change in~~
 458.23 ~~client fees and in notices where home care providers initiate transfer or discontinuation of~~
 458.24 ~~services sections 144A.43 to 144A.482.~~

458.25 Sec. 9. Minnesota Statutes 2012, section 144A.45, is amended to read:

458.26 **144A.45 REGULATION OF HOME CARE SERVICES.**

458.27 Subdivision 1. **Rules Regulations.** The commissioner shall ~~adopt rules for the~~
 458.28 ~~regulation of~~ regulate home care providers pursuant to sections 144A.43 to ~~144A.47~~
 458.29 144A.482. The ~~rules~~ regulations shall include the following:

458.30 (1) provisions to assure, to the extent possible, the health, safety ~~and~~, well-being,
 458.31 and appropriate treatment of persons who receive home care services while respecting
 458.32 a client's autonomy and choice;

458.33 (2) requirements that home care providers furnish the commissioner with specified
 458.34 information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

459.1 (3) standards of training of home care provider personnel, ~~which may vary according~~
 459.2 ~~to the nature of the services provided or the health status of the consumer;~~

459.3 (4) standards for provision of home care services;

459.4 ~~(4) (5) standards for medication management which may vary according to the~~
 459.5 ~~nature of the services provided, the setting in which the services are provided, or the~~
 459.6 ~~status of the consumer. Medication management includes the central storage, handling,~~
 459.7 ~~distribution, and administration of medications;~~

459.8 ~~(5) (6) standards for supervision of home care services requiring supervision by a~~
 459.9 ~~registered nurse or other appropriate health care professional which must occur on site~~
 459.10 ~~at least every 62 days, or more frequently if indicated by a clinical assessment, and in~~
 459.11 ~~accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a~~
 459.12 ~~person performing home care aide tasks for a class B licensee providing paraprofessional~~
 459.13 ~~services does not require nursing supervision;~~

459.14 ~~(6) (7) standards for client evaluation or assessment which may vary according to~~
 459.15 ~~the nature of the services provided or the status of the consumer;~~

459.16 ~~(7) (8) requirements for the involvement of a consumer's physician client's health~~
 459.17 ~~care provider, the documentation of physicians' health care providers' orders, if required,~~
 459.18 ~~and the consumer's treatment client's service plan, and;~~

459.19 (9) the maintenance of accurate, current clinical client records;

459.20 ~~(8) (10) the establishment of different classes basic and comprehensive levels of~~
 459.21 ~~licenses for different types of providers and different standards and requirements for~~
 459.22 ~~different kinds of home care based on services provided; and~~

459.23 ~~(9) operating procedures required to implement (11) provisions to enforce these~~
 459.24 ~~regulations and the home care bill of rights.~~

459.25 ~~Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota~~
 459.26 ~~Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting~~
 459.27 ~~toileting, transfers, and ambulation if the client is ambulatory and if the client has no~~
 459.28 ~~serious acute illness or infectious disease.~~

459.29 ~~Subd. 1b. **Home health aide qualifications.** Notwithstanding the provisions of~~
 459.30 ~~Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks~~
 459.31 ~~if the person maintains current registration as a nursing assistant on the Minnesota nursing~~
 459.32 ~~assistant registry. Maintaining current registration on the Minnesota nursing assistant~~
 459.33 ~~registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110,~~
 459.34 ~~subpart 3.~~

459.35 ~~Subd. 2. **Regulatory functions.** (a) The commissioner shall:~~

460.1 (1) ~~evaluate, monitor, and license, survey, and monitor without advance notice, home~~
 460.2 ~~care providers in accordance with sections 144A.45 to 144A.47~~ 144A.43 to 144A.482;

460.3 (2) ~~inspect the office and records of a provider during regular business hours without~~
 460.4 ~~advance notice to the home care provider;~~

460.5 (2) survey every temporary licensee within one year of the temporary license issuance
 460.6 date subject to the temporary licensee providing home care services to a client or clients;

460.7 (3) survey all licensed home care providers on an interval that will promote the
 460.8 health and safety of clients;

460.9 (3) (4) ~~with the consent of the consumer client,~~ visit the home where services are
 460.10 being provided;

460.11 (4) (5) issue correction orders and assess civil penalties in accordance with section
 460.12 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to 144A.47 ~~or the rules~~
 460.13 ~~adopted under those sections~~ 144A.482;

460.14 (5) (6) take action as authorized in section 144A.46, ~~subdivision 3~~ 144A.475; and

460.15 (6) (7) take other action reasonably required to accomplish the purposes of sections
 460.16 144A.43 to 144A.47 144A.482.

460.17 (b) ~~In the exercise of the authority granted in sections 144A.43 to 144A.47, the~~
 460.18 ~~commissioner shall comply with the applicable requirements of section 144.122, the~~
 460.19 ~~Government Data Practices Act, and the Administrative Procedure Act.~~

460.20 Subd. 4. **Medicaid reimbursement.** ~~Notwithstanding the provisions of section~~
 460.21 ~~256B.37 or state plan requirements to the contrary, certification by the federal Medicare~~
 460.22 ~~program must not be a requirement of Medicaid payment for services delivered under~~
 460.23 ~~section 144A.4605.~~

460.24 Subd. 5. **Home care providers; services for Alzheimer's disease or related**
 460.25 **disorder.** (a) ~~If a home care provider licensed under section 144A.46 or 144A.4605 markets~~
 460.26 ~~or otherwise promotes services for persons with Alzheimer's disease or related disorders,~~
 460.27 ~~the facility's direct care staff and their supervisors must be trained in dementia care.~~

460.28 (b) ~~Areas of required training include:~~

460.29 (1) ~~an explanation of Alzheimer's disease and related disorders;~~

460.30 (2) ~~assistance with activities of daily living;~~

460.31 (3) ~~problem solving with challenging behaviors; and~~

460.32 (4) ~~communication skills.~~

460.33 (c) ~~The licensee shall provide to consumers in written or electronic form a~~
 460.34 ~~description of the training program, the categories of employees trained, the frequency~~
 460.35 ~~of training, and the basic topics covered.~~

461.1 Sec. 10. [144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.

461.2 Subdivision 1. License required. A home care provider may not open, operate,
461.3 manage, conduct, maintain, or advertise itself as a home care provider or provide home
461.4 care services in Minnesota without a temporary or current home care provider license
461.5 issued by the commissioner of health.

461.6 Subd. 2. Determination of direct home care service. (a) "Direct home care
461.7 service" means a home care service provided to a client by the home care provider or its
461.8 employees, and not by contract. Factors that must be considered in determining whether
461.9 an individual or a business entity provides at least one home care service directly include,
461.10 but are not limited to, whether the individual or business entity:

461.11 (1) has the right to control, and does control, the types of services provided;

461.12 (2) has the right to control, and does control, when and how the services are provided;

461.13 (3) establishes the charges;

461.14 (4) collects fees from the clients or receives payment from third-party payers on
461.15 the clients' behalf;

461.16 (5) pays individuals providing services compensation on an hourly, weekly, or
461.17 similar basis;

461.18 (6) treats the individuals providing services as employees for the purposes of payroll
461.19 taxes and workers' compensation insurance; and

461.20 (7) holds itself out as a provider of home care services or acts in a manner that
461.21 leads clients or potential clients to believe that it is a home care provider providing home
461.22 care services.

461.23 (b) None of the factors listed in this subdivision is solely determinative.

461.24 Subd. 3. Determination of regularly engaged. (a) "Regularly engaged" means
461.25 providing, or offering to provide, home care services as a regular part of a business. The
461.26 following factors must be considered by the commissioner in determining whether an
461.27 individual or a business entity is regularly engaged in providing home care services:

461.28 (1) whether the individual or business entity states or otherwise promotes that the
461.29 individual or business entity provides home care services;

461.30 (2) whether persons receiving home care services constitute a substantial part of the
461.31 individual's or the business entity's clientele; and

461.32 (3) whether the home care services provided are other than occasional or incidental
461.33 to the provision of services other than home care services.

461.34 (b) None of the factors listed in this subdivision is solely determinative.

461.35 Subd. 4. Penalties for operating without license. A person involved in the
461.36 management, operation, or control of a home care provider that operates without an

462.1 appropriate license is guilty of a misdemeanor. This section does not apply to a person
462.2 who has no legal authority to affect or change decisions related to the management,
462.3 operation, or control of a home care provider.

462.4 Subd. 5. **Basic and comprehensive levels of licensure.** An applicant seeking
462.5 to become a home care provider must apply for either a basic or comprehensive home
462.6 care license.

462.7 Subd. 6. **Basic home care license provider.** Home care services that can be
462.8 provided with a basic home care license are assistive tasks provided by licensed or
462.9 unlicensed personnel that include:

462.10 (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting,
462.11 and bathing;

462.12 (2) providing standby assistance;

462.13 (3) providing verbal or visual reminders to the client to take regularly scheduled
462.14 medication, which includes bringing the client previously set-up medication, medication
462.15 in original containers, or liquid or food to accompany the medication;

462.16 (4) providing verbal or visual reminders to the client to perform regularly scheduled
462.17 treatments and exercises;

462.18 (5) preparing modified diets ordered by a licensed health professional; and

462.19 (6) assisting with laundry, housekeeping, meal preparation, shopping, or other
462.20 household chores and services if the provider is also providing at least one of the activities
462.21 in clauses (1) to (5)

462.22 Subd. 7. **Comprehensive home care license provider.** Home care services that
462.23 may be provided with a comprehensive home care license include any of the basic home
462.24 care services listed in subdivision 6, and one or more of the following:

462.25 (1) services of an advanced practice nurse, registered nurse, licensed practical
462.26 nurse, physical therapist, respiratory therapist, occupational therapist, speech-language
462.27 pathologist, dietitian or nutritionist, or social worker;

462.28 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a
462.29 licensed health professional within the person's scope of practice;

462.30 (3) medication management services;

462.31 (4) hands-on assistance with transfers and mobility;

462.32 (5) assisting clients with eating when the clients have complicating eating problems
462.33 as identified in the client record or through an assessment such as difficulty swallowing,
462.34 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
462.35 instruments to be fed; or

462.36 (6) providing other complex or specialty health care services.

463.1 Subd. 8. Exemptions from home care services licensure. (a) Except as otherwise
463.2 provided in this chapter, home care services that are provided by the state, counties, or
463.3 other units of government must be licensed under this chapter.

463.4 (b) An exemption under this subdivision does not excuse the exempted individual or
463.5 organization from complying with applicable provisions of the home care bill of rights
463.6 in section 144A.44. The following individuals or organizations are exempt from the
463.7 requirement to obtain a home care provider license:

463.8 (1) an individual or organization that offers, provides, or arranges for personal care
463.9 assistance services under the medical assistance program as authorized under sections
463.10 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;

463.11 (2) a provider that is licensed by the commissioner of human services to provide
463.12 semi-independent living services for persons with developmental disabilities under section
463.13 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

463.14 (3) a provider that is licensed by the commissioner of human services to provide
463.15 home and community-based services for persons with developmental disabilities under
463.16 section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

463.17 (4) an individual or organization that provides only home management services, if
463.18 the individual or organization is registered under section 144A.482; or

463.19 (5) an individual who is licensed in this state as a nurse, dietitian, social worker,
463.20 occupational therapist, physical therapist, or speech-language pathologist who provides
463.21 health care services in the home independently and not through any contractual or
463.22 employment relationship with a home care provider or other organization.

463.23 Subd. 9. Exclusions from home care licensure. The following are excluded from
463.24 home care licensure and are not required to provide the home care bill of rights:

463.25 (1) an individual or business entity providing only coordination of home care that
463.26 includes one or more of the following:

463.27 (i) determination of whether a client needs home care services, or assisting a client
463.28 in determining what services are needed;

463.29 (ii) referral of clients to a home care provider;

463.30 (iii) administration of payments for home care services; or

463.31 (iv) administration of a health care home established under section 256B.0751;

463.32 (2) an individual who is not an employee of a licensed home care provider if the
463.33 individual:

463.34 (i) only provides services as an independent contractor to one or more licensed
463.35 home care providers;

463.36 (ii) provides no services under direct agreements or contracts with clients; and

- 464.1 (iii) is contractually bound to perform services in compliance with the contracting
464.2 home care provider's policies and service plans;
- 464.3 (3) a business that provides staff to home care providers, such as a temporary
464.4 employment agency, if the business:
- 464.5 (i) only provides staff under contract to licensed or exempt providers;
464.6 (ii) provides no services under direct agreements with clients; and
464.7 (iii) is contractually bound to perform services under the contracting home care
464.8 provider's direction and supervision;
- 464.9 (4) any home care services conducted by and for the adherents of any recognized
464.10 church or religious denomination for its members through spiritual means, or by prayer
464.11 for healing;
- 464.12 (5) an individual who only provides home care services to a relative;
- 464.13 (6) an individual not connected with a home care provider that provides assistance
464.14 with basic home care needs if the assistance is provided primarily as a contribution and
464.15 not as a business;
- 464.16 (7) an individual not connected with a home care provider that shares housing with
464.17 and provides primarily housekeeping or homemaking services to an elderly or disabled
464.18 person in return for free or reduced-cost housing;
- 464.19 (8) an individual or provider providing home-delivered meal services;
- 464.20 (9) an individual providing senior companion services and other older American
464.21 volunteer programs (OAVP) established under the Domestic Volunteer Service Act of
464.22 1973, United States Code, title 42, chapter 66;
- 464.23 (10) an employee of a nursing home licensed under this chapter or an employee of a
464.24 boarding care home licensed under sections 144.50 to 144.56 who responds to occasional
464.25 emergency calls from individuals residing in a residential setting that is attached to or
464.26 located on property contiguous to the nursing home or boarding care home;
- 464.27 (11) a member of a professional corporation organized under chapter 319B that
464.28 does not regularly offer or provide home care services as defined in section 144A.43,
464.29 subdivision 3;
- 464.30 (12) the following organizations established to provide medical or surgical services
464.31 that do not regularly offer or provide home care services as defined in section 144A.43,
464.32 subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit
464.33 corporation organized under chapter 317A, a partnership organized under chapter 323, or
464.34 any other entity determined by the commissioner;

465.1 (13) an individual or agency that provides medical supplies or durable medical
 465.2 equipment, except when the provision of supplies or equipment is accompanied by a
 465.3 home care service;

465.4 (14) a physician licensed under chapter 147;

465.5 (15) an individual who provides home care services to a person with a developmental
 465.6 disability who lives in a place of residence with a family, foster family, or primary caregiver;

465.7 (16) a business that only provides services that are primarily instructional and not
 465.8 medical services or health-related support services;

465.9 (17) an individual who performs basic home care services for no more than 14 hours
 465.10 each calendar week to no more than one client;

465.11 (18) an individual or business licensed as hospice as defined in sections 144A.75 to
 465.12 144A.755 who is not providing home care services independent of hospice service;

465.13 (19) activities conducted by the commissioner of health or a board of health as
 465.14 defined in section 145A.02, subdivision 2, including communicable disease investigations
 465.15 or testing; or

465.16 (20) administering or monitoring a prescribed therapy necessary to control or
 465.17 prevent a communicable disease, or the monitoring of an individual's compliance with a
 465.18 health directive as defined in section 144.4172, subdivision 6.

465.19 Sec. 11. **[144A.472] HOME CARE PROVIDER LICENSE; APPLICATION**
 465.20 **AND RENEWAL.**

465.21 Subdivision 1. **License applications.** Each application for a home care provider
 465.22 license must include information sufficient to show that the applicant meets the
 465.23 requirements of licensure, including:

465.24 (1) the applicant's name, e-mail address, physical address, and mailing address,
 465.25 including the name of the county in which the applicant resides and has a principal
 465.26 place of business;

465.27 (2) the initial license fee in the amount specified in subdivision 7;

465.28 (3) the e-mail address, physical address, mailing address, and telephone number of
 465.29 the principal administrative office;

465.30 (4) the e-mail address, physical address, mailing address, and telephone number of
 465.31 each branch office, if any;

465.32 (5) the names, e-mail and mailing addresses, and telephone numbers of all owners
 465.33 and managerial officials;

- 466.1 (6) documentation of compliance with the background study requirements of section
466.2 144A.476 for all persons involved in the management, operation, or control of the home
466.3 care provider;
- 466.4 (7) documentation of a background study as required by section 144.057 for any
466.5 individual seeking employment, paid or volunteer, with the home care provider;
- 466.6 (8) evidence of workers' compensation coverage as required by sections 176.181
466.7 and 176.182;
- 466.8 (9) documentation of liability coverage, if the provider has it;
- 466.9 (10) identification of the license level the provider is seeking;
- 466.10 (11) documentation that identifies the managerial official who is in charge of
466.11 day-to-day operations and attestation that the person has reviewed and understands the
466.12 home care provider regulations;
- 466.13 (12) documentation that the applicant has designated one or more owners,
466.14 managerial officials, or employees as an agent or agents, which shall not affect the legal
466.15 responsibility of any other owner or managerial official under this chapter;
- 466.16 (13) the signature of the officer or managing agent on behalf of an entity, corporation,
466.17 association, or unit of government;
- 466.18 (14) verification that the applicant has the following policies and procedures in place
466.19 so that if a license is issued, the applicant will implement the policies and procedures
466.20 and keep them current:
- 466.21 (i) requirements in sections 626.556, reporting of maltreatment of minors, and
466.22 626.557, reporting of maltreatment of vulnerable adults;
- 466.23 (ii) conducting and handling background studies on employees;
- 466.24 (iii) orientation, training, and competency evaluations of home care staff, and a
466.25 process for evaluating staff performance;
- 466.26 (iv) handling complaints from clients, family members, or client representatives
466.27 regarding staff or services provided by staff;
- 466.28 (v) conducting initial evaluation of clients' needs and the providers' ability to provide
466.29 those services;
- 466.30 (vi) conducting initial and ongoing client evaluations and assessments and how
466.31 changes in a client's condition are identified, managed, and communicated to staff and
466.32 other health care providers as appropriate;
- 466.33 (vii) orientation to and implementation of the home care client bill of rights;
- 466.34 (viii) infection control practices;
- 466.35 (ix) reminders for medications, treatments, or exercises, if provided; and

467.1 (x) conducting appropriate screenings, or documentation of prior screenings, to
467.2 show that staff are free of tuberculosis, consistent with current United States Centers for
467.3 Disease Control and Prevention standards; and

467.4 (15) other information required by the department.

467.5 Subd. 2. **Comprehensive home care license applications.** In addition to the
467.6 information and fee required in subdivision 1, applicants applying for a comprehensive
467.7 home care license must also provide verification that the applicant has the following
467.8 policies and procedures in place so that if a license is issued, the applicant will implement
467.9 the policies and procedures in this subdivision and keep them current:

467.10 (1) conducting initial and ongoing assessments of the client's needs by a registered
467.11 nurse or appropriate licensed health professional, including how changes in the client's
467.12 conditions are identified, managed, and communicated to staff and other health care
467.13 providers, as appropriate;

467.14 (2) ensuring that nurses and licensed health professionals have current and valid
467.15 licenses to practice;

467.16 (3) medication and treatment management;

467.17 (4) delegation of home care tasks by registered nurses or licensed health professionals;

467.18 (5) supervision of registered nurses and licensed health professionals; and

467.19 (6) supervision of unlicensed personnel performing delegated home care tasks.

467.20 Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license
467.21 may be renewed for a period of one year if the licensee satisfies the following:

467.22 (1) submits an application for renewal in the format provided by the commissioner
467.23 at least 30 days before expiration of the license;

467.24 (2) submits the renewal fee in the amount specified in subdivision 7;

467.25 (3) has provided home care services within the past 12 months;

467.26 (4) complies with sections 144A.43 to 144A.4798;

467.27 (5) provides information sufficient to show that the applicant meets the requirements
467.28 of licensure, including items required under subdivision 1;

467.29 (6) provides verification that all policies under subdivision 1 are current; and

467.30 (7) provides any other information deemed necessary by the commissioner.

467.31 (b) A renewal applicant who holds a comprehensive home care license must also
467.32 provide verification that policies listed under subdivision 2 are current.

467.33 Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately
467.34 licensed if the commissioner determines that the units cannot adequately share supervision
467.35 and administration of services from the main office.

468.1 Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license
 468.2 issued by the commissioner may not be transferred to another party. Before acquiring
 468.3 ownership of a home care provider business, a prospective applicant must apply for a
 468.4 new temporary license. A change of ownership is a transfer of operational control to
 468.5 a different business entity and includes:

- 468.6 (1) transfer of the business to a different or new corporation;
- 468.7 (2) in the case of a partnership, the dissolution or termination of the partnership under
 468.8 chapter 323A, with the business continuing by a successor partnership or other entity;
- 468.9 (3) relinquishment of control of the provider to another party, including to a contract
 468.10 management firm that is not under the control of the owner of the business' assets;
- 468.11 (4) transfer of the business by a sole proprietor to another party or entity; or
- 468.12 (5) in the case of a privately held corporation, the change in ownership or control of
 468.13 50 percent or more of the outstanding voting stock.

468.14 Subd. 6. **Notification of changes of information.** The temporary licensee or
 468.15 licensee shall notify the commissioner in writing within ten working days after any
 468.16 change in the information required in subdivision 1, except the information required in
 468.17 subdivision 1, clause (5), is required at the time of license renewal.

468.18 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial
 468.19 applicant seeking a temporary home care licensure must submit the following application
 468.20 fee to the commissioner along with a completed application:

- 468.21 (1) for a basic home care provider, \$2,100; or
- 468.22 (2) for a comprehensive home care provider, \$4,200.

468.23 (b) A home care provider who is filing a change of ownership as required under
 468.24 subdivision 5 must submit the following application fee to the commissioner, along with
 468.25 the documentation required for the change of ownership:

- 468.26 (1) for a basic home care provider, \$2,100; or
- 468.27 (2) for a comprehensive home care provider, \$4,200.

468.28 (c) A home care provider who is seeking to renew the provider's license shall pay a
 468.29 fee to the commissioner based on revenues derived from the provision of home care
 468.30 services during the calendar year prior to the year in which the application is submitted,
 468.31 according to the following schedule:

<u>License Renewal Fee</u>	
<u>Provider Annual Revenue</u>	<u>Fee</u>
<u>greater than \$1,500,000</u>	<u>\$6,625</u>
<u>greater than \$1,275,000 and no more than</u> <u>\$1,500,000</u>	<u>\$5,797</u>

469.1	<u>greater than \$1,100,000 and no more than</u>	
469.2	<u>\$1,275,000</u>	<u>\$4,969</u>
469.3	<u>greater than \$950,000 and no more than</u>	
469.4	<u>\$1,100,000</u>	<u>\$4,141</u>
469.5	<u>greater than \$850,000 and no more than</u>	
469.6	<u>\$950,000</u>	<u>\$3,727</u>
469.7	<u>greater than \$750,000 and no more than</u>	
469.8	<u>\$850,000</u>	<u>\$3,313</u>
469.9	<u>greater than \$650,000 and no more than</u>	
469.10	<u>\$750,000</u>	<u>\$2,898</u>
469.11	<u>greater than \$550,000 and no more than</u>	
469.12	<u>\$650,000</u>	<u>\$2,485</u>
469.13	<u>greater than \$450,000 and no more than</u>	
469.14	<u>\$550,000</u>	<u>\$2,070</u>
469.15	<u>greater than \$350,000 and no more than</u>	
469.16	<u>\$450,000</u>	<u>\$1,656</u>
469.17	<u>greater than \$250,000 and no more than</u>	
469.18	<u>\$350,000</u>	<u>\$1,242</u>
469.19	<u>greater than \$100,000 and no more than</u>	
469.20	<u>\$250,000</u>	<u>\$828</u>
469.21	<u>greater than \$50,000 and no more than \$100,000</u>	<u>\$500</u>
469.22	<u>greater than \$25,000 and no more than \$50,000</u>	<u>\$400</u>
469.23	<u>no more than \$25,000</u>	<u>\$200</u>

469.24 (d) If requested, the home care provider shall provide the commissioner information
 469.25 to verify the provider's annual revenues or other information as needed, including copies
 469.26 of documents submitted to the Department of Revenue.

469.27 (e) At each annual renewal, a home care provider may elect to pay the highest
 469.28 renewal fee for its license category, and not provide annual revenue information to the
 469.29 commissioner.

469.30 (f) A temporary license or license applicant, or temporary licensee or licensee that
 469.31 knowingly provides the commissioner incorrect revenue amounts for the purpose of
 469.32 paying a lower license fee shall be subject to a civil penalty in the amount of double the
 469.33 fee the provider should have paid.

469.34 (g) Fees and penalties collected under this section shall be deposited in the state
 469.35 treasury and credited to the special state government revenue fund.

469.36 (h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

469.37 **Sec. 12. [144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE**
 469.38 **RENEWAL.**

469.39 **Subdivision 1. Temporary license and renewal of license.** (a) The department
 469.40 shall review each application to determine the applicant's knowledge of and compliance
 469.41 with Minnesota home care regulations. Before granting a temporary license or renewing a

470.1 license, the commissioner may further evaluate the applicant or licensee by requesting
470.2 additional information or documentation or by conducting an on-site survey of the
470.3 applicant to determine compliance with sections 144A.43 to 144A.482.

470.4 (b) Within 14 calendar days after receiving an application for a license,
470.5 the commissioner shall acknowledge receipt of the application in writing. The
470.6 acknowledgment must indicate whether the application appears to be complete or whether
470.7 additional information is required before the application will be considered complete.

470.8 (c) Within 90 days after receiving a complete application, the commissioner shall
470.9 issue a temporary license, renew the license, or deny the license.

470.10 (d) The commissioner shall issue a license that contains the home care provider's
470.11 name, address, license level, expiration date of the license, and unique license number. All
470.12 licenses are valid for one year from the date of issuance.

470.13 Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner
470.14 shall issue a temporary license for either the basic or comprehensive home care level. A
470.15 temporary license is effective for one year from the date of issuance. Temporary licensees
470.16 must comply with sections 144A.43 to 144A.482.

470.17 (b) During the temporary license year, the commissioner shall survey the temporary
470.18 licensee after the commissioner is notified or has evidence that the temporary licensee
470.19 is providing home care services.

470.20 (c) Within five days of beginning the provision of services, the temporary
470.21 licensee must notify the commissioner that it is serving clients. The notification to the
470.22 commissioner may be mailed or e-mailed to the commissioner at the address provided by
470.23 the commissioner. If the temporary licensee does not provide home care services during
470.24 the temporary license year, then the temporary license expires at the end of the year and
470.25 the applicant must reapply for a temporary home care license.

470.26 (d) A temporary licensee may request a change in the level of licensure prior to
470.27 being surveyed and granted a license by notifying the commissioner in writing and
470.28 providing additional documentation or materials required to update or complete the
470.29 changed temporary license application. The applicant must pay the difference between
470.30 the application fees when changing from the basic level to the comprehensive level of
470.31 licensure. No refund will be made if the provider chooses to change the license application
470.32 to the basic level.

470.33 (e) If the temporary licensee notifies the commissioner that the licensee has clients
470.34 within 45 days prior to the temporary license expiration, the commissioner may extend the
470.35 temporary license for up to 60 days in order to allow the commissioner to complete the
470.36 on-site survey required under this section and follow-up survey visits.

471.1 Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial
471.2 compliance with the survey, the commissioner shall issue either a basic or comprehensive
471.3 home care license. If the temporary licensee is not in substantial compliance with the
471.4 survey, the commissioner shall not issue a basic or comprehensive license and there will
471.5 be no contested hearing right under chapter 14.

471.6 (b) If the temporary licensee whose basic or comprehensive license has been denied
471.7 disagrees with the conclusions of the commissioner, then the licensee may request a
471.8 reconsideration by the commissioner or commissioner's designee. The reconsideration
471.9 request process must be conducted internally by the commissioner or commissioner's
471.10 designee, and chapter 14 does not apply.

471.11 (c) The temporary licensee requesting reconsideration must make the request in
471.12 writing and must list and describe the reasons why the licensee disagrees with the decision
471.13 to deny the basic or comprehensive home care license.

471.14 (d) A temporary licensee whose license is denied must comply with the requirements
471.15 for notification and transfer of clients in section 144A.475, subdivision 5.

471.16 **Sec. 13. [144A.474] SURVEYS AND INVESTIGATIONS.**

471.17 Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home
471.18 care provider. By June 30, 2016, the commissioner shall conduct a survey of home care
471.19 providers on a frequency of at least once every three years. Survey frequency may be
471.20 based on the license level, the provider's compliance history, number of clients served,
471.21 or other factors as determined by the department deemed necessary to ensure the health,
471.22 safety, and welfare of clients and compliance with the law.

471.23 Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of
471.24 a new temporary licensee conducted after the department is notified or has evidence that
471.25 the temporary licensee is providing home care services to determine if the provider is in
471.26 compliance with home care requirements. Initial full surveys must be completed within 14
471.27 months after the department's issuance of a temporary basic or comprehensive license.

471.28 (b) "Core survey" means periodic inspection of home care providers to determine
471.29 ongoing compliance with the home care requirements, focusing on the essential health and
471.30 safety requirements. Core surveys are available to licensed home care providers who have
471.31 been licensed for three years and surveyed at least once in the past three years with the
471.32 latest survey having no widespread violations beyond Level 1 as provided in subdivision
471.33 11. Providers must also not have had any substantiated licensing complaints, substantiated
471.34 complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors
471.35 Act, or an enforcement action as authorized in section 144A.475 in the past three years.

472.1 (1) The core survey for basic home care providers must review compliance in the
472.2 following areas:

472.3 (i) reporting of maltreatment;

472.4 (ii) orientation to and implementation of Home Care Client Bill of Rights;

472.5 (iii) statement of home care services;

472.6 (iv) initial evaluation of clients and initiation of services;

472.7 (v) client review and monitoring;

472.8 (vi) service plan implementation and changes to the service plan;

472.9 (vii) client complaint and investigative process;

472.10 (viii) competency of unlicensed personnel; and

472.11 (ix) infection control.

472.12 (2) For comprehensive home care providers, the core survey must include everything
472.13 in the basic core survey plus these areas:

472.14 (i) delegation to unlicensed personnel;

472.15 (ii) assessment, monitoring, and reassessment of clients; and

472.16 (iii) medication, treatment, and therapy management.

472.17 (c) "Full survey" means the periodic inspection of home care providers to determine
472.18 ongoing compliance with the home care requirements that cover the core survey areas
472.19 and all the legal requirements for home care providers. A full survey is conducted for all
472.20 temporary licensees and for providers who do not meet the requirements needed for a core
472.21 survey, and when a surveyor identifies unacceptable client health or safety risks during a
472.22 core survey. A full survey must include all the tasks identified as part of the core survey
472.23 and any additional review deemed necessary by the department, including additional
472.24 observation, interviewing, or records review of additional clients and staff.

472.25 (d) "Follow-up surveys" means surveys conducted to determine if a home care
472.26 provider has corrected deficient issues and systems identified during a core survey, full
472.27 survey, or complaint investigation. Follow-up surveys may be conducted via phone,
472.28 e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys,
472.29 shall be concluded with an exit conference and written information provided on the
472.30 process for requesting a reconsideration of the survey results.

472.31 (e) Upon receiving information alleging that a home care provider has violated or
472.32 is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner
472.33 shall investigate the complaint according to sections 144A.51 to 144A.54.

472.34 Subd. 3. **Survey process.** (a) The survey process for core surveys shall include the
472.35 following as applicable to the particular licensee and setting surveyed:

473.1 (1) presurvey review of pertinent documents and notification to the ombudsman
473.2 for long-term care;

473.3 (2) an entrance conference with available staff;

473.4 (3) communication with managerial officials or the registered nurse in charge, if
473.5 available, and ongoing communication with key staff throughout the survey regarding
473.6 information needed by the surveyor, clarifications regarding home care requirements, and
473.7 applicable standards of practice;

473.8 (4) presentation of written contact information to the provider about the survey staff
473.9 conducting the survey, the supervisor, and the process for requesting a reconsideration of
473.10 the survey results;

473.11 (5) a brief tour of a sample of the housing with services establishments in which the
473.12 provider is providing home care services;

473.13 (6) a sample selection of home care clients;

473.14 (7) information-gathering through client and staff observations, client and staff
473.15 interviews, and reviews of records, policies, procedures, practices, and other agency
473.16 information;

473.17 (8) interviews of clients' family members, if available, with clients' consent when the
473.18 client can legally give consent;

473.19 (9) except for complaint surveys conducted by the Office of Health Facilities
473.20 Complaints, an on-site exit conference, with preliminary findings shared and discussed
473.21 with the provider, documentation that an exit conference occurred, and written information
473.22 provided on the process for requesting a reconsideration of the survey results; and

473.23 (10) postsurvey analysis of findings and formulation of survey results, including
473.24 correction orders when applicable.

473.25 Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted
473.26 without advance notice to home care providers. Surveyors may contact the home care
473.27 provider on the day of a survey to arrange for someone to be available at the survey site.
473.28 The contact does not constitute advance notice.

473.29 Subd. 5. **Information provided by home care provider.** The home care provider
473.30 shall provide accurate and truthful information to the department during a survey,
473.31 investigation, or other licensing activities.

473.32 Subd. 6. **Providing client records.** Upon request of a surveyor, home care providers
473.33 shall provide a list of current and past clients or client representatives that includes
473.34 addresses and telephone numbers and any other information requested about the services
473.35 to clients within a reasonable period of time.

474.1 Subd. 7. **Contacting and visiting clients.** Surveyors may contact or visit a home
474.2 care provider's clients to gather information without notice to the home care provider.
474.3 Before visiting a client, a surveyor shall obtain the client's or client's representative's
474.4 permission by telephone, mail, or in person. Surveyors shall inform all clients or client's
474.5 representatives of their right to decline permission for a visit.

474.6 Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the
474.7 commissioner finds upon survey or during a complaint investigation that a home care
474.8 provider, a managerial official, or an employee of the provider is not in compliance with
474.9 sections 144A.43 to 144A.482. The correction order shall cite the specific statute and
474.10 document areas of noncompliance and the time allowed for correction.

474.11 (b) The commissioner shall mail copies of any correction order within 30 calendar
474.12 days after an exit survey to the last known address of the home care provider. A copy of
474.13 each correction order and copies of any documentation supplied to the commissioner shall
474.14 be kept on file by the home care provider, and public documents shall be made available
474.15 for viewing by any person upon request. Copies may be kept electronically.

474.16 (c) By the correction order date, the home care provider must document in the
474.17 provider's records any action taken to comply with the correction order. The commissioner
474.18 may request a copy of this documentation and the home care provider's action to respond
474.19 to the correction order in future surveys, upon a complaint investigation, and as otherwise
474.20 needed.

474.21 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations,
474.22 under subdivision 11, or any violations determined to be widespread, the department shall
474.23 conduct a follow-up survey within 90 calendar days of the survey. When conducting a
474.24 follow-up survey, the surveyor will focus on whether the previous violations have been
474.25 corrected and may also address any new violations that are observed while evaluating the
474.26 corrections that have been made. If a new violation is identified on a follow-up survey, no
474.27 fine will be imposed unless it is not corrected on the next follow-up survey.

474.28 Subd. 10. **Performance incentive.** A licensee is eligible for a performance
474.29 incentive if there are no violations identified in a core or full survey. The performance
474.30 incentive is a ten percent discount on the licensee's next home care renewal license fee.

474.31 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be
474.32 assessed based on the level and scope of the violations described in paragraph (c) as follows:

474.33 (1) Level 1, no fines or enforcement;

474.34 (2) Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement
474.35 mechanisms authorized in section 144A.475 for widespread violations;

475.1 (3) Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement
475.2 mechanisms authorized in section 144A.475; and

475.3 (4) Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the
475.4 enforcement mechanisms authorized in section 144A.475.

475.5 (b) Correction orders for violations are categorized by both level and scope and
475.6 fines shall be assessed as follows:

475.7 (1) Level of violation:

475.8 (i) Level 1 is a violation that has no potential to cause more than a minimal impact
475.9 on the client and does not affect health or safety;

475.10 (ii) Level 2 is a violation that did not harm a client's health or safety but had the
475.11 potential to have harmed a client's health or safety, but was not likely to cause serious
475.12 injury, impairment, or death;

475.13 (iii) Level 3 is a violation that harmed a client's health or safety, not including
475.14 serious injury, impairment, or death, or a violation that has the potential to lead to serious
475.15 injury, impairment, or death; and

475.16 (iv) Level 4 is a violation that results in serious injury, impairment, or death.

475.17 (2) Scope of violation:

475.18 (i) isolated, when one or a limited number of clients are affected or one or a limited
475.19 number of staff are involved or the situation has occurred only occasionally;

475.20 (ii) pattern, when more than a limited number of clients are affected, more than a
475.21 limited number of staff are involved, or the situation has occurred repeatedly but is not
475.22 found to be pervasive; and

475.23 (iii) widespread, when problems are pervasive or represent a systemic failure that
475.24 has affected or has the potential to affect a large portion or all of the clients.

475.25 (c) If the commissioner finds that the applicant or a home care provider required
475.26 to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the
475.27 date specified in the correction order or conditional license resulting from a survey or
475.28 complaint investigation, the commissioner may impose a fine. A notice of noncompliance
475.29 with a correction order must be mailed to the applicant's or provider's last known address.
475.30 The noncompliance notice must list the violations not corrected.

475.31 (d) The license holder must pay the fines assessed on or before the payment date
475.32 specified. If the license holder fails to fully comply with the order, the commissioner
475.33 may issue a second fine or suspend the license until the license holder complies by
475.34 paying the fine. A timely appeal shall stay payment of the fine until the commissioner
475.35 issues a final order.

476.1 (e) A license holder shall promptly notify the commissioner in writing when a
476.2 violation specified in the order is corrected. If upon reinspection the commissioner
476.3 determines that a violation has not been corrected as indicated by the order, the
476.4 commissioner may issue a second fine. The commissioner shall notify the license holder by
476.5 mail to the last known address in the licensing record that a second fine has been assessed.
476.6 The license holder may appeal the second fine as provided under this subdivision.

476.7 (f) A home care provider that has been assessed a fine under this subdivision has a
476.8 right to a reconsideration or a hearing under this section and chapter 14.

476.9 (g) When a fine has been assessed, the license holder may not avoid payment by
476.10 closing, selling, or otherwise transferring the licensed program to a third party. In such an
476.11 event, the license holder shall be liable for payment of the fine.

476.12 (h) In addition to any fine imposed under this section, the commissioner may assess
476.13 costs related to an investigation that results in a final order assessing a fine or other
476.14 enforcement action authorized by this chapter.

476.15 (i) Fines collected under this subdivision shall be deposited in the state government
476.16 special revenue fund and credited to an account separate from the revenue collected under
476.17 section 144A.472. Subject to an appropriation by the legislature, the revenue from the
476.18 finances collected may be used by the commissioner for special projects to improve home care
476.19 in Minnesota as recommended by the advisory council established in section 144A.4799.

476.20 Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home
476.21 care providers a correction order reconsideration process. This process may be used
476.22 to challenge the correction order issued, including the level and scope described in
476.23 subdivision 11, and any fine assessed. During the correction order reconsideration
476.24 request, the issuance for the correction orders under reconsideration are not stayed, but
476.25 the department shall post information on the Web site with the correction order that the
476.26 licensee has requested a reconsideration and that the review is pending.

476.27 (b) A licensed home care provider may request from the commissioner, in writing,
476.28 a correction order reconsideration regarding any correction order issued to the provider.
476.29 The correction order reconsideration shall not be reviewed by any surveyor, investigator,
476.30 or supervisor that participated in the writing or reviewing of the correction order
476.31 being disputed. The correction order reconsiderations may be conducted in person, by
476.32 telephone, by another electronic form, or in writing, as determined by the commissioner.
476.33 The commissioner shall respond in writing to the request from a home care provider
476.34 for a correction order reconsideration within 60 days of the date the provider requests a
476.35 reconsideration. The commissioner's response shall identify the commissioner's decision
476.36 regarding each citation challenged by the home care provider.

477.1 (c) The findings of a correction order reconsideration process shall be one or more of
 477.2 the following:

477.3 (1) supported in full, the correction order is supported in full, with no deletion of
 477.4 findings to the citation;

477.5 (2) supported in substance, the correction order is supported, but one or more
 477.6 findings are deleted or modified without any change in the citation;

477.7 (3) correction order cited an incorrect home care licensing requirement, the correction
 477.8 order is amended by changing the correction order to the appropriate statutory reference;

477.9 (4) correction order was issued under an incorrect citation, the correction order is
 477.10 amended to be issued under the more appropriate correction order citation;

477.11 (5) the correction order is rescinded;

477.12 (6) fine is amended, it is determined that the fine assigned to the correction order
 477.13 was applied incorrectly; or

477.14 (7) the level or scope of the citation is modified based on the reconsideration.

477.15 (d) If the correction order findings are changed by the commissioner, the
 477.16 commissioner shall update the correction order Web site.

477.17 Subd. 13. **Home care surveyor training.** (a) Before conducting a home care
 477.18 survey, each home care surveyor must receive training on the following topics:

477.19 (1) Minnesota home care licensure requirements;

477.20 (2) Minnesota Home Care Client Bill of Rights;

477.21 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

477.22 (4) principles of documentation;

477.23 (5) survey protocol and processes;

477.24 (6) Offices of the Ombudsman roles;

477.25 (7) Office of Health Facility Complaints;

477.26 (8) Minnesota landlord-tenant and housing with services laws;

477.27 (9) types of payors for home care services; and

477.28 (10) Minnesota Nurse Practice Act for nurse surveyors.

477.29 (b) Materials used for the training in paragraph (a) shall be posted on the department
 477.30 Web site. Requisite understanding of these topics will be reviewed as part of the quality
 477.31 improvement plan in section 144A.483.

477.32 Sec. 14. **[144A.475] ENFORCEMENT.**

477.33 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary
 477.34 license, renew a license, suspend or revoke a license, or impose a conditional license if the
 477.35 home care provider or owner or managerial official of the home care provider:

- 478.1 (1) is in violation of, or during the term of the license has violated, any of the
478.2 requirements in sections 144A.471 to 144A.482;
- 478.3 (2) permits, aids, or abets the commission of any illegal act in the provision of
478.4 home care;
- 478.5 (3) performs any act detrimental to the health, safety, and welfare of a client;
- 478.6 (4) obtains the license by fraud or misrepresentation;
- 478.7 (5) knowingly made or makes a false statement of a material fact in the application
478.8 for a license or in any other record or report required by this chapter;
- 478.9 (6) denies representatives of the department access to any part of the home care
478.10 provider's books, records, files, or employees;
- 478.11 (7) interferes with or impedes a representative of the department in contacting the
478.12 home care provider's clients;
- 478.13 (8) interferes with or impedes a representative of the department in the enforcement
478.14 of this chapter or has failed to fully cooperate with an inspection, survey, or investigation
478.15 by the department;
- 478.16 (9) destroys or makes unavailable any records or other evidence relating to the home
478.17 care provider's compliance with this chapter;
- 478.18 (10) refuses to initiate a background study under section 144.057 or 245A.04;
- 478.19 (11) fails to timely pay any fines assessed by the department;
- 478.20 (12) violates any local, city, or township ordinance relating to home care services;
- 478.21 (13) has repeated incidents of personnel performing services beyond their
478.22 competency level; or
- 478.23 (14) has operated beyond the scope of the home care provider's license level.
- 478.24 (b) A violation by a contractor providing the home care services of the home care
478.25 provider is a violation by the home care provider.
- 478.26 Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional
478.27 license designation may include terms that must be completed or met before a suspension
478.28 or conditional license designation is lifted. A conditional license designation may include
478.29 restrictions or conditions that are imposed on the provider. Terms for a suspension or
478.30 conditional license may include one or more of the following and the scope of each will be
478.31 determined by the commissioner:
- 478.32 (1) requiring a consultant to review, evaluate, and make recommended changes to
478.33 the home care provider's practices and submit reports to the commissioner at the cost of
478.34 the home care provider;

479.1 (2) requiring supervision of the home care provider or staff practices at the cost
479.2 of the home care provider by an unrelated person who has sufficient knowledge and
479.3 qualifications to oversee the practices and who will submit reports to the commissioner;

479.4 (3) requiring the home care provider or employees to obtain training at the cost of
479.5 the home care provider;

479.6 (4) requiring the home care provider to submit reports to the commissioner;

479.7 (5) prohibiting the home care provider from taking any new clients for a period
479.8 of time; or

479.9 (6) any other action reasonably required to accomplish the purpose of this
479.10 subdivision and section 144A.45, subdivision 2.

479.11 Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license,
479.12 the home care provider shall be entitled to notice and a hearing as provided by sections
479.13 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may,
479.14 without a prior contested case hearing, temporarily suspend a license or prohibit delivery
479.15 of services by a provider for not more than 90 days if the commissioner determines that
479.16 the health or safety of a consumer is in imminent danger, provided:

479.17 (1) advance notice is given to the home care provider;

479.18 (2) after notice, the home care provider fails to correct the problem;

479.19 (3) the commissioner has reason to believe that other administrative remedies are not
479.20 likely to be effective; and

479.21 (4) there is an opportunity for a contested case hearing within the 90 days.

479.22 Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties
479.23 under section 144A.45, subdivision 2, clause (5), and an action against a license under
479.24 this section, a provider must request a hearing no later than 15 days after the provider
479.25 receives notice of the action.

479.26 Subd. 5. **Plan required.** (a) The process of suspending or revoking a license
479.27 must include a plan for transferring affected clients to other providers by the home care
479.28 provider, which will be monitored by the commissioner. Within three business days of
479.29 being notified of the final revocation or suspension action, the home care provider shall
479.30 provide the commissioner, the lead agencies as defined in section 256B.0911, and the
479.31 ombudsman for long-term care with the following information:

479.32 (1) a list of all clients, including full names and all contact information on file;

479.33 (2) a list of each client's representative or emergency contact person, including full
479.34 names and all contact information on file;

479.35 (3) the location or current residence of each client;

480.1 (4) the payor sources for each client, including payor source identification numbers;
480.2 and

480.3 (5) for each client, a copy of the client's service plan, and a list of the types of
480.4 services being provided.

480.5 (b) The revocation or suspension notification requirement is satisfied by mailing the
480.6 notice to the address in the license record. The home care provider shall cooperate with
480.7 the commissioner and the lead agencies during the process of transferring care of clients to
480.8 qualified providers. Within three business days of being notified of the final revocation or
480.9 suspension action, the home care provider must notify and disclose to each of the home
480.10 care provider's clients, or the client's representative or emergency contact persons, that
480.11 the commissioner is taking action against the home care provider's license by providing a
480.12 copy of the revocation or suspension notice issued by the commissioner.

480.13 Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The
480.14 owner and managerial officials of a home care provider whose Minnesota license has not
480.15 been renewed or that has been revoked because of noncompliance with applicable laws or
480.16 rules shall not be eligible to apply for nor will be granted a home care license, including
480.17 other licenses under this chapter, or be given status as an enrolled personal care assistance
480.18 provider agency or personal care assistant by the Department of Human Services under
480.19 section 256B.0659 for five years following the effective date of the nonrenewal or
480.20 revocation. If the owner and managerial officials already have enrollment status, their
480.21 enrollment will be terminated by the Department of Human Services.

480.22 (b) The commissioner shall not issue a license to a home care provider for five
480.23 years following the effective date of license nonrenewal or revocation if the owner or
480.24 managerial official, including any individual who was an owner or managerial official
480.25 of another home care provider, had a Minnesota license that was not renewed or was
480.26 revoked as described in paragraph (a).

480.27 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall
480.28 suspend or revoke, the license of any home care provider that includes any individual
480.29 as an owner or managerial official who was an owner or managerial official of a home
480.30 care provider whose Minnesota license was not renewed or was revoked as described in
480.31 paragraph (a) for five years following the effective date of the nonrenewal or revocation.

480.32 (d) The commissioner shall notify the home care provider 30 days in advance of
480.33 the date of nonrenewal, suspension, or revocation of the license. Within ten days after
480.34 the receipt of the notification, the home care provider may request, in writing, that the
480.35 commissioner stay the nonrenewal, revocation, or suspension of the license. The home
480.36 care provider shall specify the reasons for requesting the stay; the steps that will be taken

481.1 to attain or maintain compliance with the licensure laws and regulations; any limits on the
481.2 authority or responsibility of the owners or managerial officials whose actions resulted in
481.3 the notice of nonrenewal, revocation, or suspension; and any other information to establish
481.4 that the continuing affiliation with these individuals will not jeopardize client health, safety,
481.5 or well-being. The commissioner shall determine whether the stay will be granted within
481.6 30 days of receiving the provider's request. The commissioner may propose additional
481.7 restrictions or limitations on the provider's license and require that the granting of the stay
481.8 be contingent upon compliance with those provisions. The commissioner shall take into
481.9 consideration the following factors when determining whether the stay should be granted:

481.10 (1) the threat that continued involvement of the owners and managerial officials with
481.11 the home care provider poses to client health, safety, and well-being;

481.12 (2) the compliance history of the home care provider; and

481.13 (3) the appropriateness of any limits suggested by the home care provider.

481.14 If the commissioner grants the stay, the order shall include any restrictions or
481.15 limitation on the provider's license. The failure of the provider to comply with any
481.16 restrictions or limitations shall result in the immediate removal of the stay and the
481.17 commissioner shall take immediate action to suspend, revoke, or not renew the license.

481.18 Subd. 7. **Request for hearing.** A request for a hearing must be in writing and must:

481.19 (1) be mailed or delivered to the department or the commissioner's designee;

481.20 (2) contain a brief and plain statement describing every matter or issue contested; and

481.21 (3) contain a brief and plain statement of any new matter that the applicant or home
481.22 care provider believes constitutes a defense or mitigating factor.

481.23 Subd. 8. **Informal conference.** At any time, the applicant or home care provider
481.24 and the commissioner may hold an informal conference to exchange information, clarify
481.25 issues, or resolve issues.

481.26 Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the
481.27 commissioner may bring an action in district court to enjoin a person who is involved in
481.28 the management, operation, or control of a home care provider or an employee of the
481.29 home care provider from illegally engaging in activities regulated by sections 144A.43 to
481.30 144A.482. The commissioner may bring an action under this subdivision in the district
481.31 court in Ramsey County or in the district in which a home care provider is providing
481.32 services. The court may grant a temporary restraining order in the proceeding if continued
481.33 activity by the person who is involved in the management, operation, or control of a home
481.34 care provider, or by an employee of the home care provider, would create an imminent
481.35 risk of harm to a recipient of home care services.

482.1 Subd. 10. **Subpoena.** In matters pending before the commissioner under sections
482.2 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance
482.3 of witnesses and the production of all necessary papers, books, records, documents, and
482.4 other evidentiary material. If a person fails or refuses to comply with a subpoena or
482.5 order of the commissioner to appear or testify regarding any matter about which the
482.6 person may be lawfully questioned or to produce any papers, books, records, documents,
482.7 or evidentiary materials in the matter to be heard, the commissioner may apply to the
482.8 district court in any district, and the court shall order the person to comply with the
482.9 commissioner's order or subpoena. The commissioner of health may administer oaths to
482.10 witnesses or take their affirmation. Depositions may be taken in or outside the state in the
482.11 manner provided by law for the taking of depositions in civil actions. A subpoena or other
482.12 process or paper may be served on a named person anywhere in the state by an officer
482.13 authorized to serve subpoenas in civil actions, with the same fees and mileage and in the
482.14 same manner as prescribed by law for a process issued out of a district court. A person
482.15 subpoenaed under this subdivision shall receive the same fees, mileage, and other costs
482.16 that are paid in proceedings in district court.

482.17 Sec. 15. **[144A.476] BACKGROUND STUDIES.**

482.18 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a)
482.19 Before the commissioner issues a temporary license or renews a license, an owner or
482.20 managerial official is required to complete a background study under section 144.057. No
482.21 person may be involved in the management, operation, or control of a home care provider
482.22 if the person has been disqualified under chapter 245C. If an individual is disqualified
482.23 under section 144.057 or chapter 245C, the individual may request reconsideration of
482.24 the disqualification. If the individual requests reconsideration and the commissioner
482.25 sets aside or rescinds the disqualification, the individual is eligible to be involved in the
482.26 management, operation, or control of the provider. If an individual has a disqualification
482.27 under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's
482.28 disqualification is barred from a set aside, and the individual must not be involved in the
482.29 management, operation, or control of the provider.

482.30 (b) For purposes of this section, owners of a home care provider subject to the
482.31 background check requirement are those individuals whose ownership interest provides
482.32 sufficient authority or control to affect or change decisions related to the operation of the
482.33 home care provider. An owner includes a sole proprietor, a general partner, or any other
482.34 individual whose individual ownership interest can affect the management and direction
482.35 of the policies of the home care provider.

483.1 (c) For the purposes of this section, managerial officials subject to the background
483.2 check requirement are individuals who provide direct contact as defined in section
483.3 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing
483.4 management or direction of the policies, services, or employees of the home care provider.
483.5 Data collected under this subdivision shall be classified as private data on individuals
483.6 under section 13.02, subdivision 12.

483.7 (d) The department shall not issue any license if the applicant or owner or managerial
483.8 official has been unsuccessful in having a background study disqualification set aside
483.9 under section 144.057 and chapter 245C; if the owner or managerial official, as an owner
483.10 or managerial official of another home care provider, was substantially responsible for
483.11 the other home care provider's failure to substantially comply with sections 144A.43 to
483.12 144A.482; or if an owner that has ceased doing business, either individually or as an
483.13 owner of a home care provider, was issued a correction order for failing to assist clients in
483.14 violation of this chapter.

483.15 Subd. 2. **Employees, contractors, and volunteers.** (a) Employees, contractors,
483.16 and volunteers of a home care provider are subject to the background study required by
483.17 section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall
483.18 be construed to prohibit a home care provider from requiring self-disclosure of criminal
483.19 conviction information.

483.20 (b) Termination of an employee in good faith reliance on information or records
483.21 obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not
483.22 subject the home care provider to civil liability or liability for unemployment benefits.

483.23 Sec. 16. **[144A.477] COMPLIANCE.**

483.24 Subdivision 1. **Medicare-certified providers; coordination of surveys.** If feasible,
483.25 the commissioner shall survey licensees to determine compliance with this chapter at the
483.26 same time as surveys for certification for Medicare if Medicare certification is based on
483.27 compliance with the federal conditions of participation and on survey and enforcement
483.28 by the Department of Health as agent for the United States Department of Health and
483.29 Human Services.

483.30 Subd. 2. **Medicare-certified providers; equivalent requirements.** For home care
483.31 providers licensed to provide comprehensive home care services that are also certified for
483.32 participation in Medicare as a home health agency under Code of Federal Regulations,
483.33 title 42, part 484, the following state licensure regulations are considered equivalent to
483.34 the federal requirements:

483.35 (1) quality management, section 144A.479, subdivision 3;

- 484.1 (2) personnel records, section 144A.479, subdivision 7;
484.2 (3) acceptance of clients, section 144A.4791, subdivision 4;
484.3 (4) referrals, section 144A.4791, subdivision 5;
484.4 (5) client assessment, sections 144A.4791, subdivision 8, and 144A.4792,
484.5 subdivisions 2 and 3;
484.6 (6) individualized monitoring and reassessment, sections 144A.4791, subdivision
484.7 8, and 144A.4792, subdivisions 2 and 3;
484.8 (7) individualized service plan, sections 144A.4791, subdivision 9, 144A.4792,
484.9 subdivision 5, and 144A.4793, subdivision 3;
484.10 (8) client complaint and investigation process, section 144A.4791, subdivision 11;
484.11 (9) prescription orders, section 144A.4792, subdivisions 13 to 16;
484.12 (10) client records, section 144A.4794, subdivisions 1 to 3;
484.13 (11) qualifications for unlicensed personnel performing delegated tasks, section
484.14 144A.4795;
484.15 (12) training and competency staff, section 144A.4795;
484.16 (13) training and competency for unlicensed personnel, section 144A.4795,
484.17 subdivision 7;
484.18 (14) delegation of home care services, section 144A.4795, subdivision 4;
484.19 (15) availability of contact person, section 144A.4797, subdivision 1; and
484.20 (16) supervision of staff, section 144A.4797, subdivisions 2 and 3.
484.21 Violations of requirements in clauses (1) to (16) may lead to enforcement actions
484.22 under section 144A.474.

484.23 **Sec. 17. [144A.478] INNOVATION VARIANCE.**

484.24 Subdivision 1. **Definition.** For purposes of this section, "innovation variance"
484.25 means a specified alternative to a requirement of this chapter. An innovation variance
484.26 may be granted to allow a home care provider to offer home care services of a type or
484.27 in a manner that is innovative, will not impair the services provided, will not adversely
484.28 affect the health, safety, or welfare of the clients, and is likely to improve the services
484.29 provided. The innovative variance cannot change any of the client's rights under section
484.30 144A.44, home care bill of rights.

484.31 Subd. 2. **Conditions.** The commissioner may impose conditions on the granting of
484.32 an innovation variance that the commissioner considers necessary.

484.33 Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any
484.34 innovation variance and may renew a limited innovation variance.

485.1 Subd. 4. **Applications; innovation variance.** An application for innovation
485.2 variance from the requirements of this chapter may be made at any time, must be made in
485.3 writing to the commissioner, and must specify the following:

- 485.4 (1) the statute or law from which the innovation variance is requested;
485.5 (2) the time period for which the innovation variance is requested;
485.6 (3) the specific alternative action that the licensee proposes;
485.7 (4) the reasons for the request; and
485.8 (5) justification that an innovation variance will not impair the services provided,
485.9 will not adversely affect the health, safety, or welfare of clients, and is likely to improve
485.10 the services provided.

485.11 The commissioner may require additional information from the home care provider before
485.12 acting on the request.

485.13 Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request
485.14 for an innovation variance in writing within 45 days of receipt of a complete request.
485.15 Notice of a denial shall contain the reasons for the denial. The terms of a requested
485.16 innovation variance may be modified upon agreement between the commissioner and
485.17 the home care provider.

485.18 Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of
485.19 an innovation variance shall be deemed to be a violation of this chapter.

485.20 Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or
485.21 deny renewal of an innovation variance if:

- 485.22 (1) it is determined that the innovation variance is adversely affecting the health,
485.23 safety, or welfare of the licensee's clients;
485.24 (2) the home care provider has failed to comply with the terms of the innovation
485.25 variance;
485.26 (3) the home care provider notifies the commissioner in writing that it wishes to
485.27 relinquish the innovation variance and be subject to the statute previously varied; or
485.28 (4) the revocation or denial is required by a change in law.

485.29 Sec. 18. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES;**
485.30 **BUSINESS OPERATION.**

485.31 Subdivision 1. **Display of license.** The original current license must be displayed
485.32 in the home care providers' principal business office and copies must be displayed in
485.33 any branch office. The home care provider must provide a copy of the license to any
485.34 person who requests it.

486.1 Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent,
486.2 or misleading advertising in the marketing of services. For purposes of this section,
486.3 advertising includes any verbal, written, or electronic means of communicating to
486.4 potential clients about the availability, nature, or terms of home care services.

486.5 Subd. 3. **Quality management.** The home care provider shall engage in quality
486.6 management appropriate to the size of the home care provider and relevant to the type
486.7 of services the home care provider provides. The quality management activity means
486.8 evaluating the quality of care by periodically reviewing client services, complaints made,
486.9 and other issues that have occurred and determining whether changes in services, staffing,
486.10 or other procedures need to be made in order to ensure safe and competent services to
486.11 clients. Documentation about quality management activity must be available for two
486.12 years. Information about quality management must be available to the commissioner at
486.13 the time of the survey, investigation, or renewal.

486.14 Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licensees
486.15 that are Minnesota counties or other units of government.

486.16 (b) A home care provider or staff cannot accept powers-of-attorney from clients for
486.17 any purpose, and may not accept appointments as guardians or conservators of clients.

486.18 (c) A home care provider cannot serve as a client's representative.

486.19 Subd. 5. **Handling of client's finances and property.** (a) A home care provider
486.20 may assist clients with household budgeting, including paying bills and purchasing
486.21 household goods, but may not otherwise manage a client's property. A home care provider
486.22 must provide a client with receipts for all transactions and purchases paid with the client's
486.23 funds. When receipts are not available, the transaction or purchase must be documented.
486.24 A home care provider must maintain records of all such transactions.

486.25 (b) A home care provider or staff may not borrow a client's funds or personal or
486.26 real property, nor in any way convert a client's property to the home care provider's or
486.27 staff's possession.

486.28 (c) Nothing in this section precludes a home care provider or staff from accepting
486.29 gifts of minimal value, or precludes the acceptance of donations or bequests made to a
486.30 home care provider that are exempt from income tax under section 501(c) of the Internal
486.31 Revenue Code of 1986.

486.32 Subd. 6. **Reporting maltreatment of vulnerable adults and minors.** (a) All home
486.33 care providers must comply with requirements for the reporting of maltreatment of minors
486.34 in section 626.556 and the requirements for the reporting of maltreatment of vulnerable
486.35 adults in section 626.557. Each home care provider must establish and implement a
486.36 written procedure to ensure that all cases of suspected maltreatment are reported.

487.1 (b) Each home care provider must develop and implement an individual abuse
 487.2 prevention plan for each vulnerable minor or adult for whom home care services are
 487.3 provided by a home care provider. The plan shall contain an individualized review or
 487.4 assessment of the person's susceptibility to abuse by another individual, including other
 487.5 vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors;
 487.6 and statements of the specific measures to be taken to minimize the risk of abuse to that
 487.7 person and other vulnerable adults or minors. For purposes of the abuse prevention plan,
 487.8 the term abuse includes self-abuse.

487.9 Subd. 7. **Employee records.** The home care provider must maintain current records
 487.10 of each paid employee, regularly scheduled volunteers providing home care services, and
 487.11 of each individual contractor providing home care services. The records must include
 487.12 the following information:

487.13 (1) evidence of current professional licensure, registration, or certification, if
 487.14 licensure, registration, or certification is required by this statute, or other rules;

487.15 (2) records of orientation, required annual training and infection control training,
 487.16 and competency evaluations;

487.17 (3) current job description, including qualifications, responsibilities, and
 487.18 identification of staff providing supervision;

487.19 (4) documentation of annual performance reviews which identify areas of
 487.20 improvement needed and training needs;

487.21 (5) for individuals providing home care services, verification that required health
 487.22 screenings under section 144A.4798 have taken place and the dates of those screenings; and

487.23 (6) documentation of the background study as required under section 144.057.

487.24 Each employee record must be retained for at least three years after a paid employee,
 487.25 home care volunteer, or contractor ceases to be employed by or under contract with the
 487.26 home care provider. If a home care provider ceases operation, employee records must be
 487.27 maintained for three years.

487.28 Sec. 19. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH**
 487.29 **RESPECT TO CLIENTS.**

487.30 Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care
 487.31 provider shall provide the client or the client's representative a written notice of the rights
 487.32 under section 144A.44 before the initiation of services to that client. The provider shall
 487.33 make all reasonable efforts to provide notice of the rights to the client or the client's
 487.34 representative in a language the client or client's representative can understand.

488.1 (b) In addition to the text of the home care bill of rights in section 144A.44,
488.2 subdivision 1, the notice shall also contain the following statement describing how to file
488.3 a complaint with these offices.

488.4 "If you have a complaint about the provider or the person providing your
488.5 home care services, you may call, write, or visit the Office of Health Facility
488.6 Complaints, Minnesota Department of Health. You may also contact the Office of
488.7 Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health
488.8 and Developmental Disabilities."

488.9 The statement should include the telephone number, Web site address, e-mail
488.10 address, mailing address, and street address of the Office of Health Facility Complaints at
488.11 the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care,
488.12 and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The
488.13 statement should also include the home care provider's name, address, e-mail, telephone
488.14 number, and name or title of the person at the provider to whom problems or complaints
488.15 may be directed. It must also include a statement that the home care provider will not
488.16 retaliate because of a complaint.

488.17 (c) The home care provider shall obtain written acknowledgment of the client's
488.18 receipt of the home care bill of rights or shall document why an acknowledgment cannot
488.19 be obtained. The acknowledgment may be obtained from the client or the client's
488.20 representative. Acknowledgment of receipt shall be retained in the client's record.

488.21 Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related**
488.22 **disorders.** The home care provider that provides services to clients with dementia shall
488.23 provide in written or electronic form, to clients and families or other persons who request
488.24 it, a description of the training program and related training it provides, including the
488.25 categories of employees trained, the frequency of training, and the basic topics covered.
488.26 This information satisfies the disclosure requirements in section 325F.72, subdivision
488.27 2, clause (4).

488.28 Subd. 3. **Statement of home care services.** Prior to the initiation of services,
488.29 a home care provider must provide to the client or the client's representative a written
488.30 statement which identifies if the provider has a basic or comprehensive home care license,
488.31 the services the provider is authorized to provide, and which services the provider cannot
488.32 provide under the scope of the provider's license. The home care provider shall obtain
488.33 written acknowledgment from the clients that the provider has provided the statement or
488.34 must document why the provider could not obtain the acknowledgment.

488.35 Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a
488.36 client unless the home care provider has staff, sufficient in qualifications, competency,

489.1 and numbers, to adequately provide the services agreed to in the service plan and that
489.2 are within the provider's scope of practice.

489.3 Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in
489.4 need of another medical or health service, including a licensed health professional, or
489.5 social service provider, the home care provider shall:

489.6 (1) determine the client's preferences with respect to obtaining the service; and

489.7 (2) inform the client of resources available, if known, to assist the client in obtaining
489.8 services.

489.9 Subd. 6. **Initiation of services.** When a provider initiates services and the
489.10 individualized review or assessment required in subdivisions 7 and 8 has not been
489.11 completed, the provider must complete a temporary plan and agreement with the client for
489.12 services.

489.13 Subd. 7. **Basic individualized client review and monitoring.** (a) When services
489.14 being provided are basic home care services, an individualized initial review of the client's
489.15 needs and preferences must be conducted at the client's residence with the client or client's
489.16 representative. This initial review must be completed within 30 days after the initiation of
489.17 the home care services.

489.18 (b) Client monitoring and review must be conducted as needed based on changes
489.19 in the needs of the client and cannot exceed 90 days from the date of the last review.
489.20 The monitoring and review may be conducted at the client's residence or through the
489.21 utilization of telecommunication methods based on practice standards that meet the
489.22 individual client's needs.

489.23 Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When
489.24 the services being provided are comprehensive home care services, an individualized
489.25 initial assessment must be conducted in-person by a registered nurse. When the services
489.26 are provided by other licensed health professionals, the assessment must be conducted by
489.27 the appropriate health professional. This initial assessment must be completed within five
489.28 days after initiation of home care services.

489.29 (b) Client monitoring and reassessment must be conducted in the client's home no
489.30 more than 14 days after initiation of services.

489.31 (c) Ongoing client monitoring and reassessment must be conducted as needed based
489.32 on changes in the needs of the client and cannot exceed 90 days from the last date of the
489.33 assessment. The monitoring and reassessment may be conducted at the client's residence
489.34 or through the utilization of telecommunication methods based on practice standards that
489.35 meet the individual client's needs.

490.1 Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later
490.2 than 14 days after the initiation of services, a home care provider shall finalize a current
490.3 written service plan.

490.4 (b) The service plan and any revisions must include a signature or other
490.5 authentication by the home care provider and by the client or the client's representative
490.6 documenting agreement on the services to be provided. The service plan must be revised,
490.7 if needed, based on client review or reassessment under subdivisions 7 and 8. The provider
490.8 must provide information to the client about changes to the provider's fee for services and
490.9 how to contact the Office of the Ombudsman for Long-Term Care.

490.10 (c) The home care provider must implement and provide all services required by
490.11 the current service plan.

490.12 (d) The service plan and revised service plan must be entered into the client's record,
490.13 including notice of a change in a client's fees when applicable.

490.14 (e) Staff providing home care services must be informed of the current written
490.15 service plan.

490.16 (f) The service plan must include:

490.17 (1) a description of the home care services to be provided, the fees for services, and
490.18 the frequency of each service, according to the client's current review or assessment and
490.19 client preferences;

490.20 (2) the identification of the staff or categories of staff who will provide the services;

490.21 (3) the schedule and methods of monitoring reviews or assessments of the client;

490.22 (4) the frequency of sessions of supervision of staff and type of personnel who
490.23 will supervise staff; and

490.24 (5) a contingency plan that includes:

490.25 (i) the action to be taken by the home care provider and by the client or client's
490.26 representative if the scheduled service cannot be provided;

490.27 (ii) information and method for a client or client's representative to contact the
490.28 home care provider;

490.29 (iii) names and contact information of persons the client wishes to have notified
490.30 in an emergency or if there is a significant adverse change in the client's condition,
490.31 including identification of and information as to who has authority to sign for the client in
490.32 an emergency; and

490.33 (iv) the circumstances in which emergency medical services are not to be summoned
490.34 consistent with chapters 145B and 145C, and declarations made by the client under those
490.35 chapters.

491.1 Subd. 10. Termination of service plan. (a) If a home care provider terminates a
491.2 service plan with a client, and the client continues to need home care services, the home
491.3 care provider shall provide the client and the client's representative, if any, with a written
491.4 notice of termination which includes the following information:

491.5 (1) the effective date of termination;

491.6 (2) the reason for termination;

491.7 (3) a list of known licensed home care providers in the client's immediate geographic
491.8 area;

491.9 (4) a statement that the home care provider will participate in a coordinated transfer
491.10 of care of the client to another home care provider, health care provider, or caregiver, as
491.11 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

491.12 (5) the name and contact information of a person employed by the home care
491.13 provider with whom the client may discuss the notice of termination; and

491.14 (6) if applicable, a statement that the notice of termination of home care services
491.15 does not constitute notice of termination of the housing with services contract with a
491.16 housing with services establishment.

491.17 (b) When the home care provider voluntarily discontinues services to all clients, the
491.18 home care provider must notify the commissioner, lead agencies, and the ombudsman for
491.19 long-term care about its clients and comply with the requirements in this subdivision.

491.20 Subd. 11. Client complaint and investigative process. (a) The home care
491.21 provider must have a written policy and system for receiving, investigating, reporting,
491.22 and attempting to resolve complaints from its clients or clients' representatives. The
491.23 policy should clearly identify the process by which clients may file a complaint or concern
491.24 about home care services and an explicit statement that the home care provider will not
491.25 discriminate or retaliate against a client for expressing concerns or complaints. A home
491.26 care provider must have a process in place to conduct investigations of complaints made
491.27 by the client or the client's representative about the services in the client's plan that are or
491.28 are not being provided or other items covered in the client's home care bill of rights. This
491.29 complaint system must provide reasonable accommodations for any special needs of the
491.30 client or client's representative if requested.

491.31 (b) The home care provider must document the complaint, name of the client,
491.32 investigation, and resolution of each complaint filed. The home care provider must
491.33 maintain a record of all activities regarding complaints received, including the date the
491.34 complaint was received, and the home care provider's investigation and resolution of the
491.35 complaint. This complaint record must be kept for each event for at least two years after
491.36 the date of entry and must be available to the commissioner for review.

492.1 (c) The required complaint system must provide for written notice to each client or
492.2 client's representative that includes:

492.3 (1) the client's right to complain to the home care provider about the services received;

492.4 (2) the name or title of the person or persons with the home care provider to contact
492.5 with complaints;

492.6 (3) the method of submitting a complaint to the home care provider; and

492.7 (4) a statement that the provider is prohibited against retaliation according to
492.8 paragraph (d).

492.9 (d) A home care provider must not take any action that negatively affects a client
492.10 in retaliation for a complaint made or a concern expressed by the client or the client's
492.11 representative.

492.12 Subd. 12. **Disaster planning and emergency preparedness plan.** The home care
492.13 provider must have a written plan of action to facilitate the management of the client's care
492.14 and services in response to a natural disaster, such as flood and storms, or other emergencies
492.15 that may disrupt the home care provider's ability to provide care or services. The licensee
492.16 must provide adequate orientation and training of staff on emergency preparedness.

492.17 Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a
492.18 client, family member, or other caregiver of the client requests that an employee or other
492.19 agent of the home care provider discontinue a life-sustaining treatment, the employee or
492.20 agent receiving the request:

492.21 (1) shall take no action to discontinue the treatment; and

492.22 (2) shall promptly inform the supervisor or other agent of the home care provider of
492.23 the client's request.

492.24 (b) Upon being informed of a request for termination of treatment, the home care
492.25 provider shall promptly:

492.26 (1) inform the client that the request will be made known to the physician who
492.27 ordered the client's treatment;

492.28 (2) inform the physician of the client's request; and

492.29 (3) work with the client and the client's physician to comply with the provisions of
492.30 the Health Care Directive Act in chapter 145C.

492.31 (c) This section does not require the home care provider to discontinue treatment,
492.32 except as may be required by law or court order.

492.33 (d) This section does not diminish the rights of clients to control their treatments,
492.34 refuse services, or terminate their relationships with the home care provider.

492.35 (e) This section shall be construed in a manner consistent with chapter 145B or
492.36 145C, whichever applies, and declarations made by clients under those chapters.

493.1 Sec. 20. **[144A.4792] MEDICATION MANAGEMENT.**

493.2 **Subdivision 1. Medication management services; comprehensive home care**
493.3 **license.** (a) This subdivision applies only to home care providers with a comprehensive
493.4 home care license that provide medication management services to clients. Medication
493.5 management services may not be provided by a home care provider who has a basic
493.6 home care license.

493.7 (b) A comprehensive home care provider who provides medication management
493.8 services must develop, implement, and maintain current written medication management
493.9 policies and procedures. The policies and procedures must be developed under the
493.10 supervision and direction of a registered nurse, licensed health professional, or pharmacist
493.11 consistent with current practice standards and guidelines.

493.12 (c) The written policies and procedures must address requesting and receiving
493.13 prescriptions for medications; preparing and giving medications; verifying that
493.14 prescription drugs are administered as prescribed; documenting medication management
493.15 activities; controlling and storing medications; monitoring and evaluating medication use;
493.16 resolving medication errors; communicating with the prescriber, pharmacist, and client
493.17 and client representative, if any; disposing of unused medications; and educating clients
493.18 and client representatives about medications. When controlled substances are being
493.19 managed, the policies and procedures must also identify how the provider will ensure
493.20 security and accountability for the overall management, control, and disposition of those
493.21 substances in compliance with state and federal regulations and with subdivision 22.

493.22 **Subd. 2. Provision of medication management services.** (a) For each client who
493.23 requests medication management services, the comprehensive home care provider shall,
493.24 prior to providing medication management services, have a registered nurse, licensed
493.25 health professional, or authorized prescriber under section 151.37 conduct an assessment
493.26 to determine what medication management services will be provided and how the services
493.27 will be provided. This assessment must be conducted face-to-face with the client. The
493.28 assessment must include an identification and review of all medications the client is known
493.29 to be taking. The review and identification must include indications for medications, side
493.30 effects, contraindications, allergic or adverse reactions, and actions to address these issues.

493.31 (b) The assessment must identify interventions needed in management of
493.32 medications to prevent diversion of medication by the client or others who may have
493.33 access to the medications. "Diversion of medications" means the misuse, theft, or illegal
493.34 or improper disposition of medications.

493.35 **Subd. 3. Individualized medication monitoring and reassessment.** The
493.36 comprehensive home care provider must monitor and reassess the client's medication

494.1 management services as needed under subdivision 14 when the client presents with
494.2 symptoms or other issues that may be medication-related and, at a minimum, annually.

494.3 Subd. 4. **Client refusal.** The home care provider must document in the client's
494.4 record any refusal for an assessment for medication management by the client. The
494.5 provider must discuss with the client the possible consequences of the client's refusal and
494.6 document the discussion in the client's record.

494.7 Subd. 5. **Individualized medication management plan.** (a) For each client
494.8 receiving medication management services, the comprehensive home care provider must
494.9 prepare and include in the service plan a written statement of the medication management
494.10 services that will be provided to the client. The provider must develop and maintain a
494.11 current individualized medication management record for each client based on the client's
494.12 assessment that must contain the following:

494.13 (1) a statement describing the medication management services that will be provided;

494.14 (2) a description of storage of medications based on the client's needs and
494.15 preferences, risk of diversion, and consistent with the manufacturer's directions;

494.16 (3) documentation of specific client instructions relating to the administration
494.17 of medications;

494.18 (4) identification of persons responsible for monitoring medication supplies and
494.19 ensuring that medication refills are ordered on a timely basis;

494.20 (5) identification of medication management tasks that may be delegated to
494.21 unlicensed personnel;

494.22 (6) procedures for staff notifying a registered nurse or appropriate licensed health
494.23 professional when a problem arises with medication management services; and

494.24 (7) any client-specific requirements relating to documenting medication
494.25 administration, verifications that all medications are administered as prescribed, and
494.26 monitoring of medication use to prevent possible complications or adverse reactions.

494.27 (b) The medication management record must be current and updated when there are
494.28 any changes.

494.29 Subd. 6. **Administration of medication.** Medications may be administered by a
494.30 nurse, physician, or other licensed health practitioner authorized to administer medications
494.31 or by unlicensed personnel who have been delegated medication administration tasks by
494.32 a registered nurse.

494.33 Subd. 7. **Delegation of medication administration.** When administration of
494.34 medications is delegated to unlicensed personnel, the comprehensive home care provider
494.35 must ensure that the registered nurse has:

495.1 (1) instructed the unlicensed personnel in the proper methods to administer the
495.2 medications, and the unlicensed personnel has demonstrated ability to competently follow
495.3 the procedures;

495.4 (2) specified, in writing, specific instructions for each client and documented those
495.5 instructions in the client's records; and

495.6 (3) communicated with the unlicensed personnel about the individual needs of
495.7 the client.

495.8 **Subd. 8. Documentation of administration of medications.** Each medication
495.9 administered by comprehensive home care provider staff must be documented in the
495.10 client's record. The documentation must include the signature and title of the person
495.11 who administered the medication. The documentation must include the medication
495.12 name, dosage, date and time administered, and method and route of administration. The
495.13 staff must document the reason why medication administration was not completed as
495.14 prescribed and document any follow-up procedures that were provided to meet the client's
495.15 needs when medication was not administered as prescribed and in compliance with the
495.16 client's medication management plan.

495.17 **Subd. 9. Documentation of medication setup.** Documentation of dates of
495.18 medication setup, name of medication, quantity of dose, times to be administered, route
495.19 of administration, and name of person completing medication setup must be done at
495.20 time of setup.

495.21 **Subd. 10. Medication management for clients who will be away from home.** (a)
495.22 A home care provider who is providing medication management services to the client and
495.23 controls the client's access to the medications must develop and implement policies and
495.24 procedures for giving accurate and current medications to clients for planned or unplanned
495.25 times away from home according to the client's individualized medication management
495.26 plan. The policy and procedures must state that:

495.27 (1) for planned time away, the medications must be obtained from the pharmacy or
495.28 set up by the registered nurse according to appropriate state and federal laws and nursing
495.29 standards of practice;

495.30 (2) for unplanned time away, when the pharmacy is not able to provide the
495.31 medications, a licensed nurse or unlicensed personnel shall give the client or client's
495.32 representative medications in amounts and dosages needed for the length of the anticipated
495.33 absence, not to exceed 120 hours;

495.34 (3) the client, or the client's representative, must be provided written information
495.35 on medications, including any special instructions for administering or handling the
495.36 medications, including controlled substances;

496.1 (4) the medications must be placed in a medication container or containers
496.2 appropriate to the provider's medication system and must be labeled with the client's name
496.3 and the dates and times that the medications are scheduled; and

496.4 (5) the client or client's representative must be provided in writing the home care
496.5 provider's name and information on how to contact the home care provider.

496.6 (b) For unplanned time away when the licensed nurse is not available, the registered
496.7 nurse may delegate this task to unlicensed personnel if:

496.8 (1) the registered nurse has trained the unlicensed staff and determined the
496.9 unlicensed staff is competent to follow the procedures for giving medications to clients;

496.10 (2) the registered nurse has developed written procedures for the unlicensed
496.11 personnel, including any special instructions or procedures regarding controlled substances
496.12 that are prescribed for the client. The procedures must address:

496.13 (i) the type of container or containers to be used for the medications appropriate to
496.14 the provider's medication system;

496.15 (ii) how the container or containers must be labeled;

496.16 (iii) the written information about the medications to be given to the client or client's
496.17 representative;

496.18 (iv) how the unlicensed staff must document in the client's record that medications
496.19 have been given to the client or the client's representative, including documenting the date
496.20 the medications were given to the client or the client's representative and who received the
496.21 medications, the person who gave the medications to the client, the number of medications
496.22 that were given to the client, and other required information;

496.23 (v) how the registered nurse shall be notified that medications have been given to
496.24 the client or client's representative and whether the registered nurse needs to be contacted
496.25 before the medications are given to the client or the client's representative; and

496.26 (vi) a review by the registered nurse of the completion of this task to verify that this
496.27 task was completed accurately by the unlicensed personnel.

496.28 Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home
496.29 care provider must determine whether the comprehensive home care provider shall require
496.30 a prescription for all medications the provider manages. The comprehensive home care
496.31 provider must inform the client or the client's representative whether the comprehensive
496.32 home care provider requires a prescription for all over-the-counter and dietary supplements
496.33 before the comprehensive home care provider agrees to manage those medications.

496.34 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.**
496.35 A comprehensive home care provider providing medication management services for
496.36 over-the-counter drugs or dietary supplements must retain those items in the original labeled

497.1 container with directions for use prior to setting up for immediate or later administration.

497.2 The provider must verify that the medications are up-to-date and stored as appropriate.

497.3 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
497.4 prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed
497.5 medications that the comprehensive home care provider is managing for the client.

497.6 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least
497.7 every 12 months or more frequently as indicated by the assessment in subdivision 2.
497.8 Prescriptions for controlled substances must comply with chapter 152.

497.9 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an
497.10 authorized prescriber must be received by a nurse or pharmacist. The order must be
497.11 handled according to Minnesota Rules, part 6800.6200.

497.12 Subd. 16. **Written or electronic prescription.** When a written or electronic
497.13 prescription is received, it must be communicated to the registered nurse in charge and
497.14 recorded or placed in the client's record.

497.15 Subd. 17. **Records confidential.** A prescription or order received verbally, in
497.16 writing, or electronically must be kept confidential according to sections 144.291 to
497.17 144.298 and 144A.44.

497.18 Subd. 18. **Medications provided by client or family members.** When the
497.19 comprehensive home care provider is aware of any medications or dietary supplements
497.20 that are being used by the client and are not included in the assessment for medication
497.21 management services, the staff must advise the registered nurse and document that in
497.22 the client's record.

497.23 Subd. 19. **Storage of medications.** A comprehensive home care provider providing
497.24 storage of medications outside of the client's private living space must store all prescription
497.25 medications in securely locked and substantially constructed compartments according to
497.26 the manufacturer's directions and permit only authorized personnel to have access.

497.27 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for
497.28 immediate or later administration, must be kept in the original container in which it was
497.29 dispensed by the pharmacy bearing the original prescription label with legible information
497.30 including the expiration or beyond-use date of a time-dated drug.

497.31 Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or
497.32 saved for use by anyone other than the client.

497.33 Subd. 22. **Disposition of medications.** (a) Any current medications being managed
497.34 by the comprehensive home care provider must be given to the client or the client's
497.35 representative when the client's service plan ends or medication management services are
497.36 no longer part of the service plan. Medications that have been stored in the client's private

498.1 living space for a client who is deceased or that have been discontinued or that have
498.2 expired may be given to the client or the client's representative for disposal.

498.3 (b) The comprehensive home care provider will dispose of any medications
498.4 remaining with the comprehensive home care provider that are discontinued or expired or
498.5 upon the termination of the service contract or the client's death according to state and
498.6 federal regulations for disposition of medications and controlled substances.

498.7 (c) Upon disposition, the comprehensive home care provider must document in the
498.8 client's record the disposition of the medication including the medication's name, strength,
498.9 prescription number as applicable, quantity, to whom the medications were given, date of
498.10 disposition, and names of staff and other individuals involved in the disposition.

498.11 Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing
498.12 medication management must develop and implement procedures for loss or spillage of all
498.13 controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must
498.14 require that when a spillage of a controlled substance occurs, a notation must be made
498.15 in the client's record explaining the spillage and the actions taken. The notation must
498.16 be signed by the person responsible for the spillage and include verification that any
498.17 contaminated substance was disposed of according to state or federal regulations.

498.18 (b) The procedures must require the comprehensive home care provider of
498.19 medication management to investigate any known loss or unaccounted for prescription
498.20 drugs and take appropriate action required under state or federal regulations and document
498.21 the investigation in required records.

498.22 Sec. 21. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT**
498.23 **SERVICES.**

498.24 Subdivision 1. **Providers with a comprehensive home care license.** This section
498.25 applies only to home care providers with a comprehensive home care license that provide
498.26 treatment or therapy management services to clients. Treatment or therapy management
498.27 services cannot be provided by a home care provider that has a basic home care license.

498.28 Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who
498.29 provides treatment and therapy management services must develop, implement, and
498.30 maintain up-to-date written treatment or therapy management policies and procedures.
498.31 The policies and procedures must be developed under the supervision and direction of
498.32 a registered nurse or appropriate licensed health professional consistent with current
498.33 practice standards and guidelines.

498.34 (b) The written policies and procedures must address requesting and receiving
498.35 orders or prescriptions for treatments or therapies, providing the treatment or therapy,

499.1 documenting of treatment or therapy activities, educating and communicating with clients
499.2 about treatments or therapy they are receiving, monitoring and evaluating the treatment
499.3 and therapy, and communicating with the prescriber.

499.4 Subd. 3. **Individualized treatment or therapy management plan.** For each
499.5 client receiving management of ordered or prescribed treatments or therapy services, the
499.6 comprehensive home care provider must prepare and include in the service plan a written
499.7 statement of the treatment or therapy services that will be provided to the client. The
499.8 provider must also develop and maintain a current individualized treatment and therapy
499.9 management record for each client which must contain at least the following:

499.10 (1) a statement of the type of services that will be provided;

499.11 (2) documentation of specific client instructions relating to the treatments or therapy
499.12 administration;

499.13 (3) identification of treatment or therapy tasks that will be delegated to unlicensed
499.14 personnel;

499.15 (4) procedures for notifying a registered nurse or appropriate licensed health
499.16 professional when a problem arises with treatments or therapy services; and

499.17 (5) any client-specific requirements relating to documentation of treatment
499.18 and therapy received, verification that all treatment and therapy was administered as
499.19 prescribed, and monitoring of treatment or therapy to prevent possible complications or
499.20 adverse reactions. The treatment or therapy management record must be current and
499.21 updated when there are any changes.

499.22 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed
499.23 treatments or therapies must be administered by a nurse, physician, or other licensed health
499.24 professional authorized to perform the treatment or therapy, or may be delegated or assigned
499.25 to unlicensed personnel by the licensed health professional according to the appropriate
499.26 practice standards for delegation or assignment. When administration of a treatment or
499.27 therapy is delegated or assigned to unlicensed personnel, the home care provider must
499.28 ensure that the registered nurse or authorized licensed health professional has:

499.29 (1) instructed the unlicensed personnel in the proper methods with respect to each
499.30 client and the unlicensed personnel has demonstrated the ability to competently follow
499.31 the procedures;

499.32 (2) specified, in writing, specific instructions for each client and documented those
499.33 instructions in the client's record; and

499.34 (3) communicated with the unlicensed personnel about the individual needs of
499.35 the client.

500.1 Subd. 5. **Documentation of administration of treatments and therapies.** Each
500.2 treatment or therapy administered by a comprehensive home care provider must be
500.3 documented in the client's record. The documentation must include the signature and title
500.4 of the person who administered the treatment or therapy and must include the date and
500.5 time of administration. When treatment or therapies are not administered as ordered or
500.6 prescribed, the provider must document the reason why it was not administered and any
500.7 follow-up procedures that were provided to meet the client's needs.

500.8 Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or
500.9 electronically recorded order or prescription for all treatments and therapies. The order
500.10 must contain the name of the client, description of the treatment or therapy to be provided,
500.11 and the frequency and other information needed to administer the treatment or therapy.

500.12 Sec. 22. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

500.13 Subdivision 1. **Client record.** (a) The home care provider must maintain records
500.14 for each client for whom it is providing services. Entries in the client records must be
500.15 current, legible, permanently recorded, dated, and authenticated with the name and title
500.16 of the person making the entry.

500.17 (b) Client records, whether written or electronic, must be protected against loss,
500.18 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
500.19 relevant federal and state laws. The home care provider shall establish and implement
500.20 written procedures to control use, storage, and security of client's records and establish
500.21 criteria for release of client information.

500.22 (c) The home care provider may not disclose to any other person any personal,
500.23 financial, medical, or other information about the client, except:

500.24 (1) as may be required by law;

500.25 (2) to employees or contractors of the home care provider, another home care
500.26 provider, other health care practitioner or provider, or inpatient facility needing
500.27 information in order to provide services to the client, but only such information that
500.28 is necessary for the provision of services;

500.29 (3) to persons authorized in writing by the client or the client's representative to
500.30 receive the information, including third-party payers; and

500.31 (4) to representatives of the commissioner authorized to survey or investigate home
500.32 care providers under this chapter or federal laws.

500.33 Subd. 2. **Access to records.** The home care provider must ensure that the
500.34 appropriate records are readily available to employees or contractors authorized to access

501.1 the records. Client records must be maintained in a manner that allows for timely access,
501.2 printing, or transmission of the records.

501.3 Subd. 3. **Contents of client record.** Contents of a client record include the
501.4 following for each client:

501.5 (1) identifying information, including the client's name, date of birth, address, and
501.6 telephone number;

501.7 (2) the name, address, and telephone number of an emergency contact, family
501.8 members, client's representative, if any, or others as identified;

501.9 (3) names, addresses, and telephone numbers of the client's health and medical
501.10 service providers and other home care providers, if known;

501.11 (4) health information, including medical history, allergies, and when the provider
501.12 is managing medications, treatments or therapies that require documentation, and other
501.13 relevant health records;

501.14 (5) client's advance directives, if any;

501.15 (6) the home care provider's current and previous assessments and service plans;

501.16 (7) all records of communications pertinent to the client's home care services;

501.17 (8) documentation of significant changes in the client's status and actions taken in
501.18 response to the needs of the client including reporting to the appropriate supervisor or
501.19 health care professional;

501.20 (9) documentation of incidents involving the client and actions taken in response
501.21 to the needs of the client including reporting to the appropriate supervisor or health
501.22 care professional;

501.23 (10) documentation that services have been provided as identified in the service plan;

501.24 (11) documentation that the client has received and reviewed the home care bill
501.25 of rights;

501.26 (12) documentation that the client has been provided the statement of disclosure on
501.27 limitations of services under section 144A.4791, subdivision 3;

501.28 (13) documentation of complaints received and resolution;

501.29 (14) discharge summary, including service termination notice and related
501.30 documentation, when applicable; and

501.31 (15) other documentation required under this chapter and relevant to the client's
501.32 services or status.

501.33 Subd. 4. **Transfer of client records.** If a client transfers to another home care
501.34 provider or other health care practitioner or provider, or is admitted to an inpatient facility,
501.35 the home care provider, upon request of the client or the client's representative, shall take

502.1 steps to ensure a coordinated transfer including sending a copy or summary of the client's
502.2 record to the new home care provider, facility, or the client, as appropriate.

502.3 Subd. 5. **Record retention.** Following the client's discharge or termination of
502.4 services, a home care provider must retain a client's record for at least five years, or as
502.5 otherwise required by state or federal regulations. Arrangements must be made for secure
502.6 storage and retrieval of client records if the home care provider ceases business.

502.7 Sec. 23. **[144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**

502.8 Subdivision 1. **Qualifications, training, and competency.** All staff providing home
502.9 care services must: (1) be trained and competent in the provision of home care services
502.10 consistent with current practice standards appropriate to the client's needs; and (2) be
502.11 informed of the home care bill of rights under section 144A.44.

502.12 Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health
502.13 professionals and nurses providing home care services as an employee of a licensed home
502.14 care provider must possess current Minnesota license or registration to practice.

502.15 (b) Licensed health professionals and registered nurses must be competent in
502.16 assessing client needs, planning appropriate home care services to meet client needs,
502.17 implementing services, and supervising staff if assigned.

502.18 (c) Nothing in this section limits or expands the rights of nurses or licensed health
502.19 professionals to provide services within the scope of their licenses or registrations, as
502.20 provided by law.

502.21 Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home
502.22 care services must have:

502.23 (1) successfully completed a training and competency evaluation appropriate to
502.24 the services provided by the home care provider and the topics listed in subdivision 7,
502.25 paragraph (b); or

502.26 (2) demonstrated competency by satisfactorily completing a written or oral test on
502.27 the tasks the unlicensed personnel will perform and in the topics listed in subdivision
502.28 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7,
502.29 paragraph (b), clauses (5), (7), and (8), by a practical skills test.

502.30 Unlicensed personnel providing home care services for a basic home care provider may
502.31 not perform delegated nursing or therapy tasks.

502.32 (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive
502.33 home care provider must:

502.34 (1) have successfully completed training and demonstrated competency by
502.35 successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b)

503.1 and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5)
503.2 and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

503.3 (2) satisfy the current requirements of Medicare for training or competency of home
503.4 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
503.5 section 483 or section 484.36; or

503.6 (3) have, before April 19, 1993, completed a training course for nursing assistants
503.7 that was approved by the commissioner.

503.8 (c) Unlicensed personnel performing therapy or treatment tasks delegated or
503.9 assigned by a licensed health professional must meet the requirements for delegated
503.10 tasks in subdivision 4 and any other training or competency requirements within the
503.11 licensed health professional scope of practice relating to delegation or assignment of tasks
503.12 to unlicensed personnel.

503.13 Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health
503.14 professional may delegate tasks only to staff that are competent and possess the knowledge
503.15 and skills consistent with the complexity of the tasks and according to the appropriate
503.16 Minnesota Practice Act. The comprehensive home care provider must establish and
503.17 implement a system to communicate up-to-date information to the registered nurse or
503.18 licensed health professional regarding the current available staff and their competency so
503.19 the registered nurse or licensed health professional has sufficient information to determine
503.20 the appropriateness of delegating tasks to meet individual client needs and preferences.

503.21 Subd. 5. **Individual contractors.** When a home care provider contracts with an
503.22 individual contractor excluded from licensure under section 144A.471 to provide home
503.23 care services, the contractor must meet the same requirements required by this section for
503.24 personnel employed by the home care provider.

503.25 Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary
503.26 staffing agency excluded from licensure under section 144A.471, those individuals must
503.27 meet the same requirements required by this section for personnel employed by the home
503.28 care provider and shall be treated as if they are staff of the home care provider.

503.29 Subd. 7. **Requirements for instructors, training content, and competency**
503.30 **evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must
503.31 meet the following requirements:

503.32 (1) training and competency evaluations of unlicensed personnel providing basic
503.33 home care services must be conducted by individuals with work experience and training in
503.34 providing home care services listed in section 144A.471, subdivisions 6 and 7; and

503.35 (2) training and competency evaluations of unlicensed personnel providing
503.36 comprehensive home care services must be conducted by a registered nurse, or another

504.1 instructor may provide training in conjunction with the registered nurse. If the home care
504.2 provider is providing services by licensed health professionals only, then that specific
504.3 training and competency evaluation may be conducted by the licensed health professionals
504.4 as appropriate.

504.5 (b) Training and competency evaluations for all unlicensed personnel must include
504.6 the following:

504.7 (1) documentation requirements for all services provided;

504.8 (2) reports of changes in the client's condition to the supervisor designated by the
504.9 home care provider;

504.10 (3) basic infection control, including blood-borne pathogens;

504.11 (4) maintenance of a clean and safe environment;

504.12 (5) appropriate and safe techniques in personal hygiene and grooming, including:

504.13 (i) hair care and bathing;

504.14 (ii) care of teeth, gums, and oral prosthetic devices;

504.15 (iii) care and use of hearing aids; and

504.16 (iv) dressing and assisting with toileting;

504.17 (6) training on the prevention of falls for providers working with the elderly or
504.18 individuals at risk of falls;

504.19 (7) standby assistance techniques and how to perform them;

504.20 (8) medication, exercise, and treatment reminders;

504.21 (9) basic nutrition, meal preparation, food safety, and assistance with eating;

504.22 (10) preparation of modified diets as ordered by a licensed health professional;

504.23 (11) communication skills that include preserving the dignity of the client and

504.24 showing respect for the client and the client's preferences, cultural background, and family;

504.25 (12) awareness of confidentiality and privacy;

504.26 (13) understanding appropriate boundaries between staff and clients and the client's
504.27 family;

504.28 (14) procedures to utilize in handling various emergency situations; and

504.29 (15) awareness of commonly used health technology equipment and assistive devices.

504.30 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
504.31 personnel providing comprehensive home care services must include:

504.32 (1) observation, reporting, and documenting of client status;

504.33 (2) basic knowledge of body functioning and changes in body functioning, injuries,
504.34 or other observed changes that must be reported to appropriate personnel;

504.35 (3) reading and recording temperature, pulse, and respirations of the client;

504.36 (4) recognizing physical, emotional, cognitive, and developmental needs of the client;

- 505.1 (5) safe transfer techniques and ambulation;
505.2 (6) range of motioning and positioning; and
505.3 (7) administering medications or treatments as required.
505.4 (d) When the registered nurse or licensed health professional delegates tasks, they
505.5 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
505.6 methods to perform the tasks or procedures for each client and are able to demonstrate
505.7 the ability to competently follow the procedures and perform the tasks. If an unlicensed
505.8 personnel has not regularly performed the delegated home care task for a period of 24
505.9 consecutive months, the unlicensed personnel must demonstrate competency in the task
505.10 to the registered nurse or appropriate licensed health professional. The registered nurse
505.11 or licensed health professional must document instructions for the delegated tasks in
505.12 the client's record.

505.13 Sec. 24. **[144A.4796] ORIENTATION AND ANNUAL TRAINING**
505.14 **REQUIREMENTS.**

505.15 Subdivision 1. **Orientation of staff and supervisors to home care.** All staff
505.16 providing and supervising direct home care services must complete an orientation to home
505.17 care licensing requirements and regulations before providing home care services to clients.
505.18 The orientation may be incorporated into the training required under subdivision 6. The
505.19 orientation need only be completed once for each staff person and is not transferable
505.20 to another home care provider.

505.21 Subd. 2. **Content.** The orientation must contain the following topics:

- 505.22 (1) an overview of sections 144A.43 to 144A.4798;
505.23 (2) introduction and review of all the provider's policies and procedures related to
505.24 the provision of home care services;
505.25 (3) handling of emergencies and use of emergency services;
505.26 (4) compliance with and reporting of the maltreatment of minors or vulnerable
505.27 adults under sections 626.556 and 626.557;
505.28 (5) home care bill of rights, under section 144A.44;
505.29 (6) handling of clients' complaints; reporting of complaints and where to report
505.30 complaints including information on the Office of Health Facility Complaints and the
505.31 Common Entry Point;
505.32 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
505.33 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
505.34 Ombudsman at the Department of Human Services, county managed care advocates,
505.35 or other relevant advocacy services; and

506.1 (8) review of the types of home care services the employee will be providing and
506.2 the provider's scope of licensure.

506.3 Subd. 3. **Verification and documentation of orientation.** Each home care provider
506.4 shall retain evidence in the employee record of each staff person having completed the
506.5 orientation required by this section.

506.6 Subd. 4. **Orientation to client.** Staff providing home care services must be oriented
506.7 specifically to each individual client and the services to be provided. This orientation may
506.8 be provided in person, orally, in writing, or electronically.

506.9 Subd. 5. **Training required relating to Alzheimer's disease and related disorders.**
506.10 For home care providers that provide services for persons with Alzheimer's or related
506.11 disorders, all direct care staff and supervisors working with those clients must receive
506.12 training that includes a current explanation of Alzheimer's disease and related disorders,
506.13 effective approaches to use to problem solve when working with a client's challenging
506.14 behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

506.15 Subd. 6. **Required annual training.** All staff that perform direct home care
506.16 services must complete at least eight hours of annual training for each 12 months of
506.17 employment. The training may be obtained from the home care provider or another source
506.18 and must include topics relevant to the provision of home care services. The annual
506.19 training must include:

506.20 (1) training on reporting of maltreatment of minors under section 626.556 and
506.21 maltreatment of vulnerable adults under section 626.557, whichever is applicable to the
506.22 services provided;

506.23 (2) review of the home care bill of rights in section 144A.44;

506.24 (3) review of infection control techniques used in the home and implementation of
506.25 infection control standards including a review of hand washing techniques; the need for
506.26 and use of protective gloves, gowns, and masks; appropriate disposal of contaminated
506.27 materials and equipment, such as dressings, needles, syringes, and razor blades;
506.28 disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of
506.29 communicable diseases; and

506.30 (4) review of the provider's policies and procedures relating to the provision of home
506.31 care services and how to implement those policies and procedures.

506.32 Subd. 7. **Documentation.** A home care provider must retain documentation in the
506.33 employee records of the staff that have satisfied the orientation and training requirements
506.34 of this section.

506.35 Sec. 25. **[144A.4797] PROVISION OF SERVICES.**

507.1 Subdivision 1. **Availability of contact person to staff.** (a) A home care provider
507.2 with a basic home care license must have a person available to staff for consultation on
507.3 items relating to the provision of services or about the client.

507.4 (b) A home care provider with a comprehensive home care license must have a
507.5 registered nurse available for consultation to staff performing delegated nursing tasks
507.6 and must have an appropriate licensed health professional available if performing other
507.7 delegated services such as therapies.

507.8 (c) The appropriate contact person must be readily available either in person, by
507.9 telephone, or by other means to the staff at times when the staff is providing services.

507.10 Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform
507.11 basic home care services must be supervised periodically where the services are being
507.12 provided to verify that the work is being performed competently and to identify problems
507.13 and solutions to address issues relating to the staff's ability to provide the services. The
507.14 supervision of the unlicensed personnel must be done by staff of the home care provider
507.15 having the authority, skills, and ability to provide the supervision of unlicensed personnel
507.16 and who can implement changes as needed, and train staff.

507.17 (b) Supervision includes direct observation of unlicensed personnel while the
507.18 unlicensed personnel are providing the services and may also include indirect methods of
507.19 gaining input such as gathering feedback from the client. Supervisory review of staff must
507.20 be provided at a frequency based on the staff person's competency and performance.

507.21 (c) For an individual who is licensed as a home care provider, this section does
507.22 not apply.

507.23 Subd. 3. **Supervision of staff providing delegated nursing or therapy home**
507.24 **care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be
507.25 supervised by an appropriate licensed health professional or a registered nurse periodically
507.26 where the services are being provided to verify that the work is being performed
507.27 competently and to identify problems and solutions related to the staff person's ability to
507.28 perform the tasks. Supervision of staff performing medication or treatment administration
507.29 shall be provided by a registered nurse or appropriate licensed health professional and
507.30 must include observation of the staff administering the medication or treatment and the
507.31 interaction with the client.

507.32 (b) The direct supervision of staff performing delegated tasks must be provided
507.33 within 30 days after the individual begins working for the home care provider and
507.34 thereafter as needed based on performance. This requirement also applies to staff who
507.35 have not performed delegated tasks for one year or longer.

508.1 Subd. 4. **Documentation.** A home care provider must retain documentation of
508.2 supervision activities in the personnel records.

508.3 Subd. 5. **Exemption.** This section does not apply to an individual licensed under
508.4 sections 144A.43 to 144A.4798.

508.5 Sec. 26. **[144A.4798] EMPLOYEE HEALTH STATUS.**

508.6 Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider
508.7 must establish and maintain a TB prevention and control program based on the most
508.8 current guidelines issued by the Centers for Disease Control and Prevention (CDC).
508.9 Components of a TB prevention and control program include screening all staff providing
508.10 home care services, both paid and unpaid, at the time of hire for active TB disease and
508.11 latent TB infection, and developing and implementing a written TB infection control plan.
508.12 The commissioner shall make the most recent CDC standards available to home care
508.13 providers on the department's Web site.

508.14 Subd. 2. **Communicable diseases.** A home care provider must follow
508.15 current federal or state guidelines for prevention, control, and reporting of human
508.16 immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other
508.17 communicable diseases as defined in Minnesota Rules, part 4605.7040.

508.18 Sec. 27. **[144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE**
508.19 **PROVIDER ADVISORY COUNCIL.**

508.20 Subdivision 1. **Membership.** The commissioner of health shall appoint eight
508.21 persons to a home care provider advisory council consisting of the following:

508.22 (1) three public members as defined in section 214.02 who shall be either persons
508.23 who are currently receiving home care services or have family members receiving home
508.24 care services, or persons who have family members who have received home care services
508.25 within five years of the application date;

508.26 (2) three Minnesota home care licensees representing basic and comprehensive
508.27 levels of licensure who may be a managerial official, an administrator, a supervising
508.28 registered nurse, or an unlicensed personnel performing home care tasks;

508.29 (3) one member representing the Minnesota Board of Nursing; and

508.30 (4) one member representing the ombudsman for long-term care.

508.31 Subd. 2. **Organizations and meetings.** The advisory council shall be organized
508.32 and administered under section 15.059 with per diems and costs paid within the limits of
508.33 available appropriations. Meetings will be held quarterly and hosted by the department.

509.1 Subcommittees may be developed as necessary by the commissioner. Advisory council
509.2 meetings are subject to the Open Meeting Law under chapter 13D.

509.3 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide
509.4 advice regarding regulations of Department of Health licensed home care providers in
509.5 this chapter such as:

509.6 (1) advice to the commissioner regarding community standards for home care
509.7 practices;

509.8 (2) advice to the commissioner on enforcement of licensing standards and whether
509.9 certain disciplinary actions are appropriate;

509.10 (3) advice to the commissioner about ways of distributing information to licensees
509.11 and consumers of home care;

509.12 (4) advice to the commissioner about training standards;

509.13 (5) identify emerging issues and opportunities in the home care field, including the
509.14 use of technology in home and telehealth capabilities; and

509.15 (6) perform other duties as directed by the commissioner.

509.16 Sec. 28. **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR**
509.17 **NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

509.18 Subdivision 1. **Temporary home care licenses and changes of ownership.** (a)
509.19 Beginning January 1, 2014, all temporary license applicants must apply for either a
509.20 temporary basic or comprehensive home care license.

509.21 (b) Temporary home care licenses issued beginning January 1, 2014, shall be
509.22 issued according to sections 144A.43 to 144A.4798, and the fees in section 144A.472.

509.23 Temporary licensees must comply with the requirements of this chapter.

509.24 (c) No temporary license applications will be accepted nor temporary licenses issued
509.25 between December 1, 2013, and December 31, 2013.

509.26 (d) Beginning October 1, 2013, changes in ownership applications will require
509.27 payment of the new fees listed in section 144A.472. Providers who are providing
509.28 nursing, delegated nursing, or professional health care services, must submit the fee for
509.29 comprehensive home care providers, and all other providers must submit the fee for basic
509.30 home care providers as provided in section 144A.472. Change of ownership applicants will
509.31 be issued a new home care license based on the licensure law in effect on June 30, 2013.

509.32 Subd. 2. **Current home care licensees with licenses prior to July 1, 2013.** (a)
509.33 Beginning July 1, 2014, department licensed home care providers must apply for either
509.34 the basic or comprehensive home care license on their regularly scheduled renewal date.

510.1 (b) By June 30, 2015, all home care providers must either have a basic or
510.2 comprehensive home care license or temporary license.

510.3 **Subd. 3. Renewal application of home care licensure during transition period.**

510.4 (a) Renewal and change of ownership applications of home care licenses issued beginning
510.5 July 1, 2014, will be issued according to sections 144A.43 to 144A.4798 and, upon license
510.6 renewal or issuance of a new license for a change of ownership, providers must comply
510.7 with sections 144A.43 to 144A.4798. Prior to renewal, providers must comply with the
510.8 home care licensure law in effect on June 30, 2013.

510.9 (b) The fees charged for licenses renewed between July 1, 2014, and June 30, 2016,
510.10 shall be the lesser of 200 percent or \$1,000, except where the 200 percent or \$1,000
510.11 increase exceeds the actual renewal fee charged, with a maximum renewal fee of \$6,625.

510.12 (c) For fiscal year 2014 only, the fees for providers with revenues greater than
510.13 \$25,000 and no more than \$100,000 will be \$313 and for providers with revenues no
510.14 more than \$25,000 the fee will be \$125.

510.15 **Sec. 29. [144A.482] REGISTRATION OF HOME MANAGEMENT**
510.16 **PROVIDERS.**

510.17 (a) For purposes of this section, a home management provider is a person or
510.18 organization that provides at least two of the following services: housekeeping, meal
510.19 preparation, and shopping to a person who is unable to perform these activities due to
510.20 illness, disability, or physical condition.

510.21 (b) A person or organization that provides only home management services may not
510.22 operate in the state without a current certificate of registration issued by the commissioner
510.23 of health. To obtain a certificate of registration, the person or organization must annually
510.24 submit to the commissioner the name, mailing and physical addresses, e-mail address, and
510.25 telephone number of the person or organization and a signed statement declaring that the
510.26 person or organization is aware that the home care bill of rights applies to their clients and
510.27 that the person or organization will comply with the home care bill of rights provisions
510.28 contained in section 144A.44. A person or organization applying for a certificate must
510.29 also provide the name, business address, and telephone number of each of the persons
510.30 responsible for the management or direction of the organization.

510.31 (c) The commissioner shall charge an annual registration fee of \$20 for persons and
510.32 \$50 for organizations. The registration fee shall be deposited in the state treasury and
510.33 credited to the state government special revenue fund.

510.34 (d) A home care provider that provides home management services and other home
510.35 care services must be licensed, but licensure requirements other than the home care bill of

511.1 rights do not apply to those employees or volunteers who provide only home management
511.2 services to clients who do not receive any other home care services from the provider.

511.3 A licensed home care provider need not be registered as a home management service
511.4 provider but must provide an orientation on the home care bill of rights to its employees
511.5 or volunteers who provide home management services.

511.6 (e) An individual who provides home management services under this section must,
511.7 within 120 days after beginning to provide services, attend an orientation session approved
511.8 by the commissioner that provides training on the home care bill of rights and an orientation
511.9 on the aging process and the needs and concerns of elderly and disabled persons.

511.10 (f) The commissioner may suspend or revoke a provider's certificate of registration
511.11 or assess fines for violation of the home care bill of rights. Any fine assessed for a
511.12 violation of the home care bill of rights by a provider registered under this section shall be
511.13 in the amount established in the licensure rules for home care providers. As a condition
511.14 of registration, a provider must cooperate fully with any investigation conducted by the
511.15 commissioner, including providing specific information requested by the commissioner on
511.16 clients served and the employees and volunteers who provide services. Fines collected
511.17 under this paragraph shall be deposited in the state treasury and credited to the fund
511.18 specified in the statute or rule in which the penalty was established.

511.19 (g) The commissioner may use any of the powers granted in sections 144A.43 to
511.20 144A.4798 to administer the registration system and enforce the home care bill of rights
511.21 under this section.

511.22 **Sec. 30. [144A.483] AGENCY QUALITY IMPROVEMENT PROGRAM.**

511.23 Subdivision 1. **Annual legislative report on home care licensing.** The
511.24 commissioner shall establish a quality improvement program for the home care survey
511.25 and home care complaint investigation processes. The commissioner shall submit to the
511.26 legislature an annual report, beginning October 1, 2015, and each October 1 thereafter.
511.27 Each report will review the previous state fiscal year of home care licensing and regulatory
511.28 activities. The report must include, but is not limited to, an analysis of:

511.29 (1) the number of FTE's in the Division of Compliance Monitoring, including the
511.30 Office of Health Facility Complaints units assigned to home care licensing, survey,
511.31 investigation and enforcement process;

511.32 (2) numbers of and descriptive information about licenses issued, complaints
511.33 received and investigated, including allegations made and correction orders issued,
511.34 surveys completed and timelines, and correction order reconsiderations and results;

- 512.1 (3) descriptions of emerging trends in home care provision and areas of concern
512.2 identified by the department in its regulation of home care providers;
512.3 (4) information and data regarding performance improvement projects underway
512.4 and planned by the commissioner in the area of home care surveys; and
512.5 (5) work of the Department of Health Home Care Advisory Council.

512.6 Subd. 2. **Study of correction order appeal process.** Starting July 1, 2015, the
512.7 commissioner shall study whether to add a correction order appeal process conducted by
512.8 an independent reviewer such as an administrative law judge or other office and submit a
512.9 report to the legislature by February 1, 2016. The commissioner shall review home care
512.10 regulatory systems in other states as part of that study. The commissioner shall consult
512.11 with the home care providers and representatives.

512.12 Sec. 31. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
512.13 **AND COMMUNITY-BASED SERVICES.**

512.14 (a) The Department of Health Compliance Monitoring Division and the Department
512.15 of Human Services Licensing Division shall jointly develop an integrated licensing system
512.16 for providers of both home care services subject to licensure under Minnesota Statutes,
512.17 chapter 144A, and for home and community-based services subject to licensure under
512.18 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

512.19 (1) require only one license of any provider of services under Minnesota Statutes,
512.20 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

512.21 (2) promote quality services that recognize a person's individual needs and protect
512.22 the person's health, safety, rights, and well-being;

512.23 (3) promote provider accountability through application requirements, compliance
512.24 inspections, investigations, and enforcement actions;

512.25 (4) reference other applicable requirements in existing state and federal laws,
512.26 including the federal Affordable Care Act;

512.27 (5) establish internal procedures to facilitate ongoing communications between the
512.28 agencies, and with providers and services recipients about the regulatory activities;

512.29 (6) create a link between the agency Web sites so that providers and the public can
512.30 access the same information regardless of which Web site is accessed initially; and

512.31 (7) collect data on identified outcome measures as necessary for the agencies to
512.32 report to the Centers for Medicare and Medicaid Services.

512.33 (b) The joint recommendations for legislative changes to implement the integrated
512.34 licensing system are due to the legislature by February 15, 2014.

513.1 (c) Before implementation of the integrated licensing system, providers licensed as
 513.2 home care providers under Minnesota Statutes, chapter 144A, may also provide home
 513.3 and community-based services subject to licensure under Minnesota Statutes, chapter
 513.4 245D, without obtaining a home and community-based services license under Minnesota
 513.5 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
 513.6 apply to these providers:

513.7 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
 513.8 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

513.9 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
 513.10 enforced by the Department of Health under the enforcement authority set forth in
 513.11 Minnesota Statutes, section 144A.475; and

513.12 (3) the Department of Health will provide information to the Department of Human
 513.13 Services about each provider licensed under this section, including the provider's license
 513.14 application, licensing documents, inspections, information about complaints received, and
 513.15 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

513.16 **Sec. 32. STUDY OF CORRECTION ORDER APPEAL PROCESS.**

513.17 Beginning July 1, 2015, the commissioner of health shall study whether to use
 513.18 a correction order appeal process conducted by an independent reviewer, such as
 513.19 an administrative law judge or other office. The commissioner shall review home
 513.20 care regulatory systems in other states and consult with the home care providers and
 513.21 representatives. By February 1, 2016, the commissioner shall submit a report to the chairs
 513.22 and ranking minority members of the committees of the legislature with jurisdiction over
 513.23 health and human services and judiciary issues with any recommendations regarding
 513.24 an independent appeal process.

513.25 **Sec. 33. REPEALER.**

513.26 (a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

513.27 (b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
 513.28 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040;
 513.29 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
 513.30 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170;
 513.31 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240;
 513.32 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830;
 513.33 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
 513.34 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

514.1 Sec. 34. **EFFECTIVE DATE.**

514.2 This article is effective the day following final enactment.

514.3 **ARTICLE 12**

514.4 **HEALTH DEPARTMENT**

514.5 Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 2, is amended to read:

514.6 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available
514.7 resources in the health care access fund exceed expenditures in that fund, effective for
514.8 the biennium beginning July 1, 2007, the commissioner of management and budget shall
514.9 transfer the excess funds from the health care access fund to the general fund on June 30
514.10 of each year, provided that the amount transferred in any fiscal biennium shall not exceed
514.11 \$96,000,000. The purpose of this transfer is to meet the rate increase required under Laws
514.12 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

514.13 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,
514.14 if necessary, the commissioner shall reduce these transfers from the health care access
514.15 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,
514.16 transfer sufficient funds from the general fund to the health care access fund to meet
514.17 annual MinnesotaCare expenditures.

514.18 (c) Notwithstanding section 295.581, to the extent available resources in the health
514.19 care access fund exceed expenditures in that fund after the transfer required in paragraph
514.20 (a), effective for the biennium beginning July 1, 2013, the commissioner of management
514.21 and budget shall transfer \$1,000,000 each fiscal year from the health access fund to
514.22 the medical education and research costs fund established under section 62J.692, for
514.23 distribution under section 62J.692, subdivision 4, paragraph (c).

514.24 Sec. 2. Minnesota Statutes 2012, section 43A.23, is amended by adding a subdivision
514.25 to read:

514.26 Subd. 4. **Coverage for autism spectrum disorders.** For participants in the state
514.27 employee group insurance program, the commissioner of management and budget must
514.28 administer the identical benefit as is required under section 62A.3094.

514.29 **EFFECTIVE DATE.** This section is effective January 1, 2016, or the date a
514.30 collective bargaining agreement or compensation plan that includes changes to this section
514.31 is approved under Minnesota Statutes, section 3.855, whichever is earlier.

514.32 Sec. 3. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

515.1 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
515.2 paragraphs (b) to (d) have the meanings given.

515.3 (b) "Autism spectrum disorders" means the conditions as determined by criteria
515.4 set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental
515.5 Disorders of the American Psychiatric Association.

515.6 (c) "Medically necessary care" means health care services appropriate, in terms of
515.7 type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic
515.8 testing and preventative services. Medically necessary care must be consistent with
515.9 generally accepted practice parameters as determined by physicians and licensed
515.10 psychologists who typically manage patients who have autism spectrum disorders.

515.11 (d) "Mental health professional" means a mental health professional as defined in
515.12 section 245.4871, subdivision 27, clause (1), (2), (3), (4), or (6), who has training and
515.13 expertise in autism spectrum disorder and child development.

515.14 Subd. 2. **Coverage required.** (a) A health plan issued to a large employer, as
515.15 defined in section 62Q.18, subdivision 1, must provide coverage for the diagnosis,
515.16 evaluation, multidisciplinary assessment, and medically necessary care of children under
515.17 18 with autism spectrum disorders, including but not limited to the following:

515.18 (1) early intensive behavioral and developmental therapy based in behavioral and
515.19 developmental science, including, but not limited to, all types of applied behavior analysis,
515.20 intensive early intervention behavior therapy, and intensive behavior intervention;

515.21 (2) neurodevelopmental and behavioral health treatments and management;

515.22 (3) speech therapy;

515.23 (4) occupational therapy;

515.24 (5) physical therapy; and

515.25 (6) medications.

515.26 (b) The diagnosis, evaluation, and assessment must include an assessment of the
515.27 child's developmental skills, functional behavior, needs, and capacities.

515.28 (c) The coverage required under this subdivision must include treatment that is in
515.29 accordance with an individualized treatment plan prescribed by the enrollee's treating
515.30 physician or mental health professional.

515.31 (d) A health carrier may not refuse to renew or reissue, or otherwise terminate or
515.32 restrict, coverage of an individual solely because the individual is diagnosed with an
515.33 autism spectrum disorder.

515.34 (e) A health carrier may request an updated treatment plan only once every six
515.35 months, unless the health carrier and the treating physician or mental health professional
515.36 agree that a more frequent review is necessary due to emerging circumstances.

516.1 (g) An independent progress evaluation conducted by a mental health professional
516.2 with expertise and training in autism spectrum disorder and child development must be
516.3 completed to determine if progress toward function and generalizable gains, as determined
516.4 in the treatment plan, is being made.

516.5 Subd. 3. **No effect on other law.** Nothing in this section limits the coverage
516.6 required under section 62Q.47.

516.7 Subd. 4. **State health care programs.** This section does not affect benefits available
516.8 under the medical assistance and MinnesotaCare programs and does not limit, restrict, or
516.9 otherwise reduce coverage under these programs.

516.10 **EFFECTIVE DATE.** This section is effective for health plans offered, sold, issued,
516.11 or renewed on or after January 1, 2014.

516.12 Sec. 4. Minnesota Statutes 2012, section 62J.692, subdivision 1, is amended to read:

516.13 Subdivision 1. **Definitions.** For purposes of this section, the following definitions
516.14 apply:

516.15 (a) "Accredited clinical training" means the clinical training provided by a medical
516.16 education program that is accredited through an organization recognized by the Department
516.17 of Education, the Centers for Medicare and Medicaid Services, or another national body
516.18 who reviews the accrediting organizations for multiple disciplines and whose standards
516.19 for recognizing accrediting organizations are reviewed and approved by the commissioner
516.20 of health ~~in consultation with the Medical Education and Research Advisory Committee.~~

516.21 (b) "Commissioner" means the commissioner of health.

516.22 (c) "Clinical medical education program" means the accredited clinical training of
516.23 physicians (medical students and residents), doctor of pharmacy practitioners, doctors
516.24 of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified
516.25 registered nurse anesthetists, nurse practitioners, and certified nurse midwives), ~~and~~
516.26 physician assistants, dental therapists and advanced dental therapists, psychologists,
516.27 clinical social workers, community paramedics, and community health workers.

516.28 (d) "Sponsoring institution" means a hospital, school, or consortium located in
516.29 Minnesota that sponsors and maintains primary organizational and financial responsibility
516.30 for a clinical medical education program in Minnesota and which is accountable to the
516.31 accrediting body.

516.32 (e) "Teaching institution" means a hospital, medical center, clinic, or other
516.33 organization that conducts a clinical medical education program in Minnesota.

516.34 (f) "Trainee" means a student or resident involved in a clinical medical education
516.35 program.

517.1 (g) "Eligible trainee FTE's" means the number of trainees, as measured by full-time
517.2 equivalent counts, that are at training sites located in Minnesota with currently active
517.3 medical assistance enrollment status and a National Provider Identification (NPI) number
517.4 where training occurs in either an inpatient or ambulatory patient care setting and where
517.5 the training is funded, in part, by patient care revenues. Training that occurs in nursing
517.6 facility settings is not eligible for funding under this section.

517.7 Sec. 5. Minnesota Statutes 2012, section 62J.692, subdivision 3, is amended to read:

517.8 Subd. 3. **Application process.** (a) A clinical medical education program conducted
517.9 in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners,
517.10 dentists, chiropractors, ~~or~~ physician assistants is, dental therapists and advanced dental
517.11 therapists, psychologists, clinical social workers, community paramedics, or community
517.12 health workers are eligible for funds under subdivision 4 if the program:

517.13 (1) is funded, in part, by patient care revenues;

517.14 (2) occurs in patient care settings that face increased financial pressure as a result
517.15 of competition with nonteaching patient care entities; and

517.16 (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

517.17 (b) A clinical medical education program for advanced practice nursing is eligible for
517.18 funds under subdivision 4 if the program meets the eligibility requirements in paragraph
517.19 (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health
517.20 Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges
517.21 and Universities system or members of the Minnesota Private College Council.

517.22 (c) Applications must be submitted to the commissioner by a sponsoring institution
517.23 on behalf of an eligible clinical medical education program and must be received by
517.24 October 31 of each year for distribution in the following year. An application for funds
517.25 must contain the following information:

517.26 (1) the official name and address of the sponsoring institution and the official
517.27 name and site address of the clinical medical education programs on whose behalf the
517.28 sponsoring institution is applying;

517.29 (2) the name, title, and business address of those persons responsible for
517.30 administering the funds;

517.31 (3) for each clinical medical education program for which funds are being sought;
517.32 the type and specialty orientation of trainees in the program; the name, site address, and
517.33 medical assistance provider number and national provider identification number of each
517.34 training site used in the program; the federal tax identification number of each training site

518.1 used in the program, where available; the total number of trainees at each training site; and
518.2 the total number of eligible trainee FTEs at each site; and

518.3 (4) other supporting information the commissioner deems necessary to determine
518.4 program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the
518.5 equitable distribution of funds.

518.6 (d) An application must include the information specified in clauses (1) to (3) for
518.7 each clinical medical education program on an annual basis for three consecutive years.
518.8 After that time, an application must include the information specified in clauses (1) to (3)
518.9 when requested, at the discretion of the commissioner:

518.10 (1) audited clinical training costs per trainee for each clinical medical education
518.11 program when available or estimates of clinical training costs based on audited financial
518.12 data;

518.13 (2) a description of current sources of funding for clinical medical education costs,
518.14 including a description and dollar amount of all state and federal financial support,
518.15 including Medicare direct and indirect payments; and

518.16 (3) other revenue received for the purposes of clinical training.

518.17 (e) An applicant that does not provide information requested by the commissioner
518.18 shall not be eligible for funds for the current funding cycle.

518.19 Sec. 6. Minnesota Statutes 2012, section 62J.692, subdivision 4, is amended to read:

518.20 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the
518.21 available medical education funds to all qualifying applicants based on a ~~distribution~~
518.22 ~~formula that reflects a summation of two factors:~~

518.23 ~~(1) a public program volume factor, which is determined by the total volume of~~
518.24 ~~public program revenue received by each training site as a percentage of all public~~
518.25 ~~program revenue received by all training sites in the fund pool; and~~

518.26 ~~(2) a supplemental public program volume factor, which is determined by providing~~
518.27 ~~a supplemental payment of 20 percent of each training site's grant to training sites whose~~
518.28 ~~public program revenue accounted for at least 0.98 percent of the total public program~~
518.29 ~~revenue received by all eligible training sites. Grants to training sites whose public~~
518.30 ~~program revenue accounted for less than 0.98 percent of the total public program revenue~~
518.31 ~~received by all eligible training sites shall be reduced by an amount equal to the total~~
518.32 ~~value of the supplemental payment.~~

518.33 Public program revenue for the distribution formula includes revenue from medical
518.34 assistance, prepaid medical assistance, general assistance medical care, and prepaid
518.35 general assistance medical care. Training sites that receive no public program revenue

519.1 are ineligible for funds available under this subdivision. For purposes of determining
519.2 training-site level grants to be distributed under ~~paragraph (a)~~ this paragraph, total
519.3 statewide average costs per trainee for medical residents is based on audited clinical
519.4 training costs per trainee in primary care clinical medical education programs for medical
519.5 residents. Total statewide average costs per trainee for dental residents is based on
519.6 audited clinical training costs per trainee in clinical medical education programs for
519.7 dental students. Total statewide average costs per trainee for pharmacy residents is based
519.8 on audited clinical training costs per trainee in clinical medical education programs for
519.9 pharmacy students. Training sites whose training site level grant is less than \$1,000
519.10 \$5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE
519.11 eligible trainees, are ineligible for funds available under this subdivision. No training sites
519.12 shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE
519.13 across all eligible training sites; grants in excess of this amount will be redistributed to
519.14 other eligible sites based on the formula described in this paragraph.

519.15 (b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall
519.16 include a supplemental public program volume factor, which is determined by providing
519.17 a supplemental payment to training sites whose public program revenue accounted for
519.18 at least 0.98 percent of the total public program revenue received by all eligible training
519.19 sites. The supplemental public program volume factor shall be equal to ten percent of each
519.20 training sites grant for funds distributed in fiscal year 2014 and for funds distributed in
519.21 fiscal year 2015. Grants to training sites whose public program revenue accounted for less
519.22 than 0.98 percent of the total public program revenue received by all eligible training sites
519.23 shall be reduced by an amount equal to the total value of the supplemental payment. For
519.24 fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public
519.25 program volume factor as described in paragraph (a).

519.26 (c) Of available medical education funds, \$1,000,000 shall be distributed each year
519.27 for grants to family medicine residency programs located outside of the seven-county
519.28 metropolitan area, as defined in section 473.121, subdivision 4, focused on education and
519.29 training of family medicine physicians to serve communities outside the metropolitan area.
519.30 To be eligible for a grant under this paragraph, a family medicine residency program must
519.31 demonstrate that over the most recent three calendar years, at least 25 percent of its residents
519.32 practice in Minnesota communities outside of the metropolitan area. Grant funds must be
519.33 allocated proportionally based on the number of residents per eligible residency program.

519.34 ~~(b)~~ (d) Funds distributed shall not be used to displace current funding appropriations
519.35 from federal or state sources.

520.1 ~~(e)~~ (e) Funds shall be distributed to the sponsoring institutions indicating the amount
520.2 to be distributed to each of the sponsor's clinical medical education programs based on
520.3 the criteria in this subdivision and in accordance with the commissioner's approval letter.
520.4 Each clinical medical education program must distribute funds allocated under ~~paragraph~~
520.5 paragraphs (a) and (b) to the training sites as specified in the commissioner's approval
520.6 letter. Sponsoring institutions, which are accredited through an organization recognized
520.7 by the Department of Education or the Centers for Medicare and Medicaid Services, may
520.8 contract directly with training sites to provide clinical training. To ensure the quality of
520.9 clinical training, those accredited sponsoring institutions must:

520.10 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
520.11 training conducted at sites; and

520.12 (2) take necessary action if the contract requirements are not met. Action may include
520.13 the withholding of payments under this section or the removal of students from the site.

520.14 ~~(d)~~ (f) Use of funds is limited to expenses related to clinical training program costs
520.15 for eligible programs.

520.16 (g) Any funds not distributed in accordance with the commissioner's approval letter
520.17 must be returned to the medical education and research fund within 30 days of receiving
520.18 notice from the commissioner. The commissioner shall distribute returned funds to the
520.19 appropriate training sites in accordance with the commissioner's approval letter.

520.20 ~~(e)~~ (h) A maximum of \$150,000 of the funds dedicated to the commissioner
520.21 under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for
520.22 administrative expenses associated with implementing this section.

520.23 Sec. 7. Minnesota Statutes 2012, section 62J.692, subdivision 5, is amended to read:

520.24 Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section
520.25 must sign and submit a medical education grant verification report (GVR) to verify that
520.26 the correct grant amount was forwarded to each eligible training site. If the sponsoring
520.27 institution fails to submit the GVR by the stated deadline, or to request and meet
520.28 the deadline for an extension, the sponsoring institution is required to return the full
520.29 amount of funds received to the commissioner within 30 days of receiving notice from
520.30 the commissioner. The commissioner shall distribute returned funds to the appropriate
520.31 training sites in accordance with the commissioner's approval letter.

520.32 (b) The reports must provide verification of the distribution of the funds and must
520.33 include:

520.34 (1) the total number of eligible trainee FTEs in each clinical medical education
520.35 program;

521.1 (2) the name of each funded program and, for each program, the dollar amount
521.2 distributed to each training site and a training site expenditure report;

521.3 (3) documentation of any discrepancies between the initial grant distribution notice
521.4 included in the commissioner's approval letter and the actual distribution;

521.5 (4) a statement by the sponsoring institution stating that the completed grant
521.6 verification report is valid and accurate; and

521.7 (5) other information the commissioner, ~~with advice from the advisory committee,~~
521.8 deems appropriate to evaluate the effectiveness of the use of funds for medical education.

521.9 (c) ~~By February 15 of~~ Each year, the commissioner, ~~with advice from the~~
521.10 ~~advisory committee,~~ shall provide an annual summary report to the legislature on the
521.11 implementation of this section.

521.12 Sec. 8. Minnesota Statutes 2012, section 62J.692, subdivision 9, is amended to read:

521.13 Subd. 9. **Review of eligible providers.** The commissioner ~~and the Medical~~
521.14 ~~Education and Research Costs Advisory Committee~~ may review provider groups included
521.15 in the definition of a clinical medical education program to assure that the distribution
521.16 of the funds continue to be consistent with the purpose of this section. The results of
521.17 any such reviews must be reported to the chairs and ranking minority members of the
521.18 legislative committees with jurisdiction over health care policy and finance.

521.19 Sec. 9. Minnesota Statutes 2012, section 62J.692, is amended by adding a subdivision
521.20 to read:

521.21 Subd. 11. **Distribution of funds.** If federal approval is not received for the formula
521.22 described in subdivision 4, paragraphs (a) and (b), 100 percent of available medical
521.23 education and research funds shall be distributed based on a distribution formula that
521.24 reflects as summation of two factors:

521.25 (1) a public program volume factor, that is determined by the total volume of public
521.26 program revenue received by each training site as a percentage of all public program
521.27 revenue received by all training sites in the fund pool; and

521.28 (2) a supplemental public program volume factor, that is determined by providing a
521.29 supplemental payment of 20 percent of each training site's grant to training sites whose
521.30 public program revenue accounted for a least 0.98 percent of the total public program
521.31 revenue received by all eligible training sites. Grants to training sites whose public
521.32 program revenue accounted for less than 0.98 percent of the total public program revenue
521.33 received by all eligible training sites shall be reduced by an amount equal to the total
521.34 value of the supplemental payment.

522.1 Sec. 10. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

522.2 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
522.3 community providers. The criteria for essential community provider designation shall be
522.4 the following:

522.5 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
522.6 with medical care for uninsured persons and high-risk and special needs populations,
522.7 underserved, and other special needs populations; and

522.8 (2) a commitment to serve low-income and underserved populations by meeting the
522.9 following requirements:

522.10 (i) has nonprofit status in accordance with chapter 317A;

522.11 (ii) has tax-exempt status in accordance with the Internal Revenue Service Code,
522.12 section 501(c)(3);

522.13 (iii) charges for services on a sliding fee schedule based on current poverty income
522.14 guidelines; and

522.15 (iv) does not restrict access or services because of a client's financial limitation;

522.16 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
522.17 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
522.18 government, an Indian health service unit, or a community health board as defined in
522.19 chapter 145A;

522.20 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
522.21 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
522.22 conditions;

522.23 (5) a sole community hospital. For these rural hospitals, the essential community
522.24 provider designation applies to all health services provided, including both inpatient and
522.25 outpatient services. For purposes of this section, "sole community hospital" means a
522.26 rural hospital that:

522.27 (i) is eligible to be classified as a sole community hospital according to Code
522.28 of Federal Regulations, title 42, section 412.92, or is located in a community with a
522.29 population of less than 5,000 and located more than 25 miles from a like hospital currently
522.30 providing acute short-term services;

522.31 (ii) has experienced net operating income losses in two of the previous three
522.32 most recent consecutive hospital fiscal years for which audited financial information is
522.33 available; and

522.34 (iii) consists of 40 or fewer licensed beds; ~~or~~

522.35 (6) a birth center licensed under section 144.615; or

523.1 (7) a hospital and affiliated specialty clinics that predominantly serve patients who
 523.2 are under 21 years of age and meet the following criteria:

523.3 (i) provide intensive specialty pediatric services that are routinely provided in fewer
 523.4 than five hospitals in the state; and

523.5 (ii) serve children from at least half of the counties in the state.

523.6 (b) Prior to designation, the commissioner shall publish the names of all applicants
 523.7 in the State Register. The public shall have 30 days from the date of publication to submit
 523.8 written comments to the commissioner on the application. No designation shall be made
 523.9 by the commissioner until the 30-day period has expired.

523.10 (c) The commissioner may designate an eligible provider as an essential community
 523.11 provider for all the services offered by that provider or for specific services designated by
 523.12 the commissioner.

523.13 (d) For the purpose of this subdivision, supportive and stabilizing services include at
 523.14 a minimum, transportation, child care, cultural, and linguistic services where appropriate.

523.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

523.16 Sec. 11. Minnesota Statutes 2012, section 103I.005, is amended by adding a
 523.17 subdivision to read:

523.18 **Subd. 1a. Bored geothermal heat exchanger.** "Bored geothermal heat exchanger"
 523.19 means an earth-coupled heating or cooling device consisting of a sealed closed-loop
 523.20 pipng system installed in a boring in the ground to transfer heat to or from the surrounding
 523.21 earth with no discharge.

523.22 Sec. 12. Minnesota Statutes 2012, section 103I.521, is amended to read:

523.23 **103I.521 FEES DEPOSITED WITH COMMISSIONER OF MANAGEMENT**
 523.24 **AND BUDGET.**

523.25 Unless otherwise specified, fees collected for licenses or registration by the
 523.26 commissioner under this chapter shall be deposited in the state treasury and credited to
 523.27 the state government special revenue fund.

523.28 Sec. 13. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

523.29 Subdivision 1. **Who must pay.** Except for the limitation contained in this section,
 523.30 the commissioner of health ~~shall charge a handling fee~~ may enter into a contractual
 523.31 agreement to recover costs incurred for analysis for diagnostic purposes for each specimen
 523.32 submitted to the Department of Health ~~for analysis for diagnostic purposes~~ by any hospital,

524.1 private laboratory, private clinic, or physician. ~~No fee shall be charged to any entity which~~
524.2 ~~receives direct or indirect financial assistance from state or federal funds administered by~~
524.3 ~~the Department of Health, including any public health department, nonprofit community~~
524.4 ~~clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged~~ The
524.5 commissioner shall not charge for any biological materials submitted to the Department
524.6 of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological
524.7 materials requested by the department to gather information for disease prevention or
524.8 control purposes. The commissioner of health may establish other exceptions to the
524.9 handling fee as may be necessary to protect the public's health. ~~All fees collected pursuant~~
524.10 ~~to this section shall be deposited in the state treasury and credited to the state government~~
524.11 ~~special revenue fund.~~ Funds generated in a contractual agreement made pursuant to this
524.12 section shall be deposited in a special account and are appropriated to the commissioner
524.13 for purposes of providing the services specified in the contracts. All such contractual
524.14 agreements shall be processed in accordance with the provisions of chapter 16C.

524.15 **EFFECTIVE DATE.** This section is effective July 1, 2014.

524.16 Sec. 14. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

524.17 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative
524.18 officer or other person in charge of each institution caring for infants 28 days or less
524.19 of age, (2) the person required in pursuance of the provisions of section 144.215, to
524.20 register the birth of a child, or (3) the nurse midwife or midwife in attendance at the
524.21 birth, to arrange to have administered to every infant or child in its care tests for heritable
524.22 and congenital disorders according to subdivision 2 and rules prescribed by the state
524.23 commissioner of health.

524.24 (b) ~~Testing and the, recording and of test results, reporting of test results, and~~
524.25 follow-up of infants with heritable congenital disorders, including hearing loss detected
524.26 through the early hearing detection and intervention program in section 144.966, shall be
524.27 performed at the times and in the manner prescribed by the commissioner of health. The
524.28 ~~commissioner shall charge a fee so that the total of fees collected will approximate the~~
524.29 ~~costs of conducting the tests and implementing and maintaining a system to follow-up~~
524.30 ~~infants with heritable or congenital disorders, including hearing loss detected through the~~
524.31 ~~early hearing detection and intervention program under section 144.966.~~

524.32 (c) ~~The fee is \$101 per specimen. Effective July 1, 2010, the fee shall be increased~~
524.33 ~~to \$106 to support the newborn screening program, including tests administered under~~
524.34 this section and section 144.966, shall be \$135 per specimen. The increased fee amount
524.35 ~~shall be deposited in the general fund. Costs associated with capital expenditures and~~

525.1 ~~the development of new procedures may be prorated over a three-year period when~~
525.2 ~~calculating the amount of the fees.~~ This fee amount shall be deposited in the state treasury
525.3 and credited to the state government special revenue fund.

525.4 (d) The fee to offset the cost of the support services provided under section 144.966,
525.5 subdivision 3a, shall be \$15 per specimen. This fee shall be deposited in the state treasury
525.6 and credited to the general fund.

525.7 Sec. 15. [144.1251] NEWBORN SCREENING FOR CRITICAL CONGENITAL
525.8 HEART DISEASE (CCHD).

525.9 Subdivision 1. **Required testing and reporting.** (a) Each licensed hospital or
525.10 state-licensed birthing center or facility that provides maternity and newborn care services
525.11 shall provide screening for congenital heart disease to all newborns prior to discharge
525.12 using pulse oximetry screening. The screening must occur after the infant is 24 hours old,
525.13 before discharge from the nursery. If discharge occurs before the infant is 24 hours old,
525.14 the screening must occur as close as possible to the time of discharge.

525.15 (b) For premature infants (less than 36 weeks of gestation) and infants admitted to a
525.16 higher-level nursery (special care or intensive care), pulse oximetry must be performed
525.17 when medically appropriate prior to discharge.

525.18 (c) Results of the screening must be reported to the Department of Health.

525.19 Subd. 2. **Implementation.** The Department of Health shall:

525.20 (1) communicate the screening protocol requirements;

525.21 (2) make information and forms available to the hospitals, birthing centers, and other
525.22 facilities that are required to provide the screening, health care providers who provide
525.23 prenatal care and care to newborns, and expectant parents and parents of newborns. The
525.24 information and forms must include screening protocol and reporting requirements and
525.25 parental options;

525.26 (3) provide training to ensure compliance with and appropriate implementation of
525.27 the screening;

525.28 (4) establish the mechanism for the required data collection and reporting of
525.29 screening and follow-up diagnostic results to the Department of Health according to the
525.30 Department of Health's recommendations;

525.31 (5) coordinate the implementation of universal standardized screening;

525.32 (6) act as a resource for providers as the screening program is implemented, and in
525.33 consultation with the Advisory Committee on Heritable and Congenital Disorders, develop
525.34 and implement policies for early medical and developmental intervention services and
525.35 long-term follow-up services for children and their families identified with a CCHD; and

526.1 (7) comply with sections 144.125 to 144.128.

526.2 Sec. 16. Minnesota Statutes 2012, section 144.212, is amended to read:

526.3 **144.212 DEFINITIONS.**

526.4 Subdivision 1. **Scope.** As used in sections 144.211 to 144.227, the following terms
526.5 have the meanings given.

526.6 Subd. 1a. **Amendment.** "Amendment" means completion or correction ~~of~~ made
526.7 to certification items on a vital record: after a certification has been issued or more
526.8 than one year after the event, whichever occurs first, that does not result in a sealed or
526.9 replaced record.

526.10 Subd. 1b. **Authorized representative.** "Authorized representative" means an agent
526.11 designated in a written and witnessed statement signed by the subject of the record or
526.12 other qualified applicant.

526.13 Subd. 1c. **Certification item.** "Certification item" means all individual items
526.14 appearing on a certificate of birth and the demographic and legal items on a certificate
526.15 of death.

526.16 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

526.17 Subd. 2a. **Correction.** "Correction" means a change made to a noncertification
526.18 item, including information collected for medical and statistical purposes. A correction
526.19 also means a change to a certification item within one year of the event provided that no
526.20 certification, whether paper or electronic, has been issued.

526.21 Subd. 2b. **Court of competent jurisdiction.** "Court of competent jurisdiction"
526.22 means a court within the United States with jurisdiction over the individual and such other
526.23 individuals that the court deems necessary.

526.24 Subd. 2a 2c. **Delayed registration.** "Delayed registration" means registration of a
526.25 record of birth or death filed one or more years after the date of birth or death.

526.26 Subd. 2d. **Disclosure.** "Disclosure" means to make available or make known
526.27 personally identifiable information contained in a vital record, by any means of
526.28 communication.

526.29 Subd. 3. **File.** "File" means to present a vital record or report for registration to the
526.30 Office of ~~the State Registrar~~ Vital Records and to have the vital record or report accepted
526.31 for registration by the Office of ~~the State Registrar~~ Vital Records.

526.32 Subd. 4. **Final disposition.** "Final disposition" means the burial, interment,
526.33 cremation, removal from the state, or other authorized disposition of a dead body or
526.34 dead fetus.

526.35 Subd. 4a. **Institution.** "Institution" means a public or private establishment that:

527.1 (1) provides inpatient or outpatient medical, surgical, or diagnostic care or treatment;
527.2 or

527.3 (2) provides nursing, custodial, or domiciliary care, or to which persons are
527.4 committed by law.

527.5 Subd. 4b. **Legal representative.** "Legal representative" means a licensed attorney
527.6 representing an individual.

527.7 Subd. 4c. **Local issuance office.** "Local issuance office" means a county
527.8 governmental office authorized by the state registrar to issue certified birth and death
527.9 records.

527.10 Subd. 4d. **Record.** "Record" means a report of a vital event that has been registered
527.11 by the state registrar.

527.12 Subd. 5. **Registration.** "Registration" means the process by which vital records
527.13 are completed, filed, and incorporated into the official records of the Office of the State
527.14 Vital Records Registrar.

527.15 Subd. 6. **State registrar.** "State registrar" means the commissioner of health or a
527.16 designee.

527.17 Subd. 7. **System of vital statistics.** "System of vital statistics" includes the
527.18 registration, collection, preservation, amendment, verification, maintenance of the security
527.19 and integrity of, and certification of vital records, the collection of other reports required
527.20 by sections 144.211 to 144.227, and related activities including the tabulation, analysis,
527.21 publication, and dissemination of vital statistics.

527.22 Subd. 7a. **Verification.** "Verification" means a confirmation of the information on a
527.23 vital record based on the facts contained in a certification.

527.24 Subd. 8. **Vital record.** "Vital record" means a record or report of birth, stillbirth,
527.25 death, marriage, dissolution and annulment, and data related thereto. The birth record is
527.26 not a medical record of the mother or the child.

527.27 Subd. 9. **Vital statistics.** "Vital statistics" means the data derived from records and
527.28 reports of birth, death, fetal death, induced abortion, marriage, dissolution and annulment,
527.29 and related reports.

527.30 ~~Subd. 10. **Local registrar.** "Local registrar" means an individual designated under~~
527.31 ~~section 144.214, subdivision 1, to perform the duties of a local registrar.~~

527.32 Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed
527.33 with the state registrar which sets forth the following information:

527.34 (1) the current name and address of the affiant;

527.35 (2) any previous name by which the affiant was known;

- 528.1 (3) the original and adopted names, if known, of the adopted child whose original
 528.2 birth record is to be disclosed;
- 528.3 (4) the place and date of birth of the adopted child;
- 528.4 (5) the biological relationship of the affiant to the adopted child; and
- 528.5 (6) the affiant's consent to disclosure of information from the original birth record of
 528.6 the adopted child.

528.7 Sec. 17. Minnesota Statutes 2012, section 144.213, is amended to read:

528.8 **144.213 OFFICE OF THE STATE REGISTRAR VITAL RECORDS.**

528.9 Subdivision 1. **Creation; state registrar; Office of Vital Records.** The
 528.10 commissioner shall establish an Office of the ~~State Registrar~~ Vital Records under the
 528.11 supervision of the state registrar. ~~The commissioner shall furnish to local registrars the~~
 528.12 ~~forms necessary for correct reporting of vital statistics, and shall instruct the local registrars~~
 528.13 ~~in the collection and compilation of the data.~~ The commissioner shall promulgate rules for
 528.14 the collection, filing, and registering of vital statistics information by the state and local
 528.15 ~~registrars~~ registrar, physicians, morticians, and others. Except as otherwise provided in
 528.16 sections 144.211 to 144.227, rules previously promulgated by the commissioner relating to
 528.17 the collection, filing and registering of vital statistics shall remain in effect until repealed,
 528.18 modified or superseded by a rule promulgated by the commissioner.

528.19 Subd. 2. **General duties.** (a) The state registrar shall coordinate the work of
 528.20 ~~local registrars to~~ maintain a statewide system of vital statistics. The state registrar is
 528.21 responsible for the administration and enforcement of sections 144.211 to 144.227; and
 528.22 shall supervise ~~local registrars in~~ the enforcement of sections 144.211 to 144.227 and the
 528.23 rules promulgated thereunder. Local issuance offices that fail to comply with the statutes
 528.24 or rules or to properly train employees may have their issuance privileges and access to
 528.25 the vital records system revoked.

528.26 (b) To preserve vital records the state registrar is authorized to prepare typewritten,
 528.27 photographic, electronic or other reproductions of original records and files in the Office
 528.28 of Vital Records. The reproductions when certified by the state registrar shall be accepted
 528.29 as the original records.

528.30 (c) The state registrar shall also:

528.31 (1) establish, designate, and eliminate offices in the state to aid in the efficient
 528.32 issuance of vital records;

528.33 (2) direct the activities of all persons engaged in activities pertaining to the operation
 528.34 of the system of vital statistics;

529.1 (3) develop and conduct training programs to promote uniformity of policy and
 529.2 procedures throughout the state in matters pertaining to the system of vital statistics; and

529.3 (4) prescribe, furnish, and distribute all forms required by sections 144.211 to
 529.4 144.227 and any rules adopted under these sections, and prescribe other means for the
 529.5 transmission of data, including electronic submission, that will accomplish the purpose of
 529.6 complete, accurate, and timely reporting and registration.

529.7 ~~Subd. 3. **Record-keeping.** To preserve vital records the state registrar is authorized~~
 529.8 ~~to prepare typewritten, photographic, electronic or other reproductions of original records~~
 529.9 ~~and files in the Office of the State Registrar. The reproductions when certified by the state~~
 529.10 ~~or local registrar shall be accepted as the original records.~~

529.11 Sec. 18. [144.2131] SECURITY OF VITAL RECORDS SYSTEM.

529.12 The state registrar shall:

529.13 (1) authenticate all users of the system of vital statistics and document that all users
 529.14 require access based on their official duties;

529.15 (2) authorize authenticated users of the system of vital statistics to access specific
 529.16 components of the vital statistics systems necessary for their official roles and duties;

529.17 (3) establish separation of duties between staff roles that may be susceptible to fraud
 529.18 or misuse and routinely perform audits of staff work for the purposes of identifying fraud
 529.19 or misuse within the vital statistics system;

529.20 (4) require that authenticated and authorized users of the system of vital
 529.21 statistics maintain a specified level of training related to security and provide written
 529.22 acknowledgment of security procedures and penalties;

529.23 (5) validate data submitted for registration through site visits or with independent
 529.24 sources outside the registration system at a frequency specified by the state registrar to
 529.25 maximize the integrity of the data collected;

529.26 (6) protect personally identifiable information and maintain systems pursuant to
 529.27 applicable state and federal laws;

529.28 (7) accept a report of death if the decedent was born in Minnesota or if the decedent
 529.29 was a resident of Minnesota from the United States Department of Defense or the United
 529.30 States Department of State when the death of a United States citizen occurs outside the
 529.31 United States;

529.32 (8) match death records registered in Minnesota and death records provided from
 529.33 other jurisdictions to live birth records in Minnesota;

530.1 (9) match death records received from the United States Department of Defense
 530.2 or the United States Department of State for deaths of United States citizens occurring
 530.3 outside the United States to live birth records in Minnesota;

530.4 (10) work with law enforcement to initiate and provide evidence for active fraud
 530.5 investigations;

530.6 (11) provide secure workplace, storage, and technology environments that have
 530.7 limited role-based access;

530.8 (12) maintain overt, covert, and forensic security measures for certifications,
 530.9 verifications, and automated systems that are part of the vital statistics system; and

530.10 (13) comply with applicable state and federal laws and rules associated with
 530.11 information technology systems and related information security requirements.

530.12 Sec. 19. Minnesota Statutes 2012, section 144.215, subdivision 3, is amended to read:

530.13 Subd. 3. **Father's name; child's name.** In any case in which paternity of a child is
 530.14 determined by a court of competent jurisdiction, ~~a declaration of parentage is executed~~
 530.15 ~~under section 257.34,~~ or a recognition of parentage is executed under section 257.75, the
 530.16 name of the father shall be entered on the birth record. If the order of the court declares
 530.17 the name of the child, it shall also be entered on the birth record. If the order of the court
 530.18 does not declare the name of the child, or there is no court order, then upon the request of
 530.19 both parents in writing, the surname of the child shall be defined by both parents.

530.20 Sec. 20. Minnesota Statutes 2012, section 144.215, subdivision 4, is amended to read:

530.21 Subd. 4. **Social Security number registration.** (a) Parents of a child born within
 530.22 this state shall give the parents' Social Security numbers to the Office of ~~the State Registrar~~
 530.23 Vital Records at the time of filing the birth record, but the numbers shall not appear on
 530.24 the certified record.

530.25 (b) The Social Security numbers are classified as private data, ~~as defined in section~~
 530.26 ~~13.02, subdivision 12, on individuals,~~ but the Office of ~~the State Registrar~~ Vital Records
 530.27 shall provide a Social Security number to the public authority responsible for child support
 530.28 services upon request by the public authority for use in the establishment of parentage and
 530.29 the enforcement of child support obligations.

530.30 Sec. 21. Minnesota Statutes 2012, section 144.216, subdivision 1, is amended to read:

530.31 Subdivision 1. **Reporting a foundling.** Whoever finds a live born infant of unknown
 530.32 parentage shall report within five days to the Office of ~~the State Registrar~~ Vital Records
 530.33 such information as the commissioner may by rule require to identify the foundling.

531.1 Sec. 22. Minnesota Statutes 2012, section 144.217, subdivision 2, is amended to read:

531.2 Subd. 2. **Court petition.** If a delayed record of birth is rejected under subdivision
531.3 1, a person may petition the appropriate court in the county in which the birth allegedly
531.4 occurred for an order establishing a record of the date and place of the birth and the
531.5 parentage of the person whose birth is to be registered. The petition shall state:

531.6 (1) that the person for whom a delayed record of birth is sought was born in this state;

531.7 (2) that no record of birth can be found in the Office of the ~~State Registrar~~ Vital
531.8 Records;

531.9 (3) that diligent efforts by the petitioner have failed to obtain the evidence required
531.10 in subdivision 1;

531.11 (4) that the state registrar has refused to register a delayed record of birth; and

531.12 (5) other information as may be required by the court.

531.13 Sec. 23. Minnesota Statutes 2012, section 144.218, subdivision 5, is amended to read:

531.14 Subd. 5. **Replacement of vital records.** Upon the order of a court of this state, upon
531.15 the request of a court of another state, ~~upon the filing of a declaration of parentage under~~
531.16 ~~section 257.34~~, or upon the filing of a recognition of parentage with a the state registrar, a
531.17 replacement birth record must be registered consistent with the findings of the court, ~~the~~
531.18 ~~declaration of parentage~~, or the recognition of parentage.

531.19 Sec. 24. [144.2181] AMENDMENT AND CORRECTION OF VITAL RECORDS.

531.20 (a) A vital record registered under sections 144.212 to 144.227 may be amended
531.21 or corrected only according to sections 144.212 to 144.227 and rules adopted by the
531.22 commissioner of health to protect the integrity and accuracy of vital records.

531.23 (b)(1) A vital record that is amended under this section shall indicate that it has been
531.24 amended, except as otherwise provided in this section or by rule.

531.25 (2) Electronic documentation shall be maintained by the state registrar that
531.26 identifies the evidence upon which the amendment or correction was based, the date
531.27 of the amendment or correction, and the identity of the authorized person making the
531.28 amendment or correction.

531.29 (c) Upon receipt of a certified copy of an order of a court of competent jurisdiction
531.30 changing the name of a person whose birth is registered in Minnesota and upon request of
531.31 such person if 18 years of age or older or having the status of emancipated minor, the state
531.32 registrar shall amend the birth record to show the new name. If the person is a minor or
531.33 an incapacitated person then a parent, guardian, or legal representative of the minor or
531.34 incapacitated person may make the request.

532.1 (d) When an applicant does not submit the minimum documentation required for
532.2 amending a vital record or when the state registrar has cause to question the validity
532.3 or completeness of the applicant's statements or the documentary evidence, and the
532.4 deficiencies are not corrected, the state registrar shall not amend the vital record. The
532.5 state registrar shall advise the applicant of the reason for this action and shall further
532.6 advise the applicant of the right of appeal to a court with competent jurisdiction over
532.7 the Department of Health.

532.8 Sec. 25. Minnesota Statutes 2012, section 144.225, subdivision 1, is amended to read:

532.9 Subdivision 1. **Public information; access to vital records.** Except as otherwise
532.10 provided for in this section and section 144.2252, information contained in vital records
532.11 shall be public information. Physical access to vital records shall be subject to the
532.12 supervision and regulation of ~~the state and local registrars~~ registrar and their employees
532.13 pursuant to rules promulgated by the commissioner in order to protect vital records from
532.14 loss, mutilation or destruction and to prevent improper disclosure of vital records which
532.15 are confidential or private data on individuals, as defined in section 13.02, subdivisions
532.16 3 and 12.

532.17 Sec. 26. Minnesota Statutes 2012, section 144.225, subdivision 4, is amended to read:

532.18 Subd. 4. **Access to records for research purposes.** The state registrar may permit
532.19 persons performing medical research access to the information restricted in subdivision
532.20 2 or 2a if those persons agree in writing not to disclose private or confidential data on
532.21 individuals.

532.22 Sec. 27. Minnesota Statutes 2012, section 144.225, subdivision 7, is amended to read:

532.23 Subd. 7. **Certified birth or death record.** (a) The state ~~or local~~ registrar or local
532.24 issuance office shall issue a certified birth or death record or a statement of no vital record
532.25 found to an individual upon the individual's proper completion of an attestation provided
532.26 by the commissioner and payment of the required fee:

532.27 (1) to a person who has a tangible interest in the requested vital record. A person
532.28 who has a tangible interest is:

532.29 (i) the subject of the vital record;

532.30 (ii) a child of the subject;

532.31 (iii) the spouse of the subject;

532.32 (iv) a parent of the subject;

532.33 (v) the grandparent or grandchild of the subject;

- 533.1 (vi) if the requested record is a death record, a sibling of the subject;
- 533.2 (vii) the party responsible for filing the vital record;
- 533.3 (viii) the legal custodian, guardian or conservator, or health care agent of the subject;
- 533.4 (ix) a personal representative, by sworn affidavit of the fact that the certified copy is
533.5 required for administration of the estate;
- 533.6 (x) a successor of the subject, as defined in section 524.1-201, if the subject is
533.7 deceased, by sworn affidavit of the fact that the certified copy is required for administration
533.8 of the estate;
- 533.9 (xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of
533.10 the fact that the certified copy is needed for the proper administration of the trust;
- 533.11 (xii) a person or entity who demonstrates that a certified vital record is necessary for
533.12 the determination or protection of a personal or property right, pursuant to rules adopted
533.13 by the commissioner; or
- 533.14 (xiii) adoption agencies in order to complete confidential postadoption searches as
533.15 required by section 259.83;
- 533.16 (2) to any local, state, or federal governmental agency upon request if the certified
533.17 vital record is necessary for the governmental agency to perform its authorized duties:
533.18 ~~An authorized governmental agency includes the Department of Human Services, the~~
533.19 ~~Department of Revenue, and the United States Citizenship and Immigration Services;~~
- 533.20 (3) to an attorney upon evidence of the attorney's license;
- 533.21 (4) pursuant to a court order issued by a court of competent jurisdiction. For
533.22 purposes of this section, a subpoena does not constitute a court order; or
- 533.23 (5) to a representative authorized by a person under clauses (1) to (4).
- 533.24 (b) The state ~~or local~~ registrar or local issuance office shall also issue a certified
533.25 death record to an individual described in paragraph (a), clause (1), items (ii) to (viii), if,
533.26 on behalf of the individual, a licensed mortician furnishes the registrar with a properly
533.27 completed attestation in the form provided by the commissioner within 180 days of the
533.28 time of death of the subject of the death record. This paragraph is not subject to the
533.29 requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

533.30 Sec. 28. Minnesota Statutes 2012, section 144.225, subdivision 8, is amended to read:

533.31 Subd. 8. **Standardized format for certified birth and death records.** ~~No later than~~
533.32 ~~July 1, 2000,~~ The commissioner shall ~~develop~~ maintain a standardized format for certified
533.33 birth records and death records issued by ~~the state and local registrars~~ registrar and local
533.34 issuance offices. The format shall incorporate security features in accordance with this
533.35 section. ~~The standardized format must be implemented on a statewide basis by July 1, 2001.~~

534.1 Sec. 29. Minnesota Statutes 2012, section 144.226, is amended to read:

534.2 **144.226 FEES.**

534.3 Subdivision 1. **Which services are for fee.** The fees for the following services shall
534.4 be the following or an amount prescribed by rule of the commissioner:

534.5 (a) The fee for the ~~issuance of~~ administrative review and processing of a request for
534.6 a certified vital record or a certification that the vital record cannot be found is \$9. ~~No~~
534.7 ~~fee shall be charged for a certified birth, stillbirth, or death record that is reissued within~~
534.8 ~~one year of the original issue, if an amendment is made to the vital record and if the~~
534.9 ~~previously issued vital record is surrendered.~~ The fee is payable at the time of application
534.10 and is nonrefundable.

534.11 (b) The fee for processing a request for the replacement of a birth record for
534.12 all events, except when filing a recognition of parentage pursuant to section 257.73,
534.13 subdivision 1, is \$40. The fee is payable at the time of application and is nonrefundable.

534.14 (c) The fee for administrative review and processing of a request for the filing of a
534.15 delayed registration of birth, stillbirth, or death is \$40. The fee is payable at the time of
534.16 application and is nonrefundable. ~~This fee includes one subsequent review of the request~~
534.17 ~~if the request is not acceptable upon the initial receipt.~~

534.18 (d) The fee for administrative review and processing of a request for the amendment
534.19 of any vital record ~~when requested more than 45 days after the filing of the vital record is~~
534.20 ~~\$40. No fee shall be charged for an amendment requested within 45 days after the filing~~
534.21 ~~of the vital record.~~ The fee is payable at the time of application and is nonrefundable.
534.22 ~~This fee includes one subsequent review of the request if the request is not acceptable~~
534.23 ~~upon the initial receipt.~~

534.24 (e) The fee for administrative review and processing of a request for the verification
534.25 of information from vital records is \$9 when the applicant furnishes the specific
534.26 information to locate the vital record. When the applicant does not furnish specific
534.27 information, the fee is \$20 per hour for staff time expended. Specific information includes
534.28 the correct date of the event and the correct name of the ~~registrant~~ subject of the record.
534.29 Fees charged shall approximate the costs incurred in searching and copying the vital
534.30 records. The fee is payable at the time of application and is nonrefundable.

534.31 (f) The fee for administrative review and processing of a request for the issuance
534.32 of a copy of any document on file pertaining to a vital record or statement that a related
534.33 document cannot be found is \$9. The fee is payable at the time of application and is
534.34 nonrefundable.

535.1 Subd. 2. **Fees to state government special revenue fund.** Fees collected under
535.2 this section by the state registrar shall be deposited in the state treasury and credited to
535.3 the state government special revenue fund.

535.4 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under
535.5 subdivision 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or
535.6 stillbirth record and for a certification that the vital record cannot be found. The ~~local or~~
535.7 state registrar or local issuance office shall forward this amount to the commissioner of
535.8 management and budget for deposit into the account for the children's trust fund for the
535.9 prevention of child abuse established under section 256E.22. This surcharge shall not be
535.10 charged under those circumstances in which no fee for a certified birth or stillbirth record
535.11 is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of
535.12 management and budget that the assets in that fund exceed \$20,000,000, this surcharge
535.13 shall be discontinued.

535.14 (b) In addition to any fee prescribed under subdivision 1, there shall be a
535.15 nonrefundable surcharge of \$10 for each certified birth record. The ~~local or~~ state registrar
535.16 or local issuance office shall forward this amount to the commissioner of management and
535.17 budget for deposit in the general fund. ~~This surcharge shall not be charged under those~~
535.18 ~~circumstances in which no fee for a certified birth record is permitted under subdivision 1,~~
535.19 ~~paragraph (a).~~

535.20 Subd. 4. **Vital records surcharge.** (a) In addition to any fee prescribed under
535.21 subdivision 1, there is a nonrefundable surcharge of ~~\$2~~ \$4 for each certified and
535.22 noncertified birth, stillbirth, or death record, and for a certification that the record cannot
535.23 be found. The local issuance office or state registrar shall forward this amount to the
535.24 commissioner of management and budget to be deposited into the state government special
535.25 revenue fund. ~~This surcharge shall not be charged under those circumstances in which no~~
535.26 ~~fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).~~

535.27 (b) ~~Effective August 1, 2005, the surcharge in paragraph (a) is \$4.~~

535.28 Subd. 5. **Electronic verification.** A fee for the electronic verification or electronic
535.29 certification of a vital event, when the information being verified or certified is obtained
535.30 from a certified birth or death record, shall be established through contractual or
535.31 interagency agreements ~~with interested local, state, or federal government agencies.~~

535.32 Subd. 6. **Alternative payment methods.** Notwithstanding subdivision 1, alternative
535.33 payment methods may be approved and implemented by the state registrar or a local
535.34 registrar issuance office.

535.35 Sec. 30. [144.492] DEFINITIONS.

536.1 Subdivision 1. **Applicability.** For the purposes of sections 144.492 to 144.494, the
536.2 terms defined in this section have the meanings given them.

536.3 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

536.4 Subd. 3. **Joint commission.** "Joint commission" means the independent,
536.5 not-for-profit organization that accredits and certifies health care organizations and
536.6 programs in the United States.

536.7 Subd. 4. **Stroke.** "Stroke" means the sudden death of brain cells in a localized
536.8 area due to inadequate blood flow.

536.9 Sec. 31. [144.493] **CRITERIA.**

536.10 Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a
536.11 comprehensive stroke center if the hospital has been certified as a comprehensive stroke
536.12 center by the joint commission or another nationally recognized accreditation entity.

536.13 Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke
536.14 center if the hospital has been certified as a primary stroke center by the joint commission
536.15 or another nationally recognized accreditation entity.

536.16 Subd. 3. **Acute stroke ready hospital.** A hospital meets the criteria for an acute
536.17 stroke ready hospital if the hospital has the following elements of an acute stroke ready
536.18 hospital:

536.19 (1) an acute stroke team available or on-call 24 hours a days, seven days a week;

536.20 (2) written stroke protocols, including triage, stabilization of vital functions, initial
536.21 diagnostic tests, and use of medications;

536.22 (3) a written plan and letter of cooperation with emergency medical services regarding
536.23 triage and communication that are consistent with regional patient care procedures;

536.24 (4) emergency department personnel who are trained in diagnosing and treating
536.25 acute stroke;

536.26 (5) the capacity to complete basic laboratory tests, electrocardiograms, and chest
536.27 x-rays 24 hours a day, seven days a week;

536.28 (6) the capacity to perform and interpret brain injury imaging studies 24 hours a
536.29 day, seven days a week;

536.30 (7) written protocols that detail available emergent therapies and reflect current
536.31 treatment guidelines, which include performance measures and are revised at least annually;

536.32 (8) a neurosurgery coverage plan, call schedule, and a triage and transportation plan;

536.33 (9) transfer protocols and agreements for stroke patients; and

536.34 (10) a designated medical director with experience and expertise in acute stroke care.

537.1 Sec. 32. **[144.494] DESIGNATING STROKE CENTERS AND STROKE**
 537.2 **HOSPITALS.**

537.3 Subdivision 1. Naming privileges. Unless it has been designated as a stroke center
 537.4 or stroke hospital pursuant to section 144.493, no hospital shall use the term "stroke
 537.5 center" or "stroke hospital" in its name or its advertising or shall otherwise indicate it
 537.6 has stroke treatment capabilities.

537.7 Subd. 2. Designation. A hospital that voluntarily meets the criteria for a
 537.8 comprehensive stroke center, primary stroke center, or acute stroke ready hospital may
 537.9 apply to the commissioner for designation, and upon the commissioner's review and
 537.10 approval of the application, shall be designated as a comprehensive stroke center, a
 537.11 primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital
 537.12 loses its certification as a comprehensive stroke center or primary stroke center from
 537.13 the joint commission or other nationally recognized accreditation entity, its Minnesota
 537.14 designation shall be immediately withdrawn. Prior to the expiration of the three-year
 537.15 designation, a hospital seeking to remain part of the voluntary acute stroke system may
 537.16 reapply to the commissioner for designation.

537.17 Sec. 33. **[144.554] HEALTH FACILITIES CONSTRUCTION PLAN**
 537.18 **SUBMITTAL AND FEES.**

537.19 For hospitals, nursing homes, boarding care homes, residential hospices, supervised
 537.20 living facilities, freestanding outpatient surgical centers, and end-stage renal disease
 537.21 facilities, the commissioner shall collect a fee for the review and approval of architectural,
 537.22 mechanical, and electrical plans and specifications submitted before construction begins
 537.23 for each project relative to construction of new buildings, additions to existing buildings,
 537.24 or remodeling or alterations of existing buildings. All fees collected in this section shall
 537.25 be deposited in the state treasury and credited to the state government special revenue
 537.26 fund. Fees must be paid at the time of submission of final plans for review and are not
 537.27 refundable. The fee is calculated as follows:

<u>Construction project total estimated cost</u>	<u>Fee</u>
<u>\$0 - \$10,000</u>	<u>\$30</u>
<u>\$10,001 - \$50,000</u>	<u>\$150</u>
<u>\$50,001 - \$100,000</u>	<u>\$300</u>
<u>\$100,001 - \$150,000</u>	<u>\$450</u>
<u>\$150,001 - \$200,000</u>	<u>\$600</u>
<u>\$200,001 - \$250,000</u>	<u>\$750</u>
<u>\$250,001 - \$300,000</u>	<u>\$900</u>
<u>\$300,001 - \$350,000</u>	<u>\$1,050</u>

538.1	<u>\$350,001 - \$400,000</u>	<u>\$1,200</u>
538.2	<u>\$400,001 - \$450,000</u>	<u>\$1,350</u>
538.3	<u>\$450,001 - \$500,000</u>	<u>\$1,500</u>
538.4	<u>\$500,001 - \$550,000</u>	<u>\$1,650</u>
538.5	<u>\$550,001 - \$600,000</u>	<u>\$1,800</u>
538.6	<u>\$600,001 - \$650,000</u>	<u>\$1,950</u>
538.7	<u>\$650,001 - \$700,000</u>	<u>\$2,100</u>
538.8	<u>\$700,001 - \$750,000</u>	<u>\$2,250</u>
538.9	<u>\$750,001 - \$800,000</u>	<u>\$2,400</u>
538.10	<u>\$800,001 - \$850,000</u>	<u>\$2,550</u>
538.11	<u>\$850,001 - \$900,000</u>	<u>\$2,700</u>
538.12	<u>\$900,001 - \$950,000</u>	<u>\$2,850</u>
538.13	<u>\$950,001 - \$1,000,000</u>	<u>\$3,000</u>
538.14	<u>\$1,000,001 - \$1,050,000</u>	<u>\$3,150</u>
538.15	<u>\$1,050,001 - \$1,100,000</u>	<u>\$3,300</u>
538.16	<u>\$1,100,001 - \$1,150,000</u>	<u>\$3,450</u>
538.17	<u>\$1,150,001 - \$1,200,000</u>	<u>\$3,600</u>
538.18	<u>\$1,200,001 - \$1,250,000</u>	<u>\$3,750</u>
538.19	<u>\$1,250,001 - \$1,300,000</u>	<u>\$3,900</u>
538.20	<u>\$1,300,001 - \$1,350,000</u>	<u>\$4,050</u>
538.21	<u>\$1,350,001 - \$1,400,000</u>	<u>\$4,200</u>
538.22	<u>\$1,400,001 - \$1,450,000</u>	<u>\$4,350</u>
538.23	<u>\$1,450,001 - \$1,500,000</u>	<u>\$4,500</u>
538.24	<u>\$1,500,001 and over</u>	<u>\$4,800</u>

538.25 Sec. 34. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:

538.26 Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The
 538.27 commissioner of health shall establish a Newborn Hearing Screening Advisory Committee
 538.28 to advise and assist the Department of Health and the Department of Education in:

538.29 (1) developing protocols and timelines for screening, rescreening, and diagnostic
 538.30 audiological assessment and early medical, audiological, and educational intervention
 538.31 services for children who are deaf or hard-of-hearing;

538.32 (2) designing protocols for tracking children from birth through age three that may
 538.33 have passed newborn screening but are at risk for delayed or late onset of permanent
 538.34 hearing loss;

538.35 (3) designing a technical assistance program to support facilities implementing the
 538.36 screening program and facilities conducting rescreening and diagnostic audiological
 538.37 assessment;

538.38 (4) designing implementation and evaluation of a system of follow-up and tracking;
 538.39 and

539.1 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
539.2 culturally appropriate services for children with a confirmed hearing loss and their families.

539.3 (b) The commissioner of health shall appoint at least one member from each of the
539.4 following groups with no less than two of the members being deaf or hard-of-hearing:

539.5 (1) a representative from a consumer organization representing culturally deaf
539.6 persons;

539.7 (2) a parent with a child with hearing loss representing a parent organization;

539.8 (3) a consumer from an organization representing oral communication options;

539.9 (4) a consumer from an organization representing cued speech communication
539.10 options;

539.11 (5) an audiologist who has experience in evaluation and intervention of infants
539.12 and young children;

539.13 (6) a speech-language pathologist who has experience in evaluation and intervention
539.14 of infants and young children;

539.15 (7) two primary care providers who have experience in the care of infants and young
539.16 children, one of which shall be a pediatrician;

539.17 (8) a representative from the early hearing detection intervention teams;

539.18 (9) a representative from the Department of Education resource center for the deaf
539.19 and hard-of-hearing or the representative's designee;

539.20 (10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing
539.21 Minnesotans;

539.22 (11) a representative from the Department of Human Services Deaf and
539.23 Hard-of-Hearing Services Division;

539.24 (12) one or more of the Part C coordinators from the Department of Education, the
539.25 Department of Health, or the Department of Human Services or the department's designees;

539.26 (13) the Department of Health early hearing detection and intervention coordinators;

539.27 (14) two birth hospital representatives from one rural and one urban hospital;

539.28 (15) a pediatric geneticist;

539.29 (16) an otolaryngologist;

539.30 (17) a representative from the Newborn Screening Advisory Committee under
539.31 this subdivision; and

539.32 (18) a representative of the Department of Education regional low-incidence
539.33 facilitators.

539.34 The commissioner must complete the appointments required under this subdivision by
539.35 September 1, 2007.

540.1 (c) The Department of Health member shall chair the first meeting of the committee.
540.2 At the first meeting, the committee shall elect a chair from its membership. The committee
540.3 shall meet at the call of the chair, at least four times a year. The committee shall adopt
540.4 written bylaws to govern its activities. The Department of Health shall provide technical
540.5 and administrative support services as required by the committee. These services shall
540.6 include technical support from individuals qualified to administer infant hearing screening,
540.7 rescreening, and diagnostic audiological assessments.

540.8 Members of the committee shall receive no compensation for their service, but
540.9 shall be reimbursed as provided in section 15.059 for expenses incurred as a result of
540.10 their duties as members of the committee.

540.11 (d) This subdivision expires June 30, ~~2013~~ 2019.

540.12 Sec. 35. Minnesota Statutes 2012, section 144.966, subdivision 3a, is amended to read:

540.13 Subd. 3a. **Support services to families.** (a) The commissioner shall contract with a
540.14 nonprofit organization to provide support and assistance to families with children who are
540.15 deaf or have a hearing loss. The family support provided must include:

540.16 (1) direct hearing loss specific parent-to-parent assistance and unbiased information
540.17 on communication, educational, and medical options; and

540.18 (2) individualized deaf or hard-of-hearing mentors who provide education, including
540.19 instruction in American Sign Language as an available option.

540.20 The commissioner shall give preference to a nonprofit organization that has the ability to
540.21 provide these services throughout the state.

540.22 (b) Family participation in the support and assistance services is voluntary.

540.23 Sec. 36. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

540.24 Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must
540.25 be accompanied by the annual fees specified in this subdivision. The annual fees include:

540.26 (1) base accreditation fee, ~~\$1,500~~ \$600;

540.27 (2) sample preparation techniques fee, \$200 per technique;

540.28 (3) an administrative fee for laboratories located outside this state, ~~\$3,750~~ \$2,000; and

540.29 (4) test category fees.

540.30 (b) For the programs in subdivision 3a, the commissioner may accredit laboratories
540.31 for fields of testing under the categories listed in clauses (1) to (10) upon completion of
540.32 the application requirements provided by subdivision 6 and receipt of the fees for each
540.33 category under each program that accreditation is requested. The categories offered and
540.34 related fees include:

- 541.1 (1) microbiology, ~~\$450~~ \$200;
- 541.2 (2) inorganics, ~~\$450~~ \$200;
- 541.3 (3) metals, ~~\$1,000~~ \$500;
- 541.4 (4) volatile organics, ~~\$1,300~~ \$1,000;
- 541.5 (5) other organics, ~~\$1,300~~ \$1,000;
- 541.6 (6) radiochemistry, ~~\$1,500~~ \$750;
- 541.7 (7) emerging contaminants, ~~\$1,500~~ \$1,000;
- 541.8 (8) agricultural contaminants, ~~\$1,250~~ \$1,000;
- 541.9 (9) toxicity (bioassay), ~~\$1,000~~ \$500; and
- 541.10 (10) physical characterization, \$250.

541.11 (c) The total annual fee includes the base fee, the sample preparation techniques
541.12 fees, the test category fees per program, and, when applicable, an administrative fee for
541.13 out-of-state laboratories.

541.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

541.15 Sec. 37. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

541.16 Subd. 5. **State government special revenue fund.** Fees collected by the
541.17 commissioner under this section must be deposited in the state treasury and credited to
541.18 the state government special revenue fund.

541.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

541.20 Sec. 38. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
541.21 to read:

541.22 Subd. 10. **Establishing a selection committee.** (a) The commissioner shall
541.23 establish a selection committee for the purpose of recommending approval of qualified
541.24 laboratory assessors and assessment bodies. Committee members shall demonstrate
541.25 competence in assessment practices. The committee shall initially consist of seven
541.26 members appointed by the commissioner as follows:

541.27 (1) one member from a municipal laboratory accredited by the commissioner;

541.28 (2) one member from an industrial treatment laboratory accredited by the
541.29 commissioner;

541.30 (3) one member from a commercial laboratory located in this state and accredited by
541.31 the commissioner;

541.32 (4) one member from a commercial laboratory located outside the state and
541.33 accredited by the commissioner;

- 542.1 (5) one member from a nongovernmental client of environmental laboratories;
542.2 (6) one member from a professional organization with a demonstrated interest in
542.3 environmental laboratory data and accreditation; and
542.4 (7) one employee of the laboratory accreditation program administered by the
542.5 department.
- 542.6 (b) Committee appointments begin on January 1 and end on December 31 of the
542.7 same year.
- 542.8 (c) The commissioner shall appoint persons to fill vacant committee positions,
542.9 expand the total number of appointed positions, or change the designated positions upon
542.10 the advice of the committee.
- 542.11 (d) The commissioner shall rescind the appointment of a selection committee
542.12 member for sufficient cause as the commissioner determines, such as:
- 542.13 (1) neglect of duty;
542.14 (2) failure to notify the commissioner of a real or perceived conflict of interest;
542.15 (3) nonconformance with committee procedures;
542.16 (4) failure to demonstrate competence in assessment practices; or
542.17 (5) official misconduct.
- 542.18 (e) Members of the selection committee shall be compensated according to the
542.19 provisions in section 15.059, subdivision 3.

542.20 Sec. 39. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
542.21 to read:

- 542.22 Subd. 11. **Activities of the selection committee.** (a) The selection committee shall
542.23 determine assessor and assessment organization application requirements, the frequency
542.24 of application submittal, and the application review schedule. The commissioner shall
542.25 publish the application requirements and procedures on the accreditation program Web site.
- 542.26 (b) In its selection process, the committee shall ensure its application requirements
542.27 and review process:
- 542.28 (1) meet the standards implemented in subdivision 2a;
542.29 (2) ensure assessors have demonstrated competence in technical disciplines offered
542.30 for accreditation by the commissioner; and
- 542.31 (3) consider any history of repeated nonconformance or complaints regarding
542.32 assessors or assessment bodies.
- 542.33 (c) The selection committee shall consider an application received from qualified
542.34 applicants and shall supply a list of recommended assessors and assessment bodies to

543.1 the commissioner of health no later than 90 days after the commissioner notifies the
543.2 committee of the need for review of applications.

543.3 Sec. 40. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
543.4 to read:

543.5 **Subd. 12. Commissioner approval of assessors and scheduling of assessments.**

543.6 (a) The commissioner shall approve assessors who:

543.7 (1) are employed by the commissioner for the purpose of accrediting laboratories
543.8 and demonstrate competence in assessment practices for environmental laboratories; or

543.9 (2) are employed by a state or federal agency with established agreements for
543.10 mutual assistance or recognition with the commissioner and demonstrate competence in
543.11 assessment practices for environmental laboratories.

543.12 (b) The commissioner may approve other assessors or assessment organizations who
543.13 are recommended by the selection committee according to subdivision 11, paragraph

543.14 (c). The commissioner shall publish the list of assessors and assessment organizations
543.15 approved from the recommendations.

543.16 (c) The commissioner shall rescind approval for an assessor or assessment
543.17 organization for sufficient cause as the commissioner determines, such as:

543.18 (1) failure to meet the minimum qualifications for performing assessments;

543.19 (2) lack of availability;

543.20 (3) nonconformance with the applicable laws, rules, standards, policies, and
543.21 procedures;

543.22 (4) misrepresentation of application information regarding qualifications and
543.23 training; or

543.24 (5) excessive cost to perform the assessment activities.

543.25 Sec. 41. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
543.26 to read:

543.27 **Subd. 13. Laboratory requirements for assessor selection and scheduling**

543.28 **assessments.** (a) A laboratory accredited or seeking accreditation that requires an
543.29 assessment by the commissioner must select an assessor, group of assessors, or assessment
543.30 organization from the published list specified in subdivision 12, paragraph (b). An
543.31 accredited laboratory must complete an assessment and make all corrective actions at least
543.32 once every 24 months. Unless the commissioner grants interim accreditation, a laboratory
543.33 seeking accreditation must complete an assessment and make all corrective actions

544.1 prior to, but no earlier than, 18 months prior to the date the application is submitted to
544.2 the commissioner.

544.3 (b) A laboratory shall not select the same assessor more than twice in succession
544.4 for assessments of the same facility unless the laboratory receives written approval
544.5 from the commissioner for the selection. The laboratory must supply a written request
544.6 to the commissioner for approval and must justify the reason for the request and provide
544.7 the alternate options considered.

544.8 (c) A laboratory must select assessors appropriate to the size and scope of the
544.9 laboratory's application or existing accreditation.

544.10 (d) A laboratory must enter into its own contract for direct payment of the assessors
544.11 or assessment organization. The contract must authorize the assessor, assessment
544.12 organization, or subcontractors to release all records to the commissioner regarding the
544.13 assessment activity, when the assessment is performed in compliance with this section.

544.14 (e) A laboratory must agree to permit other assessors as selected by the commissioner
544.15 to participate in the assessment activities.

544.16 (f) If the laboratory determines no approved assessor is available to perform
544.17 the assessment, the laboratory must notify the commissioner in writing and provide a
544.18 justification for the determination. If the commissioner confirms no approved assessor
544.19 is available, the commissioner may designate an alternate assessor from those approved
544.20 in subdivision 12, paragraph (a), or the commissioner may delay the assessment until
544.21 an assessor is available. If an approved alternate assessor performs the assessment, the
544.22 commissioner may collect fees equivalent to the cost of performing the assessment
544.23 activities.

544.24 (g) Fees collected under this section are deposited in a special account and are
544.25 annually appropriated to the commissioner for the purpose of performing assessment
544.26 activities.

544.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

544.28 Sec. 42. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:

544.29 Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an
544.30 order requiring violations to be corrected and administratively assessing monetary
544.31 penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The
544.32 procedures in section 144.991 must be followed when issuing administrative penalty
544.33 orders. Except in the case of repeated or serious violations, the penalty assessed in the
544.34 order must be forgiven if the person who is subject to the order demonstrates in writing
544.35 to the commissioner before the 31st day after receiving the order that the person has

545.1 corrected the violation or has developed a corrective plan acceptable to the commissioner.
545.2 The maximum amount of an administrative penalty order is \$10,000 for each violator for
545.3 all violations by that violator identified in an inspection or review of compliance.

545.4 (b) Notwithstanding paragraph (a), the commissioner may issue to a large public
545.5 water supply, serving a population of more than 10,000 persons, an administrative penalty
545.6 order imposing a penalty of at least \$1,000 per day per violation, not to exceed \$10,000
545.7 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

545.8 (c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead
545.9 firm or person performing regulated lead work, an administrative penalty order imposing a
545.10 penalty of at least \$5,000 per violation per day, not to exceed \$10,000 for each violation of
545.11 sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from
545.12 monetary penalties in this section shall be deposited in the state treasury and credited to
545.13 the state government special revenue fund.

545.14 Sec. 43. **[145.4716] SAFE HARBOR FOR SEXUALLY EXPLOITED YOUTH.**

545.15 Subdivision 1. **Director.** The commissioner of health shall establish a position for a
545.16 director of child sex trafficking prevention.

545.17 Subd. 2. **Duties of director.** The director of child sex trafficking prevention is
545.18 responsible for the following:

545.19 (1) developing and providing comprehensive training on sexual exploitation of
545.20 youth for social service professionals, medical professionals, public health workers, and
545.21 criminal justice professionals;

545.22 (2) collecting, organizing, maintaining, and disseminating information on sexual
545.23 exploitation and services across the state, including maintaining a list of resources on the
545.24 Department of Health Web site;

545.25 (3) monitoring and applying for federal funding for antitrafficking efforts that may
545.26 benefit victims in the state;

545.27 (4) managing grant programs established under this act;

545.28 (5) identifying best practices in serving sexually exploited youth, as defined in
545.29 section 260C.007, subdivision 31;

545.30 (6) providing oversight of and technical support to regional navigators pursuant to
545.31 section 145.4717;

545.32 (7) conducting a comprehensive evaluation of the statewide program for safe harbor
545.33 of sexually exploited youth; and

546.1 (8) developing a policy, consistent with the requirements of chapter 13, for sharing
546.2 data related to sexually exploited youth, as defined in section 260C.007, subdivision 31,
546.3 among regional navigators and community-based advocates.

546.4 Sec. 44. **[145.4717] REGIONAL NAVIGATOR GRANTS.**

546.5 The commissioner of health, through its director of child sex trafficking prevention,
546.6 established in section 145.4716, shall provide grants to regional navigators serving six
546.7 regions of the state to be determined by the commissioner. Each regional navigator must
546.8 develop and annually submit a work plan to the director of child sex trafficking prevention.
546.9 The work plans must include, but are not limited to, the following information:

546.10 (1) a needs statement specific to the region, including an examination of the
546.11 population at risk;

546.12 (2) regional resources available to sexually exploited youth, as defined in section
546.13 260C.007, subdivision 31;

546.14 (3) grant goals and measurable outcomes; and

546.15 (4) grant activities including timelines.

546.16 Sec. 45. **[145.4718] PROGRAM EVALUATION.**

546.17 (a) The director of child sex trafficking prevention, established under section
546.18 145.4716, must conduct, or contract for, comprehensive evaluation of the statewide
546.19 program for safe harbor for sexually exploited youth. The first evaluation must be
546.20 completed by June 30, 2015, and must be submitted to the commissioner of health by
546.21 September 1, 2015, and every two years thereafter. The evaluation must consider whether
546.22 the program is reaching intended victims and whether support services are available,
546.23 accessible, and adequate for sexually exploited youth, as defined in section 260C.007,
546.24 subdivision 31.

546.25 (b) In conducting the evaluation, the director of child sex trafficking prevention must
546.26 consider evaluation of outcomes, including whether the program increases identification
546.27 of sexually exploited youth, coordination of investigations, access to services and housing
546.28 available for sexually exploited youth, and improved effectiveness of services. The
546.29 evaluation must also include examination of the ways in which penalties under section
546.30 609.3241 are assessed, collected, and distributed to ensure funding for investigation,
546.31 prosecution, and victim services to combat sexual exploitation of youth.

546.32 Sec. 46. Minnesota Statutes 2012, section 145.906, is amended to read:

546.33 **145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.**

547.1 (a) The commissioner of health shall work with health care facilities, licensed health
547.2 and mental health care professionals, the women, infants, and children (WIC) program,
547.3 mental health advocates, consumers, and families in the state to develop materials and
547.4 information about postpartum depression, including treatment resources, and develop
547.5 policies and procedures to comply with this section.

547.6 (b) Physicians, traditional midwives, and other licensed health care professionals
547.7 providing prenatal care to women must have available to women and their families
547.8 information about postpartum depression.

547.9 (c) Hospitals and other health care facilities in the state must provide departing new
547.10 mothers and fathers and other family members, as appropriate, with written information
547.11 about postpartum depression, including its symptoms, methods of coping with the illness,
547.12 and treatment resources.

547.13 (d) Information about postpartum depression, including its symptoms, potential
547.14 impact on families, and treatment resources, must be available at WIC sites.

547.15 (e) The commissioner of health, in collaboration with the commissioner of human
547.16 services and to the extent authorized by the federal Centers for Disease Control and
547.17 Prevention, shall review the materials and information related to postpartum depression to
547.18 determine their effectiveness in transmitting the information in a way that reduces racial
547.19 health disparities as reported in surveys of maternal attitudes and experiences before,
547.20 during, and after pregnancy, including those conducted by the commissioner of health. The
547.21 commissioner shall implement changes to reduce racial health disparities in the information
547.22 reviewed, as needed, and ensure that women of color are receiving the information.

547.23 Sec. 47. **[145.907] MATERNAL DEPRESSION; DEFINITION.**

547.24 "Maternal depression" means depression or other perinatal mood or anxiety disorder
547.25 experienced by a woman during pregnancy or during the first year following the birth of
547.26 her child.

547.27 Sec. 48. Minnesota Statutes 2012, section 145.986, is amended to read:

547.28 **145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

547.29 Subdivision 1. **Grants to local communities Purpose.** The purpose of the statewide
547.30 health improvement program is to:

547.31 (1) address the top three leading preventable causes of illness and death: tobacco use
547.32 and exposure, poor diet, and lack of regular physical activity;

547.33 (2) promote the development, availability, and use of evidence-based, community
547.34 level, comprehensive strategies to create healthy communities; and

548.1 (3) measure the impact of the evidence-based, community health improvement
548.2 practices which over time work to contain health care costs and reduce chronic diseases.

548.3 Subd. 1a. Grants to local communities. (a) Beginning July 1, 2009, the
548.4 commissioner of health shall award competitive grants to community health boards
548.5 established pursuant to section 145A.09 and tribal governments to convene, coordinate,
548.6 and implement evidence-based strategies targeted at reducing the percentage of
548.7 Minnesotans who are obese or overweight and to reduce the use of tobacco. Grants shall
548.8 be awarded to all community health boards and tribal governments whose proposals
548.9 demonstrate the ability to implement programs designed to achieve the purposes in
548.10 subdivision 1 and other requirements of this section.

548.11 (b) Grantee activities shall:

548.12 (1) be based on scientific evidence;

548.13 (2) be based on community input;

548.14 (3) address behavior change at the individual, community, and systems levels;

548.15 (4) occur in community, school, worksite, and health care settings; and

548.16 (5) be focused on policy, systems, and environmental changes that support healthy
548.17 behaviors; and

548.18 (6) address the health disparities and inequities that exist in the grantee's community.

548.19 (c) To receive a grant under this section, community health boards and tribal
548.20 governments must submit proposals to the commissioner. A local match of ten percent
548.21 of the total funding allocation is required. This local match may include funds donated
548.22 by community partners.

548.23 (d) In order to receive a grant, community health boards and tribal governments
548.24 must submit a health improvement plan to the commissioner of health for approval. The
548.25 commissioner may require the plan to identify a community leadership team, community
548.26 partners, and a community action plan that includes an assessment of area strengths and
548.27 needs, proposed action strategies, technical assistance needs, and a staffing plan.

548.28 (e) The grant recipient must implement the health improvement plan, evaluate the
548.29 effectiveness of the interventions strategies, and modify or discontinue interventions
548.30 strategies found to be ineffective.

548.31 ~~(f) By January 15, 2011, the commissioner of health shall recommend whether any~~
548.32 ~~funding should be distributed to community health boards and tribal governments based~~
548.33 ~~on health disparities demonstrated in the populations served.~~

548.34 ~~(g)~~ (f) Grant recipients shall report their activities and their progress toward the
548.35 outcomes established under subdivision 2 to the commissioner in a format and at a time
548.36 specified by the commissioner.

549.1 ~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward
549.2 the measurable outcomes established in subdivision 2. The commissioner shall require a
549.3 corrective action plan and may reduce the funding level of grant recipients that do not
549.4 make adequate progress toward the measurable outcomes.

549.5 Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet
549.6 the goals specified in subdivision 1, and annually review the progress of grant recipients
549.7 in meeting the outcomes.

549.8 (b) The commissioner shall measure current public health status, using existing
549.9 measures and data collection systems when available, to determine baseline data against
549.10 which progress shall be monitored.

549.11 Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide
549.12 content expertise, technical expertise, and training to grant recipients and advice on
549.13 evidence-based strategies, including those based on populations and types of communities
549.14 served. The commissioner shall ensure that the statewide health improvement program
549.15 meets the outcomes established under subdivision 2 by conducting a comprehensive
549.16 statewide evaluation and assisting grant recipients to modify or discontinue interventions
549.17 found to be ineffective.

549.18 (b) For the purposes of carrying out the grant program under this section, including
549.19 for administrative purposes, the commissioner shall award contracts to appropriate entities
549.20 to assist in training and provide technical assistance to grantees.

549.21 (c) Contracts awarded under paragraph (b) may be used to provide technical
549.22 assistance and training in the areas of:

549.23 (1) community engagement and capacity building;

549.24 (2) tribal support;

549.25 (3) community asset building and risk behavior reduction;

549.26 (4) legal;

549.27 (5) communications;

549.28 (6) community, school, health care, work site, and other site-specific strategies; and

549.29 (7) health equity.

549.30 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3,
549.31 the commissioner shall conduct a biennial evaluation of the statewide health improvement
549.32 program funded under this section. Grant recipients shall cooperate with the commissioner
549.33 in the evaluation and provide the commissioner with the information necessary to conduct
549.34 the evaluation.

550.1 (b) Grant recipients will collect, monitor, and submit to the Department of Health
550.2 baseline and annual data and provide information to improve the quality and impact of
550.3 community health improvement strategies.

550.4 (c) For the purposes of carrying out the grant program under this section, including
550.5 for administrative purposes, the commissioner shall award contracts to appropriate entities
550.6 to assist in designing and implementing evaluation systems.

550.7 (d) Contracts awarded under paragraph (c) may be used to:

550.8 (1) develop grantee monitoring and reporting systems to track grantee progress,
550.9 including aggregated and disaggregated data;

550.10 (2) manage, analyze, and report program evaluation data results; and

550.11 (3) utilize innovative support tools to analyze and predict the impact of prevention
550.12 strategies on health outcomes and state health care costs over time.

550.13 Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature
550.14 on the statewide health improvement program funded under this section. ~~These reports~~
550.15 The report must include information on each grant recipients recipient, including the
550.16 activities that were conducted by the grantee using grant funds, evaluation data, and
550.17 outcome measures, if available. the grantee's progress toward achieving the measurable
550.18 outcomes established under subdivision 2, and the data provided to the commissioner by
550.19 the grantee to measure these outcomes for grant activities. The commissioner shall provide
550.20 information on grants in which a corrective action plan was required under subdivision
550.21 1a, the types of plan action, and the progress that has been made toward meeting the
550.22 measurable outcomes. In addition, the commissioner shall provide recommendations
550.23 on future areas of focus for health improvement. These reports are due by January 15
550.24 of every other year, beginning in 2010. ~~In the report due on January 15, 2010, the~~
550.25 ~~commissioner shall include recommendations on a sustainable funding source for the~~
550.26 ~~statewide health improvement program other than the health care access fund~~ In the report
550.27 due on January 15, 2014, the commissioner shall include a description of the contracts
550.28 awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems
550.29 that were designed and implemented under these contracts.

550.30 Subd. 6. **Supplantation of existing funds.** Community health boards and tribal
550.31 governments must use funds received under this section to develop new programs, expand
550.32 current programs that work to reduce the percentage of Minnesotans who are obese or
550.33 overweight or who use tobacco, or replace discontinued state or federal funds previously
550.34 used to reduce the percentage of Minnesotans who are obese or overweight or who use
550.35 tobacco. Funds must not be used to supplant current state or local funding to community

551.1 health boards or tribal governments used to reduce the percentage of Minnesotans who are
551.2 obese or overweight or to reduce tobacco use.

551.3 Sec. 49. Minnesota Statutes 2012, section 145A.17, subdivision 1, is amended to read:

551.4 Subdivision 1. **Establishment; goals.** The commissioner shall establish a program
551.5 to fund family home visiting programs designed to foster healthy beginnings, improve
551.6 pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce
551.7 juvenile delinquency, promote positive parenting and resiliency in children, and promote
551.8 family health and economic self-sufficiency for children and families. The commissioner
551.9 shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of
551.10 professionals and paraprofessionals from the fields of public health nursing, social work,
551.11 and early childhood education. A program funded under this section must serve families
551.12 at or below 200 percent of the federal poverty guidelines, and other families determined
551.13 to be at risk, including but not limited to being at risk for child abuse, child neglect, or
551.14 juvenile delinquency. Programs must begin prenatally whenever possible and must be
551.15 targeted to families with:

- 551.16 (1) adolescent parents;
- 551.17 (2) a history of alcohol or other drug abuse;
- 551.18 (3) a history of child abuse, domestic abuse, or other types of violence;
- 551.19 (4) a history of domestic abuse, rape, or other forms of victimization;
- 551.20 (5) reduced cognitive functioning;
- 551.21 (6) a lack of knowledge of child growth and development stages;
- 551.22 (7) low resiliency to adversities and environmental stresses;
- 551.23 (8) insufficient financial resources to meet family needs;
- 551.24 (9) a history of homelessness;
- 551.25 (10) a risk of long-term welfare dependence or family instability due to employment
551.26 barriers; ~~or~~
- 551.27 (11) a serious mental health disorder, including maternal depression as defined in
551.28 section 145.907; or
- 551.29 ~~(11)~~ (12) other risk factors as determined by the commissioner.

551.30 Sec. 50. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

551.31 Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead
551.32 human body to essential elements through ~~exposure to a combination of heat and alkaline~~
551.33 ~~hydrolysis and the repositioning or movement of the body during the process to facilitate~~
551.34 ~~reduction~~, a water-based dissolution process using alkaline chemicals, heat, agitation, and

552.1 pressure to accelerate natural decomposition; the processing of the hydrolyzed remains
552.2 after removal from the alkaline hydrolysis chamber, vessel; placement of the processed
552.3 remains in a hydrolyzed remains container; and release of the hydrolyzed remains to an
552.4 appropriate party. Alkaline hydrolysis is a form of final disposition.

552.5 Sec. 51. Minnesota Statutes 2012, section 149A.02, is amended by adding a
552.6 subdivision to read:

552.7 Subd. 1b. **Alkaline hydrolysis container.** "Alkaline hydrolysis container" means a
552.8 hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily
552.9 fluids that encases the body and into which a dead human body is placed prior to insertion
552.10 into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or
552.11 biodegradable alternative containers or caskets.

552.12 Sec. 52. Minnesota Statutes 2012, section 149A.02, is amended by adding a
552.13 subdivision to read:

552.14 Subd. 1c. **Alkaline hydrolysis facility.** "Alkaline hydrolysis facility" means a
552.15 building or structure containing one or more alkaline hydrolysis vessels for the alkaline
552.16 hydrolysis of dead human bodies.

552.17 Sec. 53. Minnesota Statutes 2012, section 149A.02, is amended by adding a
552.18 subdivision to read:

552.19 Subd. 1d. **Alkaline hydrolysis vessel.** "Alkaline hydrolysis vessel" means the
552.20 container in which the alkaline hydrolysis of a dead human body is performed.

552.21 Sec. 54. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:

552.22 Subd. 2. **Alternative container.** "Alternative container" means a nonmetal
552.23 receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed
552.24 for the encasement of dead human bodies and is made of hydrolyzable or biodegradable
552.25 materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

552.26 Sec. 55. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:

552.27 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means
552.28 any action normally taken by a funeral provider in anticipation of or preparation for the
552.29 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

552.30 Sec. 56. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:

553.1 Subd. 4. **Cash advance item.** "Cash advance item" means any item of service
553.2 or merchandise described to a purchaser as a "cash advance," "accommodation," "cash
553.3 disbursement," or similar term. A cash advance item is also any item obtained from a
553.4 third party and paid for by the funeral provider on the purchaser's behalf. Cash advance
553.5 items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services,
553.6 pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary
553.7 notices, gratuities, and death records.

553.8 Sec. 57. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:

553.9 Subd. 5. **Casket.** "Casket" means a rigid container which is designed for the
553.10 encasement of a dead human body and is usually constructed of hydrolyzable or
553.11 biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented
553.12 and lined with fabric.

553.13 Sec. 58. Minnesota Statutes 2012, section 149A.02, is amended by adding a
553.14 subdivision to read:

553.15 Subd. 12a. **Crypt.** "Crypt" means a space in a mausoleum of sufficient size, used or
553.16 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

553.17 Sec. 59. Minnesota Statutes 2012, section 149A.02, is amended by adding a
553.18 subdivision to read:

553.19 Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a
553.20 final disposition of a dead human body by alkaline hydrolysis, without formal viewing,
553.21 visitation, or ceremony with the body present.

553.22 Sec. 60. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:

553.23 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
553.24 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

553.25 Sec. 61. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:

553.26 Subd. 23. **Funeral services.** "Funeral services" means any services which may
553.27 be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis,
553.28 cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral
553.29 ceremony or the final disposition of dead human bodies.

554.1 Sec. 62. Minnesota Statutes 2012, section 149A.02, is amended by adding a
554.2 subdivision to read:

554.3 Subd. 24b. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a
554.4 dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not
554.5 include pacemakers, prostheses, or similar foreign materials.

554.6 Sec. 63. Minnesota Statutes 2012, section 149A.02, is amended by adding a
554.7 subdivision to read:

554.8 Subd. 24c. **Hydrolyzed remains container.** "Hydrolyzed remains container" means
554.9 a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a
554.10 hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage
554.11 jewelry.

554.12 Sec. 64. Minnesota Statutes 2012, section 149A.02, is amended by adding a
554.13 subdivision to read:

554.14 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains
554.15 in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

554.16 Sec. 65. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:

554.17 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued
554.18 a license to practice mortuary science, to operate a funeral establishment, to operate an
554.19 alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner
554.20 of health.

554.21 Sec. 66. Minnesota Statutes 2012, section 149A.02, is amended by adding a
554.22 subdivision to read:

554.23 Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be
554.24 used, for the placement of hydrolyzed or cremated remains.

554.25 Sec. 67. Minnesota Statutes 2012, section 149A.02, is amended by adding a
554.26 subdivision to read:

554.27 Subd. 32a. **Placement.** "Placement" means the placing of a container holding
554.28 hydrolyzed or cremated remains in a crypt, vault, or niche.

554.29 Sec. 68. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:

555.1 Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of
555.2 the body into an appropriate cremation or alkaline hydrolysis container, embalming of
555.3 the body or such items of care as washing, disinfecting, shaving, positioning of features,
555.4 restorative procedures, application of cosmetics, dressing, and casketing.

555.5 Sec. 69. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:

555.6 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
555.7 cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means
555.8 including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance
555.9 appropriate for final disposition.

555.10 Sec. 70. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:

555.11 Subd. 37. **Public transportation.** "Public transportation" means all manner of
555.12 transportation via common carrier available to the general public including airlines, buses,
555.13 railroads, and ships. For purposes of this chapter, a livery service providing transportation
555.14 to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public
555.15 transportation.

555.16 Sec. 71. Minnesota Statutes 2012, section 149A.02, is amended by adding a
555.17 subdivision to read:

555.18 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed
555.19 or cremated remains in a defined area of a dedicated cemetery or in areas where no local
555.20 prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable
555.21 to the public, are not in a container, and that the person who has control over disposition
555.22 of the hydrolyzed or cremated remains has obtained written permission of the property
555.23 owner or governing agency to scatter on the property.

555.24 Sec. 72. Minnesota Statutes 2012, section 149A.02, is amended by adding a
555.25 subdivision to read:

555.26 Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or
555.27 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.
555.28 Vault may also mean a sealed and lined casket enclosure.

555.29 Sec. 73. Minnesota Statutes 2012, section 149A.03, is amended to read:

555.30 **149A.03 DUTIES OF COMMISSIONER.**

555.31 The commissioner shall:

- 556.1 (1) enforce all laws and adopt and enforce rules relating to the:
- 556.2 (i) removal, preparation, transportation, arrangements for disposition, and final
- 556.3 disposition of dead human bodies;
- 556.4 (ii) licensure and professional conduct of funeral directors, morticians, interns,
- 556.5 practicum students, and clinical students;
- 556.6 (iii) licensing and operation of a funeral establishment; ~~and~~
- 556.7 (iv) licensing and operation of an alkaline hydrolysis facility; and
- 556.8 ~~(iv)~~ (v) licensing and operation of a crematory;
- 556.9 (2) provide copies of the requirements for licensure and permits to all applicants;
- 556.10 (3) administer examinations and issue licenses and permits to qualified persons
- 556.11 and other legal entities;
- 556.12 (4) maintain a record of the name and location of all current licensees and interns;
- 556.13 (5) perform periodic compliance reviews and premise inspections of licensees;
- 556.14 (6) accept and investigate complaints relating to conduct governed by this chapter;
- 556.15 (7) maintain a record of all current preneed arrangement trust accounts;
- 556.16 (8) maintain a schedule of application, examination, permit, and licensure fees,
- 556.17 initial and renewal, sufficient to cover all necessary operating expenses;
- 556.18 (9) educate the public about the existence and content of the laws and rules for
- 556.19 mortuary science licensing and the removal, preparation, transportation, arrangements
- 556.20 for disposition, and final disposition of dead human bodies to enable consumers to file
- 556.21 complaints against licensees and others who may have violated those laws or rules;
- 556.22 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary
- 556.23 science in order to refine the standards for licensing and to improve the regulatory and
- 556.24 enforcement methods used; and
- 556.25 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in
- 556.26 the laws, rules, or procedures governing the practice of mortuary science and the removal,
- 556.27 preparation, transportation, arrangements for disposition, and final disposition of dead
- 556.28 human bodies.

556.29 Sec. 74. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS**

556.30 **FACILITY.**

556.31 **Subdivision 1. License requirement.** Except as provided in section 149A.01,

556.32 subdivision 3, a place or premise shall not be maintained, managed, or operated which

556.33 is devoted to or used in the holding and alkaline hydrolysis of a dead human body

556.34 without possessing a valid license to operate an alkaline hydrolysis facility issued by the

556.35 commissioner of health.

557.1 Subd. 2. **Requirements for an alkaline hydrolysis facility.** (a) An alkaline
557.2 hydrolysis facility licensed under this section must consist of:

557.3 (1) a building or structure that complies with applicable local and state building
557.4 codes, zoning laws and ordinances, and wastewater management and environmental
557.5 standards, containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of
557.6 dead human bodies;

557.7 (2) a method approved by the commissioner of health to dry the hydrolyzed remains
557.8 and which is located within the licensed facility;

557.9 (3) a means approved by the commissioner of health for refrigeration of dead human
557.10 bodies awaiting alkaline hydrolysis;

557.11 (4) an appropriate means of processing hydrolyzed remains to a granulated
557.12 appearance appropriate for final disposition; and

557.13 (5) an appropriate holding facility for dead human bodies awaiting alkaline
557.14 hydrolysis.

557.15 (b) An alkaline hydrolysis facility licensed under this section may also contain a
557.16 display room for funeral goods.

557.17 Subd. 3. **Application procedure; documentation; initial inspection.** An
557.18 application to license and operate an alkaline hydrolysis facility shall be submitted to the
557.19 commissioner of health. A completed application includes:

557.20 (1) a completed application form, as provided by the commissioner;

557.21 (2) proof of business form and ownership;

557.22 (3) proof of liability insurance coverage or other financial documentation, as
557.23 determined by the commissioner, that demonstrates the applicant's ability to respond in
557.24 damages for liability arising from the ownership, maintenance management, or operation
557.25 of an alkaline hydrolysis facility; and

557.26 (4) copies of wastewater and other environmental regulatory permits and
557.27 environmental regulatory licenses necessary to conduct operations.

557.28 Upon receipt of the application and appropriate fee, the commissioner shall review and
557.29 verify all information. Upon completion of the verification process and resolution of any
557.30 deficiencies in the application information, the commissioner shall conduct an initial
557.31 inspection of the premises to be licensed. After the inspection and resolution of any
557.32 deficiencies found and any reinspections as may be necessary, the commissioner shall
557.33 make a determination, based on all the information available, to grant or deny licensure. If
557.34 the commissioner's determination is to grant the license, the applicant shall be notified and
557.35 the license shall issue and remain valid for a period prescribed on the license, but not to
557.36 exceed one calendar year from the date of issuance of the license. If the commissioner's

558.1 determination is to deny the license, the commissioner must notify the applicant in writing
558.2 of the denial and provide the specific reason for denial.

558.3 Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis
558.4 facility is not assignable or transferable and shall not be valid for any entity other than the
558.5 one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the
558.6 location identified on the license. A 50 percent or more change in ownership or location of
558.7 the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall
558.8 be required of two or more persons or other legal entities operating from the same location.

558.9 Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis
558.10 facility must be conspicuously displayed in the alkaline hydrolysis facility at all times.
558.11 Conspicuous display means in a location where a member of the general public within the
558.12 alkaline hydrolysis facility is able to observe and read the license.

558.13 Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility
558.14 issued by the commissioner are valid for a period of one calendar year beginning on July 1
558.15 and ending on June 30, regardless of the date of issuance.

558.16 Subd. 7. **Reporting changes in license information.** Any change of license
558.17 information must be reported to the commissioner, on forms provided by the
558.18 commissioner, no later than 30 calendar days after the change occurs. Failure to report
558.19 changes is grounds for disciplinary action.

558.20 Subd. 8. **Notification to the commissioner.** If the licensee is operating under a
558.21 wastewater or an environmental permit or license that is subsequently revoked, denied,
558.22 or terminated, the licensee shall notify the commissioner.

558.23 Subd. 9. **Application information.** All information submitted to the commissioner
558.24 for a license to operate an alkaline hydrolysis facility is classified as licensing data under
558.25 section 13.41, subdivision 5.

558.26 Sec. 75. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE**
558.27 **HYDROLYSIS FACILITY.**

558.28 Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis
558.29 facility issued by the commissioner expire on June 30 following the date of issuance of the
558.30 license and must be renewed to remain valid.

558.31 Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew
558.32 their licenses must submit to the commissioner a completed renewal application no later
558.33 than June 30 following the date the license was issued. A completed renewal application
558.34 includes:

558.35 (1) a completed renewal application form, as provided by the commissioner; and

559.1 (2) proof of liability insurance coverage or other financial documentation, as
559.2 determined by the commissioner, that demonstrates the applicant's ability to respond in
559.3 damages for liability arising from the ownership, maintenance, management, or operation
559.4 of an alkaline hydrolysis facility.

559.5 Upon receipt of the completed renewal application, the commissioner shall review and
559.6 verify the information. Upon completion of the verification process and resolution of
559.7 any deficiencies in the renewal application information, the commissioner shall make a
559.8 determination, based on all the information available, to reissue or refuse to reissue the
559.9 license. If the commissioner's determination is to reissue the license, the applicant shall
559.10 be notified and the license shall issue and remain valid for a period prescribed on the
559.11 license, but not to exceed one calendar year from the date of issuance of the license. If
559.12 the commissioner's determination is to refuse to reissue the license, section 149A.09,
559.13 subdivision 2, applies.

559.14 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration
559.15 date of a license will result in the assessment of a late filing penalty. The late filing penalty
559.16 must be paid before the reissuance of the license and received by the commissioner no
559.17 later than 31 calendar days after the expiration date of the license.

559.18 Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities
559.19 shall automatically lapse when a completed renewal application is not received by the
559.20 commissioner within 31 calendar days after the expiration date of a license, or a late
559.21 filing penalty assessed under subdivision 3 is not received by the commissioner within 31
559.22 calendar days after the expiration of a license.

559.23 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom
559.24 the license was issued is no longer licensed to operate an alkaline hydrolysis facility in
559.25 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
559.26 license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue
559.27 any additional lawful remedies as justified by the case.

559.28 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed
559.29 license upon receipt and review of a completed renewal application, receipt of the late
559.30 filing penalty, and reinspection of the premises, provided that the receipt is made within
559.31 one calendar year from the expiration date of the lapsed license and the cease and desist
559.32 order issued by the commissioner has not been violated. If a lapsed license is not restored
559.33 within one calendar year from the expiration date of the lapsed license, the holder of the
559.34 lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

559.35 Subd. 7. **Reporting changes in license information.** Any change of license
559.36 information must be reported to the commissioner, on forms provided by the

560.1 commissioner, no later than 30 calendar days after the change occurs. Failure to report
560.2 changes is grounds for disciplinary action.

560.3 Subd. 8. **Application information.** All information submitted to the commissioner
560.4 by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is
560.5 classified as licensing data under section 13.41, subdivision 5.

560.6 Sec. 76. Minnesota Statutes 2012, section 149A.65, is amended by adding a
560.7 subdivision to read:

560.8 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline
560.9 hydrolysis facility is \$300. The late fee charge for a license renewal is \$25.

560.10 Sec. 77. Minnesota Statutes 2012, section 149A.65, is amended by adding a
560.11 subdivision to read:

560.12 Subd. 7. **State government special revenue fund.** Fees collected by the
560.13 commissioner under this section must be deposited in the state treasury and credited to
560.14 the state government special revenue fund.

560.15 Sec. 78. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:

560.16 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice
560.17 mortuary science issued by the commissioner may use the title of mortician, funeral
560.18 director, or any other title implying that the licensee is engaged in the business or practice
560.19 of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis
560.20 facility issued by the commissioner may use the title of alkaline hydrolysis facility, water
560.21 cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or
560.22 any other title, word, or term implying that the licensee operates an alkaline hydrolysis
560.23 facility. Only the holder of a valid license to operate a funeral establishment issued by the
560.24 commissioner may use the title of funeral home, funeral chapel, funeral service, or any
560.25 other title, word, or term implying that the licensee is engaged in the business or practice
560.26 of mortuary science. Only the holder of a valid license to operate a crematory issued by
560.27 the commissioner may use the title of crematory, crematorium, green-cremation, or any
560.28 other title, word, or term implying that the licensee operates a crematory or crematorium.

560.29 Sec. 79. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:

560.30 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or
560.31 crematory shall not do business in a location that is not licensed as a funeral establishment,

561.1 alkaline hydrolysis facility, or crematory and shall not advertise a service that is available
561.2 from an unlicensed location.

561.3 Sec. 80. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:

561.4 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern
561.5 shall publish or disseminate false, misleading, or deceptive advertising. False, misleading,
561.6 or deceptive advertising includes, but is not limited to:

561.7 (1) identifying, by using the names or pictures of, persons who are not licensed to
561.8 practice mortuary science in a way that leads the public to believe that those persons will
561.9 provide mortuary science services;

561.10 (2) using any name other than the names under which the funeral establishment,
561.11 alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

561.12 (3) using a surname not directly, actively, or presently associated with a licensed
561.13 funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had
561.14 been previously and continuously used by the licensed funeral establishment, alkaline
561.15 hydrolysis facility, or crematory; and

561.16 (4) using a founding or establishing date or total years of service not directly or
561.17 continuously related to a name under which the funeral establishment, alkaline hydrolysis
561.18 facility, or crematory is currently or was previously licensed.

561.19 Any advertising or other printed material that contains the names or pictures of
561.20 persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory
561.21 shall state the position held by the persons and shall identify each person who is licensed
561.22 or unlicensed under this chapter.

561.23 Sec. 81. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:

561.24 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum
561.25 student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other
561.26 reimbursement in consideration for recommending or causing a dead human body to
561.27 be disposed of by a specific body donation program, funeral establishment, alkaline
561.28 hydrolysis facility, crematory, mausoleum, or cemetery.

561.29 Sec. 82. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:

561.30 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or
561.31 practices, the requirements of this subdivision must be met.

561.32 (b) Funeral providers must tell persons who ask by telephone about the funeral
561.33 provider's offerings or prices any accurate information from the price lists described in

562.1 paragraphs (c) to (e) and any other readily available information that reasonably answers
562.2 the questions asked.

562.3 (c) Funeral providers must make available for viewing to people who inquire in
562.4 person about the offerings or prices of funeral goods or burial site goods, separate printed
562.5 or typewritten price lists using a ten-point font or larger. Each funeral provider must have a
562.6 separate price list for each of the following types of goods that are sold or offered for sale:

- 562.7 (1) caskets;
- 562.8 (2) alternative containers;
- 562.9 (3) outer burial containers;
- 562.10 (4) alkaline hydrolysis containers;
- 562.11 ~~(4)~~ (5) cremation containers;
- 562.12 (6) hydrolyzed remains containers;
- 562.13 ~~(5)~~ (7) cremated remains containers;
- 562.14 ~~(6)~~ (8) markers; and
- 562.15 ~~(7)~~ (9) headstones.

562.16 (d) Each separate price list must contain the name of the funeral provider's place
562.17 of business, address, and telephone number and a caption describing the list as a price
562.18 list for one of the types of funeral goods or burial site goods described in paragraph (c),
562.19 clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion
562.20 of, but in any event before showing, the specific funeral goods or burial site goods and
562.21 must provide a photocopy of the price list, for retention, if so asked by the consumer. The
562.22 list must contain, at least, the retail prices of all the specific funeral goods and burial site
562.23 goods offered which do not require special ordering, enough information to identify each,
562.24 and the effective date for the price list. However, funeral providers are not required to
562.25 make a specific price list available if the funeral providers place the information required
562.26 by this paragraph on the general price list described in paragraph (e).

562.27 (e) Funeral providers must give a printed price list, for retention, to persons who
562.28 inquire in person about the funeral goods, funeral services, burial site goods, or burial site
562.29 services or prices offered by the funeral provider. The funeral provider must give the list
562.30 upon beginning discussion of either the prices of or the overall type of funeral service or
562.31 disposition or specific funeral goods, funeral services, burial site goods, or burial site
562.32 services offered by the provider. This requirement applies whether the discussion takes
562.33 place in the funeral establishment or elsewhere. However, when the deceased is removed
562.34 for transportation to the funeral establishment, an in-person request for authorization to
562.35 embalm does not, by itself, trigger the requirement to offer the general price list. If the
562.36 provider, in making an in-person request for authorization to embalm, discloses that

563.1 embalming is not required by law except in certain special cases, the provider is not
563.2 required to offer the general price list. Any other discussion during that time about prices
563.3 or the selection of funeral goods, funeral services, burial site goods, or burial site services
563.4 triggers the requirement to give the consumer a general price list. The general price list
563.5 must contain the following information:

563.6 (1) the name, address, and telephone number of the funeral provider's place of
563.7 business;

563.8 (2) a caption describing the list as a "general price list";

563.9 (3) the effective date for the price list;

563.10 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per
563.11 hour, mile, or other unit of computation, and other information described as follows:

563.12 (i) forwarding of remains to another funeral establishment, together with a list of
563.13 the services provided for any quoted price;

563.14 (ii) receiving remains from another funeral establishment, together with a list of
563.15 the services provided for any quoted price;

563.16 (iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral
563.17 provider, with the price including an alternative container or alkaline hydrolysis or
563.18 cremation container, any alkaline hydrolysis or crematory charges, and a description of the
563.19 services and container included in the price, where applicable, and the price of alkaline
563.20 hydrolysis or cremation where the purchaser provides the container;

563.21 (iv) separate prices for each immediate burial offered by the funeral provider,
563.22 including a casket or alternative container, and a description of the services and container
563.23 included in that price, and the price of immediate burial where the purchaser provides the
563.24 casket or alternative container;

563.25 (v) transfer of remains to the funeral establishment or other location;

563.26 (vi) embalming;

563.27 (vii) other preparation of the body;

563.28 (viii) use of facilities, equipment, or staff for viewing;

563.29 (ix) use of facilities, equipment, or staff for funeral ceremony;

563.30 (x) use of facilities, equipment, or staff for memorial service;

563.31 (xi) use of equipment or staff for graveside service;

563.32 (xii) hearse or funeral coach;

563.33 (xiii) limousine; and

563.34 (xiv) separate prices for all cemetery-specific goods and services, including all goods
563.35 and services associated with interment and burial site goods and services and excluding
563.36 markers and headstones;

564.1 (5) the price range for the caskets offered by the funeral provider, together with the
564.2 statement "A complete price list will be provided at the funeral establishment or casket
564.3 sale location." or the prices of individual caskets, as disclosed in the manner described
564.4 in paragraphs (c) and (d);

564.5 (6) the price range for the alternative containers offered by the funeral provider,
564.6 together with the statement "A complete price list will be provided at the funeral
564.7 establishment or alternative container sale location." or the prices of individual alternative
564.8 containers, as disclosed in the manner described in paragraphs (c) and (d);

564.9 (7) the price range for the outer burial containers offered by the funeral provider,
564.10 together with the statement "A complete price list will be provided at the funeral
564.11 establishment or outer burial container sale location." or the prices of individual outer
564.12 burial containers, as disclosed in the manner described in paragraphs (c) and (d);

564.13 (8) the price range for the alkaline hydrolysis container offered by the funeral
564.14 provider, together with the statement: "A complete price list will be provided at the funeral
564.15 establishment or alkaline hydrolysis container sale location.", or the prices of individual
564.16 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c)
564.17 and (d);

564.18 (9) the price range for the hydrolyzed remains container offered by the funeral
564.19 provider, together with the statement: "A complete price list will be provided at the
564.20 funeral establishment or hydrolyzed remains container sale location.", or the prices
564.21 of individual hydrolyzed remains container, as disclosed in the manner described in
564.22 paragraphs (c) and (d);

564.23 ~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider,
564.24 together with the statement "A complete price list will be provided at the funeral
564.25 establishment or cremation container sale location." or the prices of individual cremation
564.26 containers ~~and cremated remains containers~~, as disclosed in the manner described in
564.27 paragraphs (c) and (d);

564.28 (9) (11) the price range for the cremated remains containers offered by the funeral
564.29 provider, together with the statement, "A complete price list will be provided at the funeral
564.30 establishment or ~~cremation~~ cremated remains container sale location," or the prices of
564.31 individual cremation containers as disclosed in the manner described in paragraphs (c)
564.32 and (d);

564.33 ~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a
564.34 list of the principal basic services provided for any quoted price and, if the charge cannot
564.35 be declined by the purchaser, the statement "This fee for our basic services will be added
564.36 to the total cost of the funeral arrangements you select. (This fee is already included in

565.1 our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding
565.2 or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted
565.3 price shall include all charges for the recovery of unallocated funeral provider overhead,
565.4 and funeral providers may include in the required disclosure the phrase "and overhead"
565.5 after the word "services." This services fee is the only funeral provider fee for services,
565.6 facilities, or unallocated overhead permitted by this subdivision to be nondeclinable,
565.7 unless otherwise required by law;

565.8 ~~(11)~~ (13) the price range for the markers and headstones offered by the funeral
565.9 provider, together with the statement "A complete price list will be provided at the funeral
565.10 establishment or marker or headstone sale location." or the prices of individual markers
565.11 and headstones, as disclosed in the manner described in paragraphs (c) and (d); and

565.12 ~~(12)~~ (14) any package priced funerals offered must be listed in addition to and
565.13 following the information required in paragraph (e) and must clearly state the funeral
565.14 goods and services being offered, the price being charged for those goods and services,
565.15 and the discounted savings.

565.16 (f) Funeral providers must give an itemized written statement, for retention, to each
565.17 consumer who arranges an at-need funeral or other disposition of human remains at the
565.18 conclusion of the discussion of the arrangements. The itemized written statement must be
565.19 signed by the consumer selecting the goods and services as required in section 149A.80.
565.20 If the statement is provided by a funeral establishment, the statement must be signed by
565.21 the licensed funeral director or mortician planning the arrangements. If the statement is
565.22 provided by any other funeral provider, the statement must be signed by an authorized
565.23 agent of the funeral provider. The statement must list the funeral goods, funeral services,
565.24 burial site goods, or burial site services selected by that consumer and the prices to be paid
565.25 for each item, specifically itemized cash advance items (these prices must be given to the
565.26 extent then known or reasonably ascertainable if the prices are not known or reasonably
565.27 ascertainable, a good faith estimate shall be given and a written statement of the actual
565.28 charges shall be provided before the final bill is paid), and the total cost of goods and
565.29 services selected. At the conclusion of an at-need arrangement, the funeral provider is
565.30 required to give the consumer a copy of the signed itemized written contract that must
565.31 contain the information required in this paragraph.

565.32 (g) Upon receiving actual notice of the death of an individual with whom a funeral
565.33 provider has entered a preneed funeral agreement, the funeral provider must provide
565.34 a copy of all preneed funeral agreement documents to the person who controls final
565.35 disposition of the human remains or to the designee of the person controlling disposition.
565.36 The person controlling final disposition shall be provided with these documents at the time

566.1 of the person's first in-person contact with the funeral provider, if the first contact occurs
566.2 in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place
566.3 of business of the funeral provider. If the contact occurs by other means or at another
566.4 location, the documents must be provided within 24 hours of the first contact.

566.5 Sec. 83. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

566.6 Subd. 4. **Casket, alternate container, alkaline hydrolysis container, and**
566.7 **cremation container sales; records; required disclosures.** Any funeral provider who
566.8 sells or offers to sell a casket, alternate container, ~~or alkaline hydrolysis container,~~
566.9 hydrolyzed remains container, cremation container, or cremated remains container to
566.10 the public must maintain a record of each sale that includes the name of the purchaser,
566.11 the purchaser's mailing address, the name of the decedent, the date of the decedent's
566.12 death, and the place of death. These records shall be open to inspection by the regulatory
566.13 agency. Any funeral provider selling a casket, alternate container, or cremation container
566.14 to the public, and not having charge of the final disposition of the dead human body,
566.15 shall provide a copy of the statutes and rules controlling the removal, preparation,
566.16 transportation, arrangements for disposition, and final disposition of a dead human body.
566.17 This subdivision does not apply to morticians, funeral directors, funeral establishments,
566.18 crematories, or wholesale distributors of caskets, alternate containers, alkaline hydrolysis
566.19 containers, or cremation containers.

566.20 Sec. 84. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:

566.21 Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts**
566.22 **or practices.** In selling or offering to sell funeral goods or funeral services to the public, it
566.23 is a deceptive act or practice for a funeral provider to represent that a casket is required for
566.24 alkaline hydrolysis or cremations by state or local law or otherwise.

566.25 Sec. 85. Minnesota Statutes 2012, section 149A.72, is amended by adding a
566.26 subdivision to read:

566.27 Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To
566.28 prevent deceptive acts or practices, funeral providers must place the following disclosure
566.29 in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota
566.30 law does not require you to purchase a casket for alkaline hydrolysis. If you want to
566.31 arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline
566.32 hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant
566.33 to leakage of bodily fluids that encases the body and into which a dead human body is

567.1 placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide
567.2 are (specify containers provided)." This disclosure is required only if the funeral provider
567.3 arranges alkaline hydrolysis.

567.4 Sec. 86. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:

567.5 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods,
567.6 funeral services, burial site goods, or burial site services to the public, it is a deceptive act
567.7 or practice for a funeral provider to represent that federal, state, or local laws, or particular
567.8 cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral
567.9 goods, funeral services, burial site goods, or burial site services when that is not the case.

567.10 Sec. 87. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

567.11 Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive**
567.12 **acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site
567.13 goods, or burial site services to the public, it is a deceptive act or practice for a funeral
567.14 provider to require that a casket be purchased for alkaline hydrolysis or cremation.

567.15 Sec. 88. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

567.16 Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.**
567.17 To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline
567.18 hydrolysis or cremations, they must make a an alkaline hydrolysis container or cremation
567.19 container available for alkaline hydrolysis or cremations.

567.20 Sec. 89. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

567.21 Subd. 4. **Required purchases of funeral goods or services; preventive**
567.22 **requirements.** To prevent unfair or deceptive acts or practices, funeral providers must
567.23 place the following disclosure in the general price list, immediately above the prices
567.24 required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods
567.25 and services shown below are those we can provide to our customers. You may choose
567.26 only the items you desire. If legal or other requirements mean that you must buy any items
567.27 you did not specifically ask for, we will explain the reason in writing on the statement we
567.28 provide describing the funeral goods, funeral services, burial site goods, and burial site
567.29 services you selected." However, if the charge for "services of funeral director and staff"
567.30 cannot be declined by the purchaser, the statement shall include the sentence "However,
567.31 any funeral arrangements you select will include a charge for our basic services." between
567.32 the second and third sentences of the sentences specified in this subdivision. The statement

568.1 may include the phrase "and overhead" after the word "services" if the fee includes a
568.2 charge for the recovery of unallocated funeral overhead. If the funeral provider does
568.3 not include this disclosure statement, then the following disclosure statement must be
568.4 placed in the statement of funeral goods, funeral services, burial site goods, and burial site
568.5 services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges
568.6 are only for those items that you selected or that are required. If we are required by law or
568.7 by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain
568.8 the reasons in writing below." A funeral provider is not in violation of this subdivision by
568.9 failing to comply with a request for a combination of goods or services which would be
568.10 impossible, impractical, or excessively burdensome to provide.

568.11 Sec. 90. Minnesota Statutes 2012, section 149A.74, is amended to read:

568.12 **149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.**

568.13 Subdivision 1. **Services provided without prior approval; deceptive acts or**
568.14 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it
568.15 is a deceptive act or practice for any funeral provider to embalm a dead human body
568.16 unless state or local law or regulation requires embalming in the particular circumstances
568.17 regardless of any funeral choice which might be made, or prior approval for embalming
568.18 has been obtained from an individual legally authorized to make such a decision. In
568.19 seeking approval to embalm, the funeral provider must disclose that embalming is not
568.20 required by law except in certain circumstances; that a fee will be charged if a funeral
568.21 is selected which requires embalming, such as a funeral with viewing; and that no
568.22 embalming fee will be charged if the family selects a service which does not require
568.23 embalming, such as direct alkaline hydrolysis, direct cremation,₂ or immediate burial.

568.24 Subd. 2. **Services provided without prior approval; preventive requirement.**

568.25 To prevent unfair or deceptive acts or practices, funeral providers must include on
568.26 the itemized statement of funeral goods or services, as described in section 149A.71,
568.27 subdivision 2, paragraph (f), the statement "If you selected a funeral that may require
568.28 embalming, such as a funeral with viewing, you may have to pay for embalming. You do
568.29 not have to pay for embalming you did not approve if you selected arrangements such
568.30 as direct alkaline hydrolysis, direct cremation,₂ or immediate burial. If we charged for
568.31 embalming, we will explain why below."

568.32 Sec. 91. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:

568.33 Subd. 9. **Embalmed Bodies awaiting final disposition.** All embalmed bodies
568.34 awaiting final disposition shall be kept in an appropriate holding facility or preparation

569.1 and embalming room. The holding facility must be secure from access by anyone except
569.2 the authorized personnel of the funeral establishment, preserve the dignity and integrity of
569.3 the body, and protect the health and safety of the personnel of the funeral establishment.

569.4 Sec. 92. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:

569.5 Subd. 3. **Disposition permit.** A disposition permit is required before a body can
569.6 be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be
569.7 issued until a fact of death record has been completed and filed with the local or state
569.8 registrar of vital statistics.

569.9 Sec. 93. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:

569.10 Subd. 6. **Conveyances permitted for transportation.** A dead human body may be
569.11 transported by means of private vehicle or private aircraft, provided that the body must be
569.12 encased in an appropriate container, that meets the following standards:

569.13 (1) promotes respect for and preserves the dignity of the dead human body;

569.14 (2) shields the body from being viewed from outside of the conveyance;

569.15 (3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket,
569.16 alternative container, alkaline hydrolysis container, or cremation container in a horizontal
569.17 position;

569.18 (4) is designed to permit loading and unloading of the body without excessive tilting
569.19 of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container,
569.20 or cremation container; and

569.21 (5) if used for the transportation of more than one dead human body at one time,
569.22 the vehicle must be designed so that a body or container does not rest directly on top of
569.23 another body or container and that each body or container is secured to prevent the body
569.24 or container from excessive movement within the conveyance.

569.25 A vehicle that is a dignified conveyance and was specified for use by the deceased
569.26 or by the family of the deceased may be used to transport the body to the place of final
569.27 disposition.

569.28 Sec. 94. Minnesota Statutes 2012, section 149A.94, is amended to read:

569.29 **149A.94 FINAL DISPOSITION.**

569.30 Subdivision 1. **Generally.** Every dead human body lying within the state, except
569.31 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
569.32 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
569.33 the state for the purpose of disposition elsewhere; and the remains of any dead human

570.1 body after dissection or anatomical study, shall be decently buried, or entombed in a
570.2 public or private cemetery, alkaline hydrolyzed or cremated, within a reasonable time
570.3 after death. Where final disposition of a body will not be accomplished within 72 hours
570.4 following death or release of the body by a competent authority with jurisdiction over the
570.5 body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body
570.6 may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry
570.7 ice for a period that exceeds four calendar days, from the time of death or release of the
570.8 body from the coroner or medical examiner.

570.9 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or
570.10 cremated without a disposition permit. The disposition permit must be filed with the person
570.11 in charge of the place of final disposition. Where a dead human body will be transported out
570.12 of this state for final disposition, the body must be accompanied by a certificate of removal.

570.13 Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or
570.14 cremated remains and release to an appropriate party is considered final disposition and no
570.15 further permits or authorizations are required for transportation, interment, entombment, or
570.16 placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

570.17 Sec. 95. **[149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE**
570.18 **HYDROLYSIS.**

570.19 Subdivision 1. **License required.** A dead human body may only be hydrolyzed in
570.20 this state at an alkaline hydrolysis facility licensed by the commissioner of health.

570.21 Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis
570.22 facility must comply with all applicable local and state building codes, zoning laws and
570.23 ordinances, wastewater management regulations, and environmental statutes, rules, and
570.24 standards. An alkaline hydrolysis facility must have, on site, a purpose built human
570.25 alkaline hydrolysis system approved by the commissioner of health, a system approved by
570.26 the commissioner of health for drying the hydrolyzed remains, a motorized mechanical
570.27 device approved by the commissioner of health for processing hydrolyzed remains, and in
570.28 the building a holding facility approved by the commissioner of health for the retention
570.29 of dead human bodies awaiting alkaline hydrolysis. The holding facility must be secure
570.30 from access by anyone except the authorized personnel of the alkaline hydrolysis facility,
570.31 preserve the dignity of the remains, and protect the health and safety of the alkaline
570.32 hydrolysis facility personnel.

570.33 Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel
570.34 is located and the room where the chemical storage takes place shall be properly lit and
570.35 ventilated with an exhaust fan that provides at least 12 air changes per hour.

571.1 Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines,
571.2 plumbing vents, and waste drains shall be properly vented and connected pursuant to the
571.3 Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a
571.4 functional sink with hot and cold running water.

571.5 Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the
571.6 alkaline hydrolysis vessel is located and the room where the chemical storage takes place
571.7 shall have nonporous flooring, so that a sanitary condition is provided. The walls and
571.8 ceiling of the room where the alkaline hydrolysis vessel is located and the room where
571.9 the chemical storage takes place shall run from floor to ceiling and be covered with tile,
571.10 or by plaster or sheetrock painted with washable paint or other appropriate material so
571.11 that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be
571.12 constructed to prevent odors from entering any other part of the building. All windows
571.13 or other openings to the outside must be screened, and all windows must be treated in a
571.14 manner that prevents viewing into the room where the alkaline hydrolysis vessel is located
571.15 and the room where the chemical storage takes place. A viewing window for authorized
571.16 family members or their designees is not a violation of this subdivision.

571.17 Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a
571.18 functional emergency eye wash and quick drench shower.

571.19 Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is
571.20 located and the room where the chemical storage takes place must be private and have no
571.21 general passageway through it. The room shall, at all times, be secure from the entrance of
571.22 unauthorized persons. Authorized persons are:

571.23 (1) licensed morticians;

571.24 (2) registered interns or students as described in section 149A.91, subdivision 6;

571.25 (3) public officials or representatives in the discharge of their official duties;

571.26 (4) trained alkaline hydrolysis facility operators; and

571.27 (5) the person or persons with the right to control the dead human body as defined in
571.28 section 149A.80, subdivision 2, and their designees.

571.29 (b) Each door allowing ingress or egress shall carry a sign that indicates that the
571.30 room is private and access is limited. All authorized persons who are present in or enter
571.31 the room where the alkaline hydrolysis vessel is located while a body is being prepared for
571.32 final disposition must be attired according to all applicable state and federal regulations
571.33 regarding the control of infectious disease and occupational and workplace health and
571.34 safety.

571.35 Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline
571.36 hydrolysis vessel is located and the room where the chemical storage takes place and all

572.1 fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies
572.2 stored or used in the room must be maintained in a clean and sanitary condition at all times.

572.3 Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline
572.4 hydrolysis vessel for its operation, all state and local regulations for that boiler must be
572.5 followed.

572.6 Subd. 10. **Occupational and workplace safety.** All applicable provisions of state
572.7 and federal regulations regarding exposure to workplace hazards and accidents shall be
572.8 followed in order to protect the health and safety of all authorized persons at the alkaline
572.9 hydrolysis facility.

572.10 Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ
572.11 a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body.
572.12 It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for
572.13 all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for
572.14 compliance with this chapter and other applicable state and federal regulations regarding
572.15 occupational and workplace health and safety.

572.16 Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility
572.17 shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part
572.18 without receiving written authorization to do so from the person or persons who have the
572.19 legal right to control disposition as described in section 149A.80 or the person's legal
572.20 designee. The written authorization must include:

572.21 (1) the name of the deceased and the date of death of the deceased;

572.22 (2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;

572.23 (3) the name, address, telephone number, relationship to the deceased, and signature
572.24 of the person or persons with legal right to control final disposition or a legal designee;

572.25 (4) directions for the disposition of any nonhydrolyzed materials or items recovered
572.26 from the alkaline hydrolysis vessel;

572.27 (5) acknowledgment that the hydrolyzed remains will be dried and mechanically
572.28 reduced to a granulated appearance and placed in an appropriate container and
572.29 authorization to place any hydrolyzed remains that a selected urn or container will not
572.30 accommodate into a temporary container;

572.31 (6) acknowledgment that, even with the exercise of reasonable care, it is not possible
572.32 to recover all particles of the hydrolyzed remains and that some particles may inadvertently
572.33 become commingled with particles of other hydrolyzed remains that remain in the alkaline
572.34 hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;

572.35 (7) directions for the ultimate disposition of the hydrolyzed remains; and

573.1 (8) a statement that includes, but is not limited to, the following information:
573.2 "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an
573.3 alkaline solution is used to chemically break down the human tissue and the hydrolyzable
573.4 alkaline hydrolysis container. After the process is complete, the liquid effluent solution
573.5 contains the chemical by-products of the alkaline hydrolysis process except for the
573.6 deceased's bone fragments. The solution is cooled and released according to local
573.7 environmental regulations. A water rinse is applied to the hydrolyzed remains which are
573.8 then dried and processed to facilitate inurnment or scattering."

573.9 Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in
573.10 good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an
573.11 authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from
573.12 civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis
573.13 facility.

573.14 Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be
573.15 accepted for final disposition by alkaline hydrolysis unless:

573.16 (1) encased in an appropriate alkaline hydrolysis container;

573.17 (2) accompanied by a disposition permit issued pursuant to section 149A.93,
573.18 subdivision 3, including a photocopy of the completed death record or a signed release
573.19 authorizing alkaline hydrolysis of the body received from the coroner or medical
573.20 examiner; and

573.21 (3) accompanied by an alkaline hydrolysis authorization that complies with
573.22 subdivision 12.

573.23 (b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline
573.24 hydrolysis container where there is:

573.25 (1) evidence of leakage of fluids from the alkaline hydrolysis container;

573.26 (2) a known dispute concerning hydrolysis of the body delivered;

573.27 (3) a reasonable basis for questioning any of the representations made on the written
573.28 authorization to hydrolyze; or

573.29 (4) any other lawful reason.

573.30 Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed
573.31 within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of
573.32 the body.

573.33 Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.**

573.34 All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for
573.35 dead human bodies shall use universal precautions and otherwise exercise all reasonable

574.1 precautions to minimize the risk of transmitting any communicable disease from the body.

574.2 No dead human body shall be removed from the container in which it is delivered.

574.3 Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall
574.4 develop, implement, and maintain an identification procedure whereby dead human
574.5 bodies can be identified from the time the alkaline hydrolysis facility accepts delivery
574.6 of the remains until the hydrolyzed remains are released to an authorized party. After
574.7 hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the
574.8 hydrolyzed remains container before the hydrolyzed remains are released from the alkaline
574.9 hydrolysis facility. Each identification disk, tab, or label shall have a number that shall
574.10 be recorded on all paperwork regarding the decedent. This procedure shall be designed
574.11 to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains
574.12 are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the
574.13 inability to individually identify the hydrolyzed remains is a violation of this subdivision.

574.14 Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline
574.15 hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains
574.16 in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for
574.17 infectious disease control.

574.18 Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of
574.19 dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is
574.20 written authorization from the person with the legal right to control the disposition,
574.21 only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline
574.22 hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting
574.23 alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline
574.24 hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

574.25 Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains**
574.26 **prohibited.** Except with the express written permission of the person with the legal right
574.27 to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one
574.28 dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce
574.29 a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have
574.30 been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze
574.31 a dead human body and other human remains at the same time and in the same alkaline
574.32 hydrolysis vessel. This section does not apply where commingling of human remains
574.33 during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental
574.34 and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is
574.35 not a violation of this subdivision.

575.1 Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis**
575.2 **vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be
575.3 made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed
575.4 remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be
575.5 made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed
575.6 human remains and dispose of these materials in a lawful manner, by the alkaline
575.7 hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate
575.8 container to be transported to the processing area.

575.9 Subd. 22. **Drying device or mechanical processor procedures; commingling of**
575.10 **hydrolyzed remains prohibited.** Except with the express written permission of the
575.11 person with the legal right to control the final disposition or otherwise provided by
575.12 law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed
575.13 human remains of more than one body at a time in the same drying device or mechanical
575.14 processor, or introduce the hydrolyzed human remains of a second body into a drying
575.15 device or mechanical processor until processing of any preceding hydrolyzed human
575.16 remains has been terminated and reasonable efforts have been employed to remove all
575.17 fragments of the preceding hydrolyzed remains. The fact that there is incidental and
575.18 unavoidable residue in the drying device, the mechanical processor, or any container used
575.19 in a prior alkaline hydrolysis process, is not a violation of this provision.

575.20 Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The
575.21 hydrolyzed human remains shall be dried and then reduced by a motorized mechanical
575.22 device to a granulated appearance appropriate for final disposition and placed in an
575.23 alkaline hydrolysis remains container along with the appropriate identifying disk, tab,
575.24 or permanent label. Processing must take place within the licensed alkaline hydrolysis
575.25 facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they
575.26 can be identified, may be removed prior to processing the hydrolyzed remains, only by
575.27 staff licensed or registered by the commissioner of health; however, any dental gold and
575.28 silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains
575.29 container unless otherwise directed by the person or persons having the right to control the
575.30 final disposition. Every person who removes or possesses dental gold or silver, jewelry,
575.31 or mementos from any hydrolyzed remains without specific written permission of the
575.32 person or persons having the right to control those remains is guilty of a misdemeanor.
575.33 The fact that residue and any unavoidable dental gold or dental silver, or other precious
575.34 metals remain in the alkaline hydrolysis vessel or other equipment or any container used
575.35 in a prior hydrolysis is not a violation of this section.

576.1 Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.**

576.2 If a hydrolyzed remains container is of insufficient capacity to accommodate all
576.3 hydrolyzed remains of a given dead human body, subject to directives provided in the
576.4 written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess
576.5 hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the
576.6 second container, in a manner so as not to be easily detached through incidental contact, to
576.7 the primary alkaline hydrolysis remains container. The secondary container shall contain a
576.8 duplicate of the identification disk, tab, or permanent label that was placed in the primary
576.9 container and all paperwork regarding the given body shall include a notation that the
576.10 hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature
576.11 hydrolyzed remains containers are not subject to the requirements of this subdivision.

576.12 Subd. 25. **Disposition procedures; commingling of hydrolyzed remains**

576.13 **prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in
576.14 a location where the hydrolyzed remains are commingled with those of another person
576.15 without the express written permission of the person with the legal right to control
576.16 disposition or as otherwise provided by law. This subdivision does not apply to the
576.17 scattering or burial of hydrolyzed remains at sea or in a body of water from individual
576.18 containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to
576.19 the disposal in a dedicated cemetery of accumulated residue removed from an alkaline
576.20 hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members
576.21 of the same family in a common container designed for the hydrolyzed remains of more
576.22 than one body, or to the inurnment in a container or interment in a space that has been
576.23 previously designated, at the time of sale or purchase, as being intended for the inurnment
576.24 or interment of the hydrolyzed remains of more than one person.

576.25 Subd. 26. **Alkaline hydrolysis procedures; disposition of accumulated residue.**

576.26 Every alkaline hydrolysis facility shall provide for the removal and disposition in a
576.27 dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel,
576.28 drying device, mechanical processor, container, or other equipment used in alkaline
576.29 hydrolysis. Disposition of accumulated residue shall be according to the regulations of the
576.30 dedicated cemetery and any applicable local ordinances.

576.31 Subd. 27. **Alkaline hydrolysis procedures; release of hydrolyzed remains.**

576.32 Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be
576.33 released according to the instructions given on the written authorization to hydrolyze. If
576.34 the hydrolyzed remains are to be shipped, they must be securely packaged and transported
576.35 by a method which has an internal tracing system available and which provides for a
576.36 receipt signed by the person accepting delivery. Where there is a dispute over release

577.1 or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit
577.2 the hydrolyzed remains with a court of competent jurisdiction pending resolution of the
577.3 dispute or retain the hydrolyzed remains until the person with the legal right to control
577.4 disposition presents satisfactory indication that the dispute is resolved.

577.5 Subd. 28. **Unclaimed hydrolyzed remains.** If, after 30 calendar days following
577.6 the inurnment, the hydrolyzed remains are not claimed or disposed of according to the
577.7 written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment
577.8 may give written notice, by certified mail, to the person with the legal right to control
577.9 the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and
577.10 requesting further release directions. Should the hydrolyzed remains be unclaimed 120
577.11 calendar days following the mailing of the written notification, the alkaline hydrolysis
577.12 facility or funeral establishment may dispose of the hydrolyzed remains in any lawful
577.13 manner deemed appropriate.

577.14 Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and
577.15 maintain on its premises or other business location in Minnesota an accurate record of
577.16 every hydrolyzation provided. The record shall include all of the following information
577.17 for each hydrolyzation:

577.18 (1) the name of the person or funeral establishment delivering the body for alkaline
577.19 hydrolysis;

577.20 (2) the name of the deceased and the identification number assigned to the body;

577.21 (3) the date of acceptance of delivery;

577.22 (4) the names of the alkaline hydrolysis vessel, drying device, and mechanical
577.23 processor operator;

577.24 (5) the time and date that the body was placed in and removed from the alkaline
577.25 hydrolysis vessel;

577.26 (6) the time and date that processing and inurnment of the hydrolyzed remains
577.27 was completed;

577.28 (7) the time, date, and manner of release of the hydrolyzed remains;

577.29 (8) the name and address of the person who signed the authorization to hydrolyze;

577.30 (9) all supporting documentation, including any transit or disposition permits, a
577.31 photocopy of the death record, and the authorization to hydrolyze; and

577.32 (10) the type of alkaline hydrolysis container.

577.33 Subd. 30. **Retention of records.** Records required under subdivision 29 shall be
577.34 maintained for a period of three calendar years after the release of the hydrolyzed remains.
577.35 Following this period and subject to any other laws requiring retention of records, the
577.36 alkaline hydrolysis facility may then place the records in storage or reduce them to

578.1 microfilm, microfiche, laser disc, or any other method that can produce an accurate
578.2 reproduction of the original record, for retention for a period of ten calendar years from
578.3 the date of release of the hydrolyzed remains. At the end of this period and subject to any
578.4 other laws requiring retention of records, the alkaline hydrolysis facility may destroy
578.5 the records by shredding, incineration, or any other manner that protects the privacy of
578.6 the individuals identified.

578.7 Sec. 96. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:

578.8 Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95,
578.9 subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an
578.10 appropriate party is considered final disposition and no further permits or authorizations
578.11 are required for disinterment, transportation, or placement of the hydrolyzed or cremated
578.12 remains.

578.13 Sec. 97. Minnesota Statutes 2012, section 257.75, subdivision 7, is amended to read:

578.14 Subd. 7. **Hospital and Department of Health; recognition form.** Hospitals that
578.15 provide obstetric services and the state registrar of vital statistics shall distribute the
578.16 educational materials and recognition of parentage forms prepared by the commissioner of
578.17 human services to new parents, shall assist parents in understanding the recognition of
578.18 parentage form, including following the provisions for notice under subdivision 5, shall
578.19 provide notary services for parents who complete the recognition of parentage form, and
578.20 shall timely file the completed recognition of parentage form with the Office of ~~the State~~
578.21 ~~Registrar of Vital Statistics Records~~ unless otherwise instructed by the Office of ~~the State~~
578.22 ~~Registrar of Vital Statistics Records~~. ~~On and after January 1, 1994, hospitals may not~~
578.23 ~~distribute the declaration of parentage forms.~~

578.24 Sec. 98. Minnesota Statutes 2012, section 260C.635, subdivision 1, is amended to read:

578.25 Subdivision 1. **Legal effect.** (a) Upon adoption, the adopted child becomes the legal
578.26 child of the adopting parent and the adopting parent becomes the legal parent of the child
578.27 with all the rights and duties between them of a birth parent and child.

578.28 (b) The child shall inherit from the adoptive parent and the adoptive parent's
578.29 relatives the same as though the child were the birth child of the parent, and in case of the
578.30 child's death intestate, the adoptive parent and the adoptive parent's relatives shall inherit
578.31 the child's estate as if the child had been the adoptive parent's birth child.

578.32 (c) After a decree of adoption is entered, the birth parents or previous legal parents
578.33 of the child shall be relieved of all parental responsibilities for the child except child

579.1 support that has accrued to the date of the order for guardianship to the commissioner
579.2 which continues to be due and owing. The child's birth or previous legal parent shall not
579.3 exercise or have any rights over the adopted child or the adopted child's property, person,
579.4 privacy, or reputation.

579.5 (d) The adopted child shall not owe the birth parents or the birth parent's relatives
579.6 any legal duty nor shall the adopted child inherit from the birth parents or kindred unless
579.7 otherwise provided for in a will of the birth parent or kindred.

579.8 (e) Upon adoption, the court shall complete a certificate of adoption form and mail
579.9 the form to the Office of ~~the State Registrar~~ Vital Records at the Minnesota Department
579.10 of Health. Upon receiving the certificate of adoption, the state registrar shall register a
579.11 replacement vital record in the new name of the adopted child as required under section
579.12 144.218.

579.13 Sec. 99. Minnesota Statutes 2012, section 517.001, is amended to read:

579.14 **517.001 DEFINITION.**

579.15 As used in this chapter, "local registrar" ~~has the meaning given in section 144.212,~~
579.16 ~~subdivision 10~~ means an individual designated by the county board of commissioners to
579.17 register marriages.

579.18 Sec. 100. Laws 2011, First Special Session chapter 9, article 2, section 27, is amended
579.19 to read:

579.20 Sec. 27. **MINNESOTA TASK FORCE ON PREMATURITY.**

579.21 Subdivision 1. **Establishment.** The Minnesota Task Force on Prematurity is
579.22 established to evaluate and make recommendations on methods for reducing prematurity
579.23 and improving premature infant health care in the state.

579.24 Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of at
579.25 least the following members, who serve at the pleasure of their appointing authority:

579.26 (1) ~~15~~ 11 representatives of the Minnesota Prematurity Coalition including, but not
579.27 limited to, health care providers who treat pregnant women or neonates, organizations
579.28 focused on preterm births, early childhood education and development professionals, and
579.29 families affected by prematurity;

579.30 (2) one representative appointed by the commissioner of human services;

579.31 (3) two representatives appointed by the commissioner of health;

579.32 (4) one representative appointed by the commissioner of education;

579.33 (5) two members of the house of representatives, one appointed by the speaker of
579.34 the house and one appointed by the minority leader; and

580.1 (6) two members of the senate, appointed according to the rules of the senate.

580.2 (b) Members of the task force serve without compensation or payment of expenses.

580.3 (c) The commissioner of health must convene the first meeting of the Minnesota
580.4 Task Force on Prematurity by July 31, 2011. The task force must continue to meet at
580.5 least quarterly. Staffing and technical assistance shall be provided by the Minnesota
580.6 Perinatal Coalition.

580.7 Subd. 3. **Duties.** The task force must report the current state of prematurity in
580.8 Minnesota and develop recommendations on strategies for reducing prematurity and
580.9 improving premature infant health care in the state by ~~considering the following:~~

580.10 (1) promoting adherence to standards of care for premature infants born less than 37
580.11 weeks gestational age, including recommendations to improve utilization of appropriate
580.12 hospital discharge and follow-up care procedures;

580.13 (2) coordination of information among appropriate professional and advocacy
580.14 organizations on measures to improve health care for infants born prematurely;

580.15 (3) identification and centralization of available resources to improve access and
580.16 awareness for caregivers of premature infants; and

580.17 ~~(4) development and dissemination of evidence-based practices through networking~~
580.18 ~~and educational opportunities;~~

580.19 ~~(5) a review of relevant evidence-based research regarding the causes and effects of~~
580.20 ~~premature births in Minnesota;~~

580.21 ~~(6) a review of relevant evidence-based research regarding premature infant health~~
580.22 ~~care, including methods for improving quality of and access to care for premature infants;~~

580.23 ~~(7) (4) a review of the potential improvements in health status related to the use of~~
580.24 ~~health care homes to provide and coordinate pregnancy-related services; and~~

580.25 ~~(8) identification of gaps in public reporting measures and possible effects of these~~
580.26 ~~measures on prematurity rates.~~

580.27 Subd. 4. **Report; expiration.** (a) By ~~November 30, 2011~~ January 15, 2015, the
580.28 task force must submit a final report to the chairs and ranking minority members of
580.29 the legislative policy committees on health and human services on the ~~current~~ state of
580.30 prematurity in Minnesota ~~to the chairs of the legislative policy committees on health and~~
580.31 ~~human services, including any recommendations to reduce premature births and improve~~
580.32 premature infant health in the state.

580.33 (b) ~~By January 15, 2013, the task force must report its final recommendations,~~
580.34 ~~including any draft legislation necessary for implementation, to the chairs of the legislative~~
580.35 ~~policy committees on health and human services.~~

581.1 (e) ~~(b)~~ This task force expires on January 31, ~~2013~~ 2015, or upon submission of the
581.2 final report required in paragraph ~~(b)~~ (a), whichever is earlier.

581.3 Sec. 101. **FUNERAL ESTABLISHMENTS; BRANCH LOCATIONS.**

581.4 The commissioner of health shall review the statutory requirements for preparation
581.5 and embalming rooms and develop legislation with input from stakeholders that provides
581.6 appropriate health and safety protection for funeral home locations where deceased bodies
581.7 are present, but are branch locations associated through a majority ownership of a licensed
581.8 funeral establishment that meets the requirements of Minnesota Statutes, sections 149A.50
581.9 and 149A.92, subdivisions 2 to 10. The review shall include consideration of distance
581.10 between the main location and branch, and other health and safety issues.

581.11 Sec. 102. **HEALTH EQUITY REPORT.**

581.12 By February 1, 2014, the commissioner of health, in consultation with local public
581.13 health, health care, and community partners, must submit a report to the chairs and ranking
581.14 minority members of the committees with jurisdiction over health policy and finance, on a
581.15 plan for advancing health equity in Minnesota. The report must include the following:

581.16 (1) assessment of health disparities that exist in the state and how these disparities
581.17 relate to health equity;

581.18 (2) identification of policies, processes, and systems that contribute to health
581.19 inequity in the state;

581.20 (3) recommendations for changes to policies, processes and systems within the
581.21 Department of Health that would increase the department's leadership in addressing health
581.22 inequities;

581.23 (4) identification of best practices for local public health, health care, and community
581.24 partners to provide culturally responsive services and advance health equity; and

581.25 (5) recommendations for strategies for the use of data to document and monitor
581.26 existing health inequities and to evaluate effectiveness of policies, processes, systems,
581.27 and environmental changes that will advance health equity.

581.28 Sec. 103. **GUARANTEED RENEWABILITY STUDY.**

581.29 The commissioner of commerce, in consultation with the commissioner of health,
581.30 and representatives of health carriers and consumer advocates, shall study guaranteed
581.31 renewability of health plans in the individual market and assess the need for statutory
581.32 provisions related to permitting the discontinuance or modification of health plan
581.33 coverage in the individual market by a health carrier. The commissioner shall submit

582.1 recommendations and draft legislation, if needed, to the chairs and ranking minority
582.2 members of the legislative committees with jurisdiction over health insurance policy
582.3 issues by February 1, 2014.

582.4 Sec. 104. **CAPITAL RESERVES LIMITS STUDY.**

582.5 By February 1, 2014, the commissioner of health, in consultation with the
582.6 commissioners of human services and commerce, shall study methodologies for
582.7 determining appropriate levels for capital reserves of health maintenance organizations
582.8 and requirements for reducing capital reserves to any recommended maximum levels.
582.9 In conducting the study, the commissioner shall consult with health maintenance
582.10 organizations, stakeholders, consumers, and other states' insurance regulators. The
582.11 commissioner shall make recommendations on the need for a level of capital reserves, and
582.12 framework for implementing any recommended levels. The commissioner shall submit
582.13 a report to the chairs and ranking minority members of the legislative committees with
582.14 jurisdiction over health and human services.

582.15 Sec. 105. **STUDY AND RECOMMENDATIONS REGARDING MINNESOTA**
582.16 **COMPREHENSIVE HEALTH ASSOCIATION.**

582.17 By August 15, 2013, the Department of Commerce shall study and report to the
582.18 legislature on reasonable and efficient options for coverage for high-quality, medically
582.19 necessary, evidence-based treatment of autism spectrum disorders up to age 18, including
582.20 whether the Minnesota Comprehensive Health Association could provide coverage
582.21 options through January 1, 2016, under Minnesota Statutes, chapter 62E.

582.22 Sec. 106. **ESSENTIAL HEALTH BENEFITS.**

582.23 By December 31, 2014, the Department of Commerce shall request that the United
582.24 States Department of Human Services include autism services in Minnesota's Essential
582.25 Health Benefits when the next benefit set is selected in 2016. These services should
582.26 include but not be limited to the services listed in Minnesota Statutes, section 62A.3094,
582.27 subdivision 2, paragraph (a).

582.28 Sec. 107. **ATTORNEY GENERAL LEGAL OPINION REQUIRED.**

582.29 Pursuant to the requirements of Minnesota Statutes, section 8.05, and no later than
582.30 October 1, 2013, the attorney general shall give a written legal opinion on whether a
582.31 health plan, as defined by Minnesota Statutes, section 62Q.01, subdivision 3, is required
582.32 to provide coverage of treatment for mental health and mental health-related illnesses,

583.1 including autism spectrum disorders and any other mental health condition as determined
583.2 by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of
583.3 Mental Disorders of the American Psychiatric Association. The attorney general shall
583.4 provide copies of this legal opinion to the commissioners of commerce and human
583.5 services, the board of directors of the Minnesota Insurance Marketplace, and the legislative
583.6 chairs with jurisdiction over commerce and health policy.

583.7 Sec. 108. **REVISOR'S INSTRUCTION.**

583.8 The revisor shall substitute the term "vertical heat exchangers" or "vertical
583.9 heat exchanger" with "bored geothermal heat exchangers" or "bored geothermal heat
583.10 exchanger" wherever it appears in Minnesota Statutes, sections 103I.005, subdivisions
583.11 2 and 12; 103I.101, subdivisions 2 and 5; 103I.105; 103I.205, subdivision 4; 103I.208,
583.12 subdivision 2; 103I.501; 103I.531, subdivision 5; and 103I.641, subdivisions 1, 2, and 3.

583.13 Sec. 109. **REPEALER.**

583.14 (a) Minnesota Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 149A.025;
583.15 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45,
583.16 subdivision 6; 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a;
583.17 149A.53, subdivision 9; and 485.14, are repealed.

583.18 (b) Minnesota Statutes 2012, section 144.123, subdivision 2, is repealed effective
583.19 July 1, 2014.

583.20 ARTICLE 13

583.21 PAYMENT METHODOLOGIES FOR HOME AND 583.22 COMMUNITY-BASED SERVICES

583.23 Section 1. Minnesota Statutes 2012, section 252.41, subdivision 3, is amended to read:

583.24 Subd. 3. **Day training and habilitation services for adults with developmental**
583.25 **disabilities.** "Day training and habilitation services for adults with developmental
583.26 disabilities" means services that:

583.27 (1) include supervision, training, assistance, and supported employment,
583.28 work-related activities, or other community-integrated activities designed and
583.29 implemented in accordance with the individual service and individual habilitation plans
583.30 required under Minnesota Rules, parts 9525.0015 to 9525.0165, to help an adult reach
583.31 and maintain the highest possible level of independence, productivity, and integration
583.32 into the community; and

584.1 (2) are provided ~~under contract with the county where the services are delivered~~
584.2 by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to
584.3 provide day training and habilitation services.

584.4 Day training and habilitation services reimbursable under this section do not include
584.5 special education and related services as defined in the Education of the Individuals with
584.6 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and
584.7 (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973,
584.8 United States Code, title 29, section 720, as amended.

584.9 **EFFECTIVE DATE.** This section is effective January 1, 2014.

584.10 Sec. 2. Minnesota Statutes 2012, section 252.42, is amended to read:

584.11 **252.42 SERVICE PRINCIPLES.**

584.12 The design and delivery of services eligible for reimbursement ~~under the rates~~
584.13 ~~established in section 252.46~~ should reflect the following principles:

584.14 (1) services must suit a person's chronological age and be provided in the least
584.15 restrictive environment possible, consistent with the needs identified in the person's
584.16 individual service and individual habilitation plans under Minnesota Rules, parts
584.17 9525.0015 to 9525.0165;

584.18 (2) a person with a developmental disability whose individual service and individual
584.19 habilitation plans authorize employment or employment-related activities shall be given
584.20 the opportunity to participate in employment and employment-related activities in which
584.21 nondisabled persons participate;

584.22 (3) a person with a developmental disability participating in work shall be paid
584.23 wages commensurate with the rate for comparable work and productivity except as
584.24 regional centers are governed by section 246.151;

584.25 (4) a person with a developmental disability shall receive services which include
584.26 services offered in settings used by the general public and designed to increase the person's
584.27 active participation in ordinary community activities;

584.28 (5) a person with a developmental disability shall participate in the patterns,
584.29 conditions, and rhythms of everyday living and working that are consistent with the norms
584.30 of the mainstream of society.

584.31 **EFFECTIVE DATE.** This section is effective January 1, 2014.

584.32 Sec. 3. Minnesota Statutes 2012, section 252.43, is amended to read:

584.33 **252.43 COMMISSIONER'S DUTIES.**

585.1 The commissioner shall supervise county boards' provision of day training and
 585.2 habilitation services to adults with developmental disabilities. The commissioner shall:

585.3 (1) determine the need for day training and habilitation services under section 252.28;

585.4 (2) ~~approve~~ establish payment rates ~~established by a county under section 252.46,~~
 585.5 ~~subdivision 1~~ as provided under section 256B.4914;

585.6 (3) adopt rules for the administration and provision of day training and habilitation
 585.7 services under sections ~~252.40~~ 252.41 to 252.46 and sections 245A.01 to 245A.16 and
 585.8 252.28, subdivision 2;

585.9 (4) enter into interagency agreements necessary to ensure effective coordination and
 585.10 provision of day training and habilitation services;

585.11 (5) monitor and evaluate the costs and effectiveness of day training and habilitation
 585.12 services; and

585.13 (6) provide information and technical help to county boards and vendors in their
 585.14 administration and provision of day training and habilitation services.

585.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

585.16 Sec. 4. Minnesota Statutes 2012, section 252.44, is amended to read:

585.17 **252.44 COUNTY BOARD RESPONSIBILITIES.**

585.18 (a) When the need for day training and habilitation services in a county has been
 585.19 determined under section 252.28, the board of commissioners for that county shall:

585.20 (1) authorize the delivery of services according to the individual service and
 585.21 habilitation plans required as part of the county's provision of case management services
 585.22 under Minnesota Rules, parts 9525.0015 to 9525.0165. For calendar years for which
 585.23 section 252.46, subdivisions 2 to 10, apply, the county board shall not authorize a change
 585.24 in service days from the number of days authorized for the previous calendar year unless
 585.25 there is documentation for the change in the individual service plan. An increase in service
 585.26 days must also be supported by documentation that the goals and objectives assigned to the
 585.27 vendor cannot be met more economically and effectively by other available community
 585.28 services and that without the additional days of service the individual service plan could
 585.29 not be implemented in a manner consistent with the service principles in section 252.42;

585.30 ~~(2) contract with licensed vendors, as specified in paragraph (b), under sections~~
 585.31 ~~256E.12 and 256B.092 and rules adopted under those sections;~~

585.32 ~~(3)~~ (2) ensure that transportation is provided or arranged by the vendor in the most
 585.33 efficient and reasonable way possible; and

585.34 ~~(4) set payment rates under section 252.46;~~

586.1 ~~(5) (3) monitor and evaluate the cost and effectiveness of the services; and~~
586.2 ~~(6) reimburse vendors for the provision of authorized services according to the rates,~~
586.3 ~~procedures, and regulations governing reimbursement.~~

586.4 ~~(b) With all vendors except regional centers, the contract must include the approved~~
586.5 ~~payment rates, the projected budget for the contract period, and any actual expenditures~~
586.6 ~~of previous and current contract periods. With all vendors, including regional centers,~~
586.7 ~~the contract must also include the amount, availability, and components of day training~~
586.8 ~~and habilitation services to be provided, the performance standards governing service~~
586.9 ~~provision and evaluation, and the time period in which the contract is effective.~~

586.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

586.11 Sec. 5. Minnesota Statutes 2012, section 252.45, is amended to read:

586.12 **252.45 VENDOR'S DUTIES.**

586.13 A vendor's responsibility vendor enrolled with the commissioner is responsible for
586.14 items under clauses (1), (2), and (3), and extends only to the provision of services that are
586.15 reimbursable under state and federal law. A vendor ~~under contract with a county board to~~
586.16 ~~provide~~ providing day training and habilitation services shall:

586.17 (1) provide the amount and type of services authorized in the individual service plan
586.18 under Minnesota Rules, parts 9525.0015 to 9525.0165;

586.19 (2) design the services to achieve the outcomes assigned to the vendor in the
586.20 individual service plan;

586.21 (3) provide or arrange for transportation of persons receiving services to and from
586.22 service sites;

586.23 (4) enter into agreements with community-based intermediate care facilities for
586.24 persons with developmental disabilities to ensure compliance with applicable federal
586.25 regulations; and

586.26 (5) comply with state and federal law.

586.27 **EFFECTIVE DATE.** This section is effective January 1, 2014.

586.28 Sec. 6. Minnesota Statutes 2012, section 252.46, subdivision 1a, is amended to read:

586.29 Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish
586.30 a statewide rate-setting methodology for all day training and habilitation services as
586.31 provided under section 256B.4914. The rate-setting methodology must abide by the
586.32 principles of transparency and equitability across the state. The methodology must involve

587.1 a uniform process of structuring rates for each service and must promote quality and
587.2 participant choice.

587.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

587.4 Sec. 7. Minnesota Statutes 2012, section 256B.4912, subdivision 2, is amended to read:

587.5 Subd. 2. **Payment methodologies.** (a) The commissioner shall establish, as defined
587.6 under section 256B.4914, statewide payment methodologies that meet federal waiver
587.7 requirements for home and community-based waiver services for individuals with
587.8 disabilities. The payment methodologies must abide by the principles of transparency
587.9 and equitability across the state. The methodologies must involve a uniform process of
587.10 structuring rates for each service and must promote quality and participant choice.

587.11 (b) As of January 1, 2012, counties shall not implement changes to established
587.12 processes for rate-setting methodologies for individuals using components of or data
587.13 from research rates.

587.14 Sec. 8. Minnesota Statutes 2012, section 256B.4912, subdivision 3, is amended to read:

587.15 Subd. 3. **Payment requirements.** The payment methodologies established under
587.16 this section shall accommodate:

- 587.17 (1) supervision costs;
587.18 (2) ~~staffing patterns~~ staff compensation;
587.19 (3) staffing and supervisory patterns;
587.20 ~~(3)~~ (4) program-related expenses;
587.21 ~~(4)~~ (5) general and administrative expenses; and
587.22 ~~(5)~~ (6) consideration of recipient intensity.

587.23 Sec. 9. Minnesota Statutes 2012, section 256B.4913, is amended by adding a
587.24 subdivision to read:

587.25 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
587.26 "implementation period" shall mean the period beginning January 1, 2014, and ending
587.27 on the last day of the month in which the rate management system is populated with the
587.28 data necessary to calculate rates for substantially all individuals receiving home and
587.29 community-based services.

587.30 (b) For purposes of this subdivision, the banding value for all service recipients
587.31 shall mean the individual reimbursement rate for a recipient in effect on December 1,
587.32 2013, except that:

588.1 (1)(i) for day training and habilitation pilot program service recipients, the banding
588.2 value shall be the authorized rate for the provider in the county of service effective
588.3 December 1, 2013, if the recipient: was not authorized to receive these waiver services
588.4 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
588.5 changed providers on or after January 1, 2014; and

588.6 (ii) for all other unit or day service recipients, the banding value shall be the
588.7 weighted average authorized rate for each provider number in the county of service
588.8 effective December 1, 2013, if the recipient: was not authorized to receive these waiver
588.9 services prior to January 1, 2014; added a new service or services on or after January 1,
588.10 2014; or changed providers on or after January 1, 2014; and

588.11 (2) for residential service recipients who change providers on or after January 1,
588.12 2014, the banding value shall be set by each lead agency within their county aggregate
588.13 budget using their respective methodology for residential services effective December 1,
588.14 2013, for determining the provider rate for a similarly situated recipient being served by
588.15 that provider.

588.16 (c) The commissioner shall adjust individual reimbursement rates determined under
588.17 this section so that the unit rate is no higher or lower than:

588.18 (1) 0.5 percent from the banding value for the implementation period;

588.19 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period
588.20 immediately following the time period of clause (1);

588.21 (3) 1.0 percent from the rate in effect in clause (2), for the 12-month period
588.22 immediately following the time period of clause (2);

588.23 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period
588.24 immediately following the time period of clause (3); and

588.25 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period
588.26 immediately following the time period of clause (4).

588.27 (d) This subdivision shall not apply to rates for recipients served by providers new
588.28 to a given county after January 1, 2014.

588.29 Sec. 10. Minnesota Statutes 2012, section 256B.4913, subdivision 5, is amended to read:

588.30 Subd. 5. **Stakeholder consultation.** The commissioner shall continue consultation
588.31 on regular intervals with the existing stakeholder group established as part of the
588.32 rate-setting methodology process and others, to gather input, concerns, and data, and
588.33 exchange ideas for the legislative proposals for to assist in the full implementation of
588.34 the new rate payment system and to make pertinent information available to the public
588.35 through the department's Web site.

589.1 Sec. 11. Minnesota Statutes 2012, section 256B.4913, subdivision 6, is amended to read:

589.2 Subd. 6. **Implementation.** (a) The commissioner ~~may~~ shall implement changes
589.3 ~~no sooner than~~ on January 1, 2014, to payment rates for individuals receiving home and
589.4 community-based waived services after the enactment of legislation that establishes
589.5 specific payment methodology frameworks, processes for rate calculations, and specific
589.6 values to populate the ~~payment methodology frameworks~~ disability waiver rates system.

589.7 (b) On January 1, 2014, all new service authorizations must use the disability waiver
589.8 rates system. Beginning January 1, 2014, all renewing individual service plans must use the
589.9 disability waiver rates system as reassessment and reauthorization occurs. By December
589.10 31, 2014, data for all recipients must be entered into the disability waiver rates system.

589.11 Sec. 12. **[256B.4914] HOME AND COMMUNITY-BASED SERVICES**
589.12 **WAIVERS; RATE SETTING.**

589.13 Subdivision 1. **Application.** The payment methodologies in this section apply to
589.14 home and community-based services waivers under sections 256B.092 and 256B.49. This
589.15 section does not change existing waiver policies and procedures.

589.16 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
589.17 meanings given them, unless the context clearly indicates otherwise.

589.18 (b) "Commissioner" means the commissioner of human services.

589.19 (c) "Component value" means underlying factors that are part of the cost of providing
589.20 services that are built into the waiver rates methodology to calculate service rates.

589.21 (d) "Customized living tool" means a methodology for setting service rates that
589.22 delineates and documents the amount of each component service included in a recipient's
589.23 customized living service plan.

589.24 (e) "Disability waiver rates system" means a statewide system that establishes rates
589.25 that are based on uniform processes and captures the individualized nature of waiver
589.26 services and recipient needs.

589.27 (f) "Lead agency" means a county, partnership of counties, or tribal agency charged
589.28 with administering waived services under sections 256B.092 and 256B.49.

589.29 (g) "Median" means the amount that divides distribution into two equal groups,
589.30 one-half above the median and one-half below the median.

589.31 (h) "Payment or rate" means reimbursement to an eligible provider for services
589.32 provided to a qualified individual based on an approved service authorization.

589.33 (i) "Rates management system" means a Web-based software application that uses
589.34 a framework and component values, as determined by the commissioner, to establish
589.35 service rates.

590.1 (j) "Recipient" means a person receiving home and community-based services
590.2 funded under any of the disability waivers.

590.3 Subd. 3. **Applicable services.** Applicable services are those authorized under
590.4 the state's home and community-based services waivers under sections 256B.092 and
590.5 256B.49, including the following, as defined in the federally approved home and
590.6 community-based services plan:

590.7 (1) 24 hour customized living;

590.8 (2) adult day care;

590.9 (3) adult day care bath;

590.10 (4) behavioral programming;

590.11 (5) companion services;

590.12 (6) customized living;

590.13 (7) day training and habilitation;

590.14 (8) housing access coordination;

590.15 (9) independent living skills;

590.16 (10) in-home family support;

590.17 (11) night supervision;

590.18 (12) personal support;

590.19 (13) prevocational services;

590.20 (14) residential care services;

590.21 (15) residential support services;

590.22 (16) respite services;

590.23 (17) structured day services;

590.24 (18) supported employment services;

590.25 (19) supported living services;

590.26 (20) transportation services; and

590.27 (21) other services as approved by the federal government in the state home and
590.28 community-based services plan.

590.29 Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home
590.30 and community-based waived services, including rate exceptions under subdivision 12,
590.31 are set by the rates management system.

590.32 (b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a
590.33 manner prescribed by the commissioner.

590.34 (c) Data and information in the rates management system may be used to calculate
590.35 an individual's rate.

591.1 (d) Service providers, with information from the community support plan and
 591.2 oversight by lead agencies, shall provide values and information needed to calculate an
 591.3 individual's rate into the rates management system. These values and information include:

591.4 (1) shared staffing hours;

591.5 (2) individual staffing hours;

591.6 (3) direct RN hours;

591.7 (4) direct LPN hours;

591.8 (5) staffing ratios;

591.9 (6) information to document variable levels of service qualification for variable
 591.10 levels of reimbursement in each framework;

591.11 (7) shared or individualized arrangements for unit-based services, including the
 591.12 staffing ratio;

591.13 (8) number of trips and miles for transportation services; and

591.14 (9) service hours provided through monitoring technology.

591.15 (e) Updates to individual data shall include:

591.16 (1) data for each individual that is updated annually when renewing service plans; and

591.17 (2) requests by individuals or lead agencies to update a rate whenever there is a
 591.18 change in an individual's service needs, with accompanying documentation.

591.19 (f) Lead agencies shall review and approve values to calculate the final payment rate
 591.20 for each individual. Lead agencies must notify the individual and the service provider
 591.21 of the final agreed-upon values and rate. If a value used was mistakenly or erroneously
 591.22 entered and used to calculate a rate, a provider may petition lead agencies to correct it.
 591.23 Lead agencies must respond to these requests.

591.24 Subd. 5. **Base wage index and standard component values.** (a) The base wage
 591.25 index is established to determine staffing costs associated with providing services to
 591.26 individuals receiving home and community-based services. For purposes of developing
 591.27 and calculating the proposed base wage, Minnesota-specific wages taken from job
 591.28 descriptions and standard occupational classification (SOC) codes from the Bureau of
 591.29 Labor Statistics as defined in the most recent edition of the Occupational Handbook shall
 591.30 be used. The base wage index shall be calculated as follows:

591.31 (1) for residential direct care staff, the sum of:

591.32 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and
 591.33 home health aide (SOC code 39-9021); 30 percent of the median wage for nursing aide
 591.34 (SOC code 31-1012); and 20 percent of the median wage for social and human services
 591.35 aide (SOC code 21-1093); and

592.1 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
592.2 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
592.3 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
592.4 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
592.5 percent of the median wage for social and human services aide (SOC code 21-1093);
592.6 (2) for day services, 20 percent of the median wage for nursing aide (SOC code
592.7 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
592.8 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);
592.9 (3) for residential asleep-overnight staff, the wage will be \$7.66 per hour, except in
592.10 a family foster care setting, the wage is \$2.80 per hour;
592.11 (4) for behavior program analyst staff, 100 percent of the median wage for mental
592.12 health counselors (SOC code 21-1014);
592.13 (5) for behavior program professional staff, 100 percent of the median wage for
592.14 clinical counseling and school psychologist (SOC code 19-3031);
592.15 (6) for behavior program specialist staff, 100 percent of the median wage for
592.16 psychiatric technicians (SOC code 29-2053);
592.17 (7) for supportive living services staff, 20 percent of the median wage for nursing
592.18 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
592.19 code 29-2053); and 60 percent of the median wage for social and human services aide
592.20 (SOC code 21-1093);
592.21 (8) for housing access coordination staff, 50 percent of the median wage for
592.22 community and social services specialist (SOC code 21-1099); and 50 percent of the
592.23 median wage for social and human services aide (SOC code 21-1093);
592.24 (9) for in-home family support staff, 20 percent of the median wage for nursing
592.25 aide (SOC code 31-1012); 30 percent of the median wage for community social service
592.26 specialist (SOC code 21-1099); 40 percent of the median wage for social and human
592.27 services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
592.28 technician (SOC code 29-2053);
592.29 (10) for independent living skills staff, 40 percent of the median wage for community
592.30 social service specialist (SOC code 21-1099); 50 percent of the median wage for social
592.31 and human services aide (SOC code 21-1093); and ten percent of the median wage for
592.32 psychiatric technician (SOC code 29-2053);
592.33 (11) for supported employment staff, 20 percent of the median wage for nursing aide
592.34 (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
592.35 code 29-2053); and 60 percent of the median wage for social and human services aide
592.36 (SOC code 21-1093);

593.1 (12) for adult companion staff, 50 percent of the median wage for personal and home
593.2 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
593.3 orderlies, and attendants (SOC code 31-1012);

593.4 (13) for night supervision staff, 20 percent of the median wage for home health aide
593.5 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
593.6 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
593.7 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
593.8 percent of the median wage for social and human services aide (SOC code 21-1093);

593.9 (14) for respite staff, 50 percent of the median wage for personal and home care aide
593.10 (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and
593.11 attendants (SOC code 31-1012);

593.12 (15) for personal support staff, 50 percent of the median wage for personal and home
593.13 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
593.14 orderlies, and attendants (SOC code 31-1012);

593.15 (16) for supervisory staff, the basic wage is \$17.43 per hour with exception of the
593.16 supervisor of behavior analyst and behavior specialists, which shall be \$30.75 per hour;

593.17 (17) for RN, the basic wage is \$30.82 per hour; and

593.18 (18) for LPN, the basic wage is \$18.64 per hour.

593.19 (b) Component values for residential support services are:

593.20 (1) supervisory span of control ratio: 11 percent;

593.21 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

593.22 (3) employee-related cost ratio: 23.6 percent;

593.23 (4) general administrative support ratio: 13.25 percent;

593.24 (5) program-related expense ratio: 1.3 percent; and

593.25 (6) absence and utilization factor ratio: 3.9 percent.

593.26 (c) Component values for family foster care are:

593.27 (1) supervisory span of control ratio: 11 percent;

593.28 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

593.29 (3) employee-related cost ratio: 23.6 percent;

593.30 (4) general administrative support ratio: 3.3 percent;

593.31 (5) program-related expense ratio: 1.3 percent; and

593.32 (6) absence factor: 1.7 percent.

593.33 (d) Component values for day services for all services are:

593.34 (1) supervisory span of control ratio: 11 percent;

593.35 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

593.36 (3) employee-related cost ratio: 23.6 percent;

- 594.1 (4) program plan support ratio: 5.6 percent;
- 594.2 (5) client programming and support ratio: ten percent;
- 594.3 (6) general administrative support ratio: 13.25 percent;
- 594.4 (7) program-related expense ratio: 1.8 percent; and
- 594.5 (8) absence and utilization factor ratio: 3.9 percent.
- 594.6 (e) Component values for unit-based services with programming are:
- 594.7 (1) supervisory span of control ratio: 11 percent;
- 594.8 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 594.9 (3) employee-related cost ratio: 23.6 percent;
- 594.10 (4) program plan supports ratio: 3.1 percent;
- 594.11 (5) client programming and supports ratio: 8.6 percent;
- 594.12 (6) general administrative support ratio: 13.25 percent;
- 594.13 (7) program-related expense ratio: 6.1 percent; and
- 594.14 (8) absence and utilization factor ratio: 3.9 percent.
- 594.15 (f) Component values for unit-based services without programming except respite
- 594.16 are:
- 594.17 (1) supervisory span of control ratio: 11 percent;
- 594.18 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 594.19 (3) employee-related cost ratio: 23.6 percent;
- 594.20 (4) program plan support ratio: 3.1 percent;
- 594.21 (5) client programming and support ratio: 8.6 percent;
- 594.22 (6) general administrative support ratio: 13.25 percent;
- 594.23 (7) program-related expense ratio: 6.1 percent; and
- 594.24 (8) absence and utilization factor ratio: 3.9 percent.
- 594.25 (g) Component values for unit-based services without programming for respite are:
- 594.26 (1) supervisory span of control ratio: 11 percent;
- 594.27 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 594.28 (3) employee-related cost ratio: 23.6 percent;
- 594.29 (4) general administrative support ratio: 13.25 percent;
- 594.30 (5) program-related expense ratio: 6.1 percent; and
- 594.31 (6) absence and utilization factor ratio: 3.9 percent.
- 594.32 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
- 594.33 (b) based on the wage data by standard occupational code (SOC) from the Bureau of
- 594.34 Labor Statistics available on December 31, 2016. The commissioner shall publish these
- 594.35 updated values and load them into the rate management system. This adjustment occurs

595.1 every five years. For adjustments in 2021 and beyond, the commissioner shall use the data
595.2 available on December 31 of the calendar year five years prior.

595.3 (i) On July 1, 2017, the commissioner shall update the framework components in
595.4 paragraph (c) for changes in the Consumer Price Index. The commissioner will adjust
595.5 these values higher or lower by the percentage change in the Consumer Price Index-All
595.6 Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The
595.7 commissioner shall publish these updated values and load them into the rate management
595.8 system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the
595.9 commissioner shall use the data available on January 1 of the calendar year four years
595.10 prior and January 1 of the current calendar year.

595.11 Subd. 6. **Payments for residential support services.** (a) Payments for residential
595.12 support services, as defined in sections 256B.092, subdivision 11, and 256B.49,
595.13 subdivision 22, must be calculated as follows:

595.14 (1) determine the number of shared and individual direct staff hours to meet a
595.15 recipient's needs provided on-site or through monitoring technology;

595.16 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
595.17 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
595.18 5. This is defined as the direct-care rate;

595.19 (3) for a recipient requiring customization for deaf and hard-of-hearing language
595.20 accessibility under subdivision 12, add the customization rate provided in subdivision 12
595.21 to the result of clause (2). This is defined as the customized direct-care rate;

595.22 (4) multiply the number of shared and individual direct staff hours provided on-site
595.23 or through monitoring technology and direct nursing hours by the appropriate staff wages
595.24 in subdivision 5, paragraph (a), or the customized direct-care rate;

595.25 (5) multiply the number of shared and individual direct staff hours provided
595.26 on-site or through monitoring technology and direct nursing hours by the product of
595.27 the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the
595.28 appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

595.29 (6) combine the results of clauses (4) and (5), excluding any shared and individual
595.30 direct staff hours provided through monitoring technology, and multiply the result by one
595.31 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
595.32 (b), clause (2). This is defined as the direct staffing cost;

595.33 (7) for employee-related expenses, multiply the direct staffing cost, excluding any
595.34 shared and individual direct staff hours provided through monitoring technology, by one
595.35 plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

595.36 (8) for client programming and supports, the commissioner shall add \$2,179; and

596.1 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
596.2 customized for adapted transport, per year.

596.3 (b) The total rate shall be calculated using the following steps:

596.4 (1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any
596.5 shared and individual direct staff hours provided through monitoring technology that
596.6 was excluded in clause (7);

596.7 (2) sum the standard general and administrative rate, the program-related expense
596.8 ratio, and the absence and utilization ratio;

596.9 (3) divide the result of clause (1) by one minus the result of clause (2). This is
596.10 the total payment amount; and

596.11 (4) adjust the result of clause (3) by a factor to be determined by the commissioner
596.12 to adjust for regional differences in the cost of providing services.

596.13 (c) The payment methodology for customized living, 24-hour customized living, and
596.14 residential care services shall be the customized living tool. Revisions to the customized
596.15 living tool shall be made to reflect the services and activities unique to disability-related
596.16 recipient needs.

596.17 (d) The commissioner shall establish a Monitoring Technology Review Panel to
596.18 annually review and approve the plans, safeguards, and rates that include residential
596.19 direct care provided remotely through monitoring technology. Lead agencies shall submit
596.20 individual service plans that include supervision using monitoring technology to the
596.21 Monitoring Technology Review Panel for approval. Individual service plans that include
596.22 supervision using monitoring technology as of December 31, 2013, shall be submitted to
596.23 the Monitoring Technology Review Panel, but the plans are not subject to approval.

596.24 Subd. 7. **Payments for day programs.** Payments for services with day programs
596.25 including adult day care, day treatment and habilitation, prevocational services, and
596.26 structured day services must be calculated as follows:

596.27 (1) determine the number of units of service to meet a recipient's needs;

596.28 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
596.29 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

596.30 (3) for a recipient requiring customization for deaf and hard-of-hearing language
596.31 accessibility under subdivision 12, add the customization rate provided in subdivision 12
596.32 to the result of clause (2). This is defined as the customized direct-care rate;

596.33 (4) multiply the number of day program direct staff hours and direct nursing hours
596.34 by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care
596.35 rate;

597.1 (5) multiply the number of day direct staff hours by the product of the supervision
597.2 span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate
597.3 supervision wage in subdivision 5, paragraph (a), clause (16);

597.4 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
597.5 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d),
597.6 clause (2). This is defined as the direct staffing rate;

597.7 (7) for program plan support, multiply the result of clause (6) by one plus the
597.8 program plan support ratio in subdivision 5, paragraph (d), clause (4);

597.9 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
597.10 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

597.11 (9) for client programming and supports, multiply the result of clause (8) by one plus
597.12 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

597.13 (10) for program facility costs, add \$19.30 per week with consideration of staffing
597.14 ratios to meet individual needs;

597.15 (11) for adult day bath services, add \$7.01 per 15 minute unit;

597.16 (12) this is the subtotal rate;

597.17 (13) sum the standard general and administrative rate, the program-related expense
597.18 ratio, and the absence and utilization factor ratio;

597.19 (14) divide the result of clause (12) by one minus the result of clause (13). This is
597.20 the total payment amount;

597.21 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
597.22 to adjust for regional differences in the cost of providing services;

597.23 (16) for transportation provided as part of day training and habilitation for an
597.24 individual who does not require a lift, add:

597.25 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle
597.26 without a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared
597.27 ride in a vehicle with a lift;

597.28 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle
597.29 without a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared
597.30 ride in a vehicle with a lift;

597.31 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle
597.32 without a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared
597.33 ride in a vehicle with a lift; or

597.34 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a
597.35 lift, \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a
597.36 vehicle with a lift;

598.1 (17) for transportation provide as part of day training and habilitation for an
598.2 individual who does require a lift, add:

598.3 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with
598.4 a lift, and \$15.05 for a shared ride in a vehicle with a lift;

598.5 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
598.6 lift, and \$28.16 for a shared ride in a vehicle with a lift;

598.7 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with
598.8 a lift, and \$58.76 for a shared ride in a vehicle with a lift; or

598.9 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a
598.10 lift, and \$80.93 for a shared ride in a vehicle with a lift.

598.11 Subd. 8. **Payments for unit-based services with programming.** Payments for
598.12 unit-based with program services, including behavior programming, housing access
598.13 coordination, in-home family support, independent living skills training, hourly supported
598.14 living services, and supported employment provided to an individual outside of any day or
598.15 residential service plan must be calculated as follows, unless the services are authorized
598.16 separately under subdivision 6 or 7:

598.17 (1) determine the number of units of service to meet a recipient's needs;

598.18 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
598.19 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

598.20 (3) for a recipient requiring customization for deaf and hard-of-hearing language
598.21 accessibility under subdivision 12, add the customization rate provided in subdivision 12
598.22 to the result of clause (2). This is defined as the customized direct-care rate;

598.23 (4) multiply the number of direct staff hours by the appropriate staff wage in
598.24 subdivision 5, paragraph (a), or the customized direct care rate;

598.25 (5) multiply the number of direct staff hours by the product of the supervision span
598.26 of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
598.27 wage in subdivision 5, paragraph (a), clause (16);

598.28 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
598.29 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e),
598.30 clause (2). This is defined as the direct staffing rate;

598.31 (7) for program plan support, multiply the result of clause (6) by one plus the
598.32 program plan supports ratio in subdivision 5, paragraph (e), clause (4);

598.33 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
598.34 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

598.35 (9) for client programming and supports, multiply the result of clause (8) by one plus
598.36 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

599.1 (10) this is the subtotal rate;

599.2 (11) sum the standard general and administrative rate, the program-related expense
599.3 ratio, and the absence and utilization factor ratio;

599.4 (12) divide the result of clause (10) by one minus the result of clause (11). This is
599.5 the total payment amount;

599.6 (13) for supported employment provided in a shared manner, divide the total
599.7 payment amount in clause (12) by the number of service recipients, not to exceed three.

599.8 For independent living skills training provided in a shared manner, divide the total
599.9 payment amount in clause (12) by the number of service recipients, not to exceed two; and

599.10 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
599.11 to adjust for regional differences in the cost of providing services.

599.12 Subd. 9. **Payments for unit-based services without programming.** Payments
599.13 for unit-based without program services, including night supervision, personal support,
599.14 respite, and companion care provided to an individual outside of any day or residential
599.15 service plan must be calculated as follows unless the services are authorized separately
599.16 under subdivision 6 or 7:

599.17 (1) for all services except respite, determine the number of units of service to meet
599.18 a recipient's needs;

599.19 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
599.20 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

599.21 (3) for a recipient requiring customization for deaf and hard-of-hearing language
599.22 accessibility under subdivision 12, add the customization rate provided in subdivision 12
599.23 to the result of clause (2). This is defined as the customized direct care rate;

599.24 (4) multiply the number of direct staff hours by the appropriate staff wage in
599.25 subdivision 5 or the customized direct care rate;

599.26 (5) multiply the number of direct staff hours by the product of the supervision span
599.27 of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
599.28 wage in subdivision 5, paragraph (a), clause (16);

599.29 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
599.30 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f),
599.31 clause (2). This is defined as the direct staffing rate;

599.32 (7) for program plan support, multiply the result of clause (6) by one plus the
599.33 program plan support ratio in subdivision 5, paragraph (f), clause (4);

599.34 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
599.35 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

600.1 (9) for client programming and supports, multiply the result of clause (8) by one plus
600.2 the client programming and support ratio in subdivision 5, paragraph (f), clause (5);
600.3 (10) this is the subtotal rate;
600.4 (11) sum the standard general and administrative rate, the program-related expense
600.5 ratio, and the absence and utilization factor ratio;
600.6 (12) divide the result of clause (10) by one minus the result of clause (11). This is
600.7 the total payment amount;
600.8 (13) for respite services, determine the number of daily units of service to meet an
600.9 individual's needs;
600.10 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
600.11 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
600.12 (15) for a recipient requiring deaf and hard-of-hearing customization under
600.13 subdivision 12, add the customization rate provided in subdivision 12 to the result of
600.14 clause (14). This is defined as the customized direct care rate;
600.15 (16) multiply the number of direct staff hours by the appropriate staff wage in
600.16 subdivision 5, paragraph (a);
600.17 (17) multiply the number of direct staff hours by the product of the supervisory span
600.18 of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
600.19 wage in subdivision 5, paragraph (a), clause (16);
600.20 (18) combine the results of clauses (16) and (17), and multiply the result by one plus
600.21 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g),
600.22 clause (2). This is defined as the direct staffing rate;
600.23 (19) for employee-related expenses, multiply the result of clause (18) by one plus
600.24 the employee-related cost ratio in subdivision 5, paragraph (g), clause (3).
600.25 (20) this is the subtotal rate;
600.26 (21) sum the standard general and administrative rate, the program-related expense
600.27 ratio, and the absence and utilization factor ratio;
600.28 (22) divide the result of clause (20) by one minus the result of clause (21). This is
600.29 the total payment amount; and
600.30 (23) adjust the result of clauses (12) and (22) by a factor to be determined by the
600.31 commissioner to adjust for regional differences in the cost of providing services.
600.32 **Subd. 10. Updating payment values and additional information.** (a) From
600.33 January 1, 2014, through December 31, 2017, the commissioner shall develop and
600.34 implement uniform procedures to refine terms and adjust values used to calculate payment
600.35 rates in this section.

601.1 (b) The commissioner shall, within available resources, conduct research and
601.2 gather data and information from existing state systems or other outside sources on the
601.3 following items:

601.4 (1) differences in the underlying cost to provide services and care across the state; and

601.5 (2) mileage and utilization of transportation for all day and unit-based services.

601.6 (c) Using a statistically valid set of rates management system data, the commissioner,
601.7 in consultation with stakeholders, shall analyze for each service the average difference in
601.8 the rate on December 31, 2013, and the framework rate at the individual, provider, lead
601.9 agency, and state levels.

601.10 (d) The commissioner, in consultation with stakeholders, shall review and evaluate
601.11 the following values already in subdivisions 6 to 9, or issues that impact all services,
601.12 including, but not limited to:

601.13 (1) values for transportation rates for day services;

601.14 (2) values for transportation rates in residential services;

601.15 (3) values for services where monitoring technology replaces staff time;

601.16 (4) values for indirect services;

601.17 (5) values for nursing;

601.18 (6) component values for independent living skills;

601.19 (7) component values for family foster care that reflect licensing requirements;

601.20 (8) adjustments to other components to replace the budget neutrality factor;

601.21 (9) remote monitoring technology for nonresidential services;

601.22 (10) values for basic and intensive services in residential services;

601.23 (11) values for the facility use rate in day services;

601.24 (12) values for workers compensation as part of employee-related expenses;

601.25 (13) values for unemployment insurance as part of employee-related expenses;

601.26 (14) a component value to reflect costs for individuals with rates previously adjusted
601.27 for the inclusion of group residential housing rate 3 costs, only for any individual enrolled
601.28 as of December 31, 2013; and

601.29 (15) any changes in state or federal law with an impact on the underlying cost of
601.30 providing home and community-based services.

601.31 (e) The commissioner shall report to the chairs and the ranking minority members of
601.32 the legislative committees and divisions with jurisdiction over health and human services
601.33 policy and finance with the information and data gathered under paragraphs (b) to (d)
601.34 on the following dates:

601.35 (1) January 15, 2015, with preliminary results and data;

602.1 (2) January 15, 2016, with a status implementation update, and additional data
602.2 and summary information;

602.3 (3) January 15, 2017, with the full report; and

602.4 (4) January 15, 2019, with another full report, and a full report once every four
602.5 years thereafter.

602.6 (f) Based on the commissioner's evaluation of the information and data collected in
602.7 paragraphs (b) to (d), the commissioner may make recommendations to the legislature
602.8 to address any potential issues.

602.9 (g) The commissioner shall implement a regional adjustment factor to all rate
602.10 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to
602.11 implementation, the commissioner shall consult with stakeholders on the methodology to
602.12 calculate the adjustment.

602.13 (h) The commissioner shall provide a public notice via LISTSERV in October of
602.14 each year beginning October 1, 2014, containing information detailing legislatively
602.15 approved changes in:

602.16 (1) calculation values including derived wage rates and related employee and
602.17 administrative factors;

602.18 (2) service utilization;

602.19 (3) county and tribal allocation changes; and

602.20 (4) information on adjustments made to calculation values and the timing of those
602.21 adjustments.

602.22 The information in this notice shall be effective January 1 of the following year.

602.23 Subd. 11. **Payment implementation.** Upon implementation of the payment
602.24 methodologies under this section, those payment rates supersede rates established in county
602.25 contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

602.26 Subd. 12. **Customization of rates for individuals.** (a) For persons determined to
602.27 have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be
602.28 increased by an adjustment factor prior to calculating the rate under subdivisions 6, 7, 8,
602.29 and 9. The customization rate with respect to deaf or hard-of-hearing persons shall be
602.30 \$2.50 per hour for waiver recipients who meet the respective criteria as determined by
602.31 the commissioner.

602.32 (b) For the purposes of this section, "deaf and hard-of-hearing" means:

602.33 (1) the person has a developmental disability and an assessment score which
602.34 indicates a hearing impairment that is severe or that the person has no useful hearing;

602.35 (2) the person has a developmental disability and an expressive communications
602.36 score that indicates the person uses single signs or gestures, uses an augmentative

603.1 communication aid, or does not have functional communication, or the person's expressive
603.2 communications is unknown; and

603.3 (3) the person has a developmental disability and a communication score which
603.4 indicates the person comprehends signs, gestures and modeling prompts or does not
603.5 comprehend verbal, visual or gestural communication or that the person's receptive
603.6 communication score is unknown; or

603.7 (4) the person receives long-term care services and has an assessment score that
603.8 indicates they hear only very loud sounds, have no useful hearing, or a determination
603.9 cannot be made; and the person receives long-term care services and has an assessment
603.10 that indicates the person communicates needs with sign language, symbol board, written
603.11 messages, gestures or an interpreter; communicates with inappropriate content, makes
603.12 garbled sounds or displays echolalia, or does not communicate needs.

603.13 Subd. 13. **Transportation.** The commissioner shall require that the purchase
603.14 of transportation services be cost-effective and be limited to market rates where the
603.15 transportation mode is generally available and accessible.

603.16 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead
603.17 agencies must identify individuals with exceptional needs that cannot be met under the
603.18 disability waiver rate system. The commissioner shall use that information to evaluate
603.19 and, if necessary, approve an alternative payment rate for those individuals.

603.20 (b) Lead agencies must submit exception requests to the state.

603.21 (c) An application for a rate exception may be submitted for the following criteria:

603.22 (1) an individual has service needs that cannot be met through additional units
603.23 of service; or

603.24 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results in an
603.25 individual being discharged.

603.26 (d) Exception requests must include the following information:

603.27 (1) the service needs required by each individual that are not accounted for in
603.28 subdivisions 6, 7, 8, and 9;

603.29 (2) the service rate requested and the difference from the rate determined in
603.30 subdivisions 6, 7, 8, and 9;

603.31 (3) a basis for the underlying costs used for the rate exception and any accompanying
603.32 documentation;

603.33 (4) the duration of the rate exception; and

603.34 (5) any contingencies for approval.

603.35 (e) Approved rate exceptions shall be managed within lead agency allocations under
603.36 sections 256B.092 and 256B.49.

604.1 (f) Individual disability waiver recipients may request that a lead agency submit an
604.2 exception request. A lead agency that denies such a request shall notify the individual
604.3 waiver recipient of its decision and the reasons for denying the request in writing no later
604.4 than 30 days after the individual's request has been made.

604.5 (g) The commissioner shall determine whether to approve or deny an exception
604.6 request no more than 30 days after receiving the request. If the commissioner denies the
604.7 request, the commissioner shall notify the lead agency and the individual disability waiver
604.8 recipient in writing of the reasons for the denial.

604.9 (h) The individual disability waiver recipient may appeal any denial of an exception
604.10 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
604.11 256.0451. When the denial of an exception request results in the proposed demission of a
604.12 waiver recipient from a residential or day habilitation program, the commissioner shall
604.13 issue a temporary stay of demission, when requested by the disability waiver recipient,
604.14 consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c).
604.15 The temporary stay shall remain in effect until the lead agency can provide an informed
604.16 choice of appropriate, alternative services to the disability waiver.

604.17 (i) Providers may petition lead agencies to update values that were entered
604.18 incorrectly or erroneously into the rate management system, based on past service level
604.19 discussions and determination in subdivision 4, without applying for a rate exception.

604.20 Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability
604.21 waiver rates management system on January 1, 2014, the commissioner shall establish
604.22 a method of tracking and reporting the fiscal impact of the disability waiver rates
604.23 management system on individual lead agencies.

604.24 (b) Beginning January 1, 2014, the commissioner shall make annual adjustments to
604.25 lead agencies' home and community-based waived service budget allocations to adjust
604.26 for rate differences and the resulting impact on county allocations upon implementation of
604.27 the disability waiver rates system.

604.28 Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the
604.29 following adjustments to the rate generated by the framework to assure budget neutrality
604.30 until the rate information is available to implement paragraph (b). The rate generated by
604.31 the framework shall be multiplied by the appropriate factor, as designated below:

604.32 (1) for residential services: 1.003;

604.33 (2) for day services: 1.000;

604.34 (3) for unit-based services with programming: 0.941; and

604.35 (4) for unit-based services without programming: 0.796.

605.1 (b) Within 12 months of January 1, 2014, the commissioner shall compare estimated
605.2 spending for all home and community-based waiver services under the new payment rates
605.3 defined in subdivisions 6 to 9 with estimated spending for the same recipients and services
605.4 under the rates in effect on July 1, 2013. This comparison must distinguish spending under
605.5 each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients
605.6 and services for one or more service months after the new rates have gone into effect.
605.7 The commissioner shall consult with the commissioner of management and budget on
605.8 this analysis to ensure budget neutrality. If estimated spending under the new rates for
605.9 services under one or more subdivisions differs in this comparison by 0.3 percent or
605.10 more, the commissioner shall assure aggregate budget neutrality across all service areas
605.11 by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total
605.12 estimated spending for each subdivision under the new rates matches estimated spending
605.13 under the rates in effect on July 1, 2013.

605.14 Sec. 13. **FEDERAL APPROVAL.**

605.15 During the transition to a new disability waivers payment methodology system, the
605.16 commissioner of human services has the authority to manage the disability home and
605.17 community-based service waiver programs within federally required parameters. The
605.18 commissioner may negotiate an agreement with the Centers for Medicare and Medicaid
605.19 Services for the implementation of the disability waivers payment methodology system
605.20 in order to prevent federal action that would withhold or disallow federal funding for
605.21 current waiver recipients, or new waiver recipients as authorized by the legislature. The
605.22 commissioner must provide for public notice and comment, as required by state and
605.23 federal law, to changes related to federal approval of the disability waivers payment
605.24 methodology system. If the Centers for Medicare and Medicaid Services requires
605.25 changes to the disability waivers payment rate methodology implementation plan, the
605.26 commissioner shall implement the changes in accordance with Minnesota Statutes, section
605.27 256B.4914, subdivision 16, and upon:

605.28 (1) public notice;

605.29 (2) federal approval;

605.30 (3) Legislative Advisory Commission review and recommendation, in a manner
605.31 described under Minnesota Statutes, section 3.3005, subdivision 4; and

605.32 (4) recommendation of necessary legislation to the chairs and ranking minority
605.33 members of the legislative committees with jurisdiction over health and human services
605.34 policy and finance by January 15, 2014. The changed implementation plan must provide
605.35 for a transition from the historical to the new rate setting methodology.

606.1 Sec. 14. **REPEALER.**

606.2 (a) Minnesota Statutes 2012, sections 252.40; 252.46, subdivisions 1, 2, 3, 4, 5, 6,
 606.3 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, and 21; 256B.4913, subdivisions 1, 2, 3, and 4; and
 606.4 256B.501, subdivision 8, are repealed effective January 1, 2014.

606.5 (b) Minnesota Rules, part 9525.1860, subparts 3, items B and C and 4, item D, are
 606.6 repealed effective January 1, 2014.

606.7 **ARTICLE 14**

606.8 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

606.9 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

606.10 The sums shown in the columns marked "Appropriations" are appropriated to the
 606.11 agencies and for the purposes specified in this article. The appropriations are from the
 606.12 general fund, or another named fund, and are available for the fiscal years indicated
 606.13 for each purpose. The figures "2014" and "2015" used in this article mean that the
 606.14 appropriations listed under them are available for the fiscal year ending June 30, 2014, or
 606.15 June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal
 606.16 year 2015. "The biennium" is fiscal years 2014 and 2015.

606.17 **APPROPRIATIONS**
 606.18 **Available for the Year**
 606.19 **Ending June 30**
 606.20 **2014 2015**

606.21 Sec. 2. **COMMISSIONER OF HUMAN**
 606.22 **SERVICES**

606.23 **Subdivision 1. Total Appropriation** \$ **6,438,485,000** \$ **6,457,117,000**

606.24	<u>Appropriations by Fund</u>		
606.25		<u>2014</u>	<u>2015</u>
606.26	<u>General</u>	<u>5,654,765,000</u>	<u>5,677,458,000</u>
606.27	<u>State Government</u>		
606.28	<u>Special Revenue</u>	<u>4,099,000</u>	<u>4,510,000</u>
606.29	<u>Health Care Access</u>	<u>519,816,000</u>	<u>518,446,000</u>
606.30	<u>Federal TANF</u>	<u>257,915,000</u>	<u>254,813,000</u>
606.31	<u>Lottery Prize Fund</u>	<u>1,890,000</u>	<u>1,890,000</u>

606.32 **Receipts for Systems Projects.**

606.33 Appropriations and federal receipts for

606.34 information systems projects for MAXIS,

606.35 PRISM, MMIS, and SSIS must be deposited

606.36 in the state system account authorized

607.1 in Minnesota Statutes, section 256.014.
607.2 Money appropriated for computer projects
607.3 approved by the commissioner of Minnesota
607.4 information technology services, funded
607.5 by the legislature, and approved by the
607.6 commissioner of management and budget,
607.7 may be transferred from one project to
607.8 another and from development to operations
607.9 as the commissioner of human services
607.10 considers necessary. Any unexpended
607.11 balance in the appropriation for these
607.12 projects does not cancel but is available for
607.13 ongoing development and operations.

607.14 **Nonfederal Share Transfers.** The
607.15 nonfederal share of activities for which
607.16 federal administrative reimbursement is
607.17 appropriated to the commissioner may be
607.18 transferred to the special revenue fund.

607.19 **ARRA Supplemental Nutrition Assistance**
607.20 **Benefit Increases.** The funds provided for
607.21 food support benefit increases under the
607.22 Supplemental Nutrition Assistance Program
607.23 provisions of the American Recovery and
607.24 Reinvestment Act (ARRA) of 2009 must be
607.25 used for benefit increases beginning July 1,
607.26 2009.

607.27 **Supplemental Nutrition Assistance**
607.28 **Program Employment and Training.**
607.29 (1) Notwithstanding Minnesota Statutes,
607.30 sections 256D.051, subdivisions 1a, 6b,
607.31 and 6c, and 256J.626, federal Supplemental
607.32 Nutrition Assistance employment and
607.33 training funds received as reimbursement of
607.34 MFIP consolidated fund grant expenditures
607.35 for diversionary work program participants

608.1 and child care assistance program
608.2 expenditures must be deposited in the general
608.3 fund. The amount of funds must be limited to
608.4 \$4,900,000 per year in fiscal years 2014 and
608.5 2015, and to \$4,400,000 per year in fiscal
608.6 years 2016 and 2017, contingent on approval
608.7 by the federal Food and Nutrition Service.

608.8 (2) Consistent with the receipt of the federal
608.9 funds, the commissioner may adjust the
608.10 level of working family credit expenditures
608.11 claimed as TANF maintenance of effort.
608.12 Notwithstanding any contrary provision in
608.13 this article, this rider expires June 30, 2017.

608.14 **TANF Maintenance of Effort.** (a) In order
608.15 to meet the basic maintenance of effort
608.16 (MOE) requirements of the TANF block grant
608.17 specified under Code of Federal Regulations,
608.18 title 45, section 263.1, the commissioner may
608.19 only report nonfederal money expended for
608.20 allowable activities listed in the following
608.21 clauses as TANF/MOE expenditures:

608.22 (1) MFIP cash, diversionary work program,
608.23 and food assistance benefits under Minnesota
608.24 Statutes, chapter 256J;

608.25 (2) the child care assistance programs
608.26 under Minnesota Statutes, sections 119B.03
608.27 and 119B.05, and county child care
608.28 administrative costs under Minnesota
608.29 Statutes, section 119B.15;

608.30 (3) state and county MFIP administrative
608.31 costs under Minnesota Statutes, chapters
608.32 256J and 256K;

608.33 (4) state, county, and tribal MFIP
608.34 employment services under Minnesota
608.35 Statutes, chapters 256J and 256K;

609.1 (5) expenditures made on behalf of legal
609.2 noncitizen MFIP recipients who qualify for
609.3 the MinnesotaCare program under Minnesota
609.4 Statutes, chapter 256L;

609.5 (6) qualifying working family credit
609.6 expenditures under Minnesota Statutes,
609.7 section 290.0671;

609.8 (7) qualifying Minnesota education credit
609.9 expenditures under Minnesota Statutes,
609.10 section 290.0674; and

609.11 (8) qualifying Head Start expenditures under
609.12 Minnesota Statutes, section 119A.50.

609.13 (b) The commissioner shall ensure that
609.14 sufficient qualified nonfederal expenditures
609.15 are made each year to meet the state's
609.16 TANF/MOE requirements. For the activities
609.17 listed in paragraph (a), clauses (2) to
609.18 (8), the commissioner may only report
609.19 expenditures that are excluded from the
609.20 definition of assistance under Code of
609.21 Federal Regulations, title 45, section 260.31.

609.22 (c) For fiscal years beginning with state fiscal
609.23 year 2003, the commissioner shall ensure
609.24 that the maintenance of effort used by the
609.25 commissioner of management and budget
609.26 for the February and November forecasts
609.27 required under Minnesota Statutes, section
609.28 16A.103, contains expenditures under
609.29 paragraph (a), clause (1), equal to at least 16
609.30 percent of the total required under Code of
609.31 Federal Regulations, title 45, section 263.1.

609.32 (d) The requirement in Minnesota Statutes,
609.33 section 256.011, subdivision 3, that federal
609.34 grants or aids secured or obtained under that
609.35 subdivision be used to reduce any direct

610.1 appropriations provided by law, do not apply
610.2 if the grants or aids are federal TANF funds.

610.3 (e) For the federal fiscal years beginning on
610.4 or after October 1, 2007, the commissioner
610.5 may not claim an amount of TANF/MOE in
610.6 excess of the 75 percent standard in Code
610.7 of Federal Regulations, title 45, section
610.8 263.1(a)(2), except:

610.9 (1) to the extent necessary to meet the 80
610.10 percent standard under Code of Federal
610.11 Regulations, title 45, section 263.1(a)(1),
610.12 if it is determined by the commissioner
610.13 that the state will not meet the TANF work
610.14 participation target rate for the current year;

610.15 (2) to provide any additional amounts
610.16 under Code of Federal Regulations, title 45,
610.17 section 264.5, that relate to replacement of
610.18 TANF funds due to the operation of TANF
610.19 penalties; and

610.20 (3) to provide any additional amounts that
610.21 may contribute to avoiding or reducing
610.22 TANF work participation penalties through
610.23 the operation of the excess MOE provisions
610.24 of Code of Federal Regulations, title 45,
610.25 section 261.43(a)(2).

610.26 For the purposes of clauses (1) to (3),
610.27 the commissioner may supplement the
610.28 MOE claim with working family credit
610.29 expenditures or other qualified expenditures
610.30 to the extent such expenditures are otherwise
610.31 available after considering the expenditures
610.32 allowed in this subdivision and subdivisions
610.33 2 and 3.

611.1 (f) Notwithstanding any contrary provision
611.2 in this article, paragraphs (a) to (e) expire
611.3 June 30, 2017.

611.4 **Working Family Credit Expenditures**
611.5 **as TANF/MOE.** The commissioner may
611.6 claim as TANF maintenance of effort up to
611.7 \$6,707,000 per year of working family credit
611.8 expenditures in each fiscal year.

611.9 **Subd. 2. Working Family Credit to be Claimed**
611.10 **for TANF/MOE**

611.11 The commissioner may count the following
611.12 amounts of working family credit
611.13 expenditures as TANF/MOE:

611.14 (1) fiscal year 2014, \$50,272,000;

611.15 (2) fiscal year 2015, \$34,894,000;

611.16 (3) fiscal year 2016, \$0; and

611.17 (4) fiscal year 2017, \$1,283,000.

611.18 **Subd. 3. TANF Transfer to Federal Child Care**
611.19 **and Development Fund**

611.20 (a) The following TANF fund amounts
611.21 are appropriated to the commissioner for
611.22 purposes of MFIP/transition year child care
611.23 assistance under Minnesota Statutes, section
611.24 119B.05:

611.25 (1) fiscal year 2014; \$14,020,000; and

611.26 (2) fiscal year 2015, \$14,020,000.

611.27 (b) The commissioner shall authorize the
611.28 transfer of sufficient TANF funds to the
611.29 federal child care and development fund to
611.30 meet this appropriation and shall ensure that
611.31 all transferred funds are expended according
611.32 to federal child care and development fund
611.33 regulations.

611.34 **Subd. 4. Central Office**

612.1 The amounts that may be spent from this
 612.2 appropriation for each purpose are as follows:

612.3 **(a) Operations**

612.4	<u>Appropriations by Fund</u>		
612.5	<u>General</u>	<u>101,979,000</u>	<u>96,858,000</u>
612.6	<u>State Government</u>		
612.7	<u>Special Revenue</u>	<u>3,974,000</u>	<u>4,385,000</u>
612.8	<u>Health Care Access</u>	<u>13,177,000</u>	<u>13,004,000</u>
612.9	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

612.10 **DHS Receipt Center Accounting.** The
 612.11 commissioner is authorized to transfer
 612.12 appropriations to, and account for DHS
 612.13 receipt center operations in, the special
 612.14 revenue fund.

612.15 **Administrative Recovery; Set-Aside.** The
 612.16 commissioner may invoice local entities
 612.17 through the SWIFT accounting system as an
 612.18 alternative means to recover the actual cost
 612.19 of administering the following provisions:

612.20 (1) Minnesota Statutes, section 125A.744,
 612.21 subdivision 3;

612.22 (2) Minnesota Statutes, section 245.495,
 612.23 paragraph (b);

612.24 (3) Minnesota Statutes, section 256B.0625,
 612.25 subdivision 20, paragraph (k);

612.26 (4) Minnesota Statutes, section 256B.0924,
 612.27 subdivision 6, paragraph (g);

612.28 (5) Minnesota Statutes, section 256B.0945,
 612.29 subdivision 4, paragraph (d); and

612.30 (6) Minnesota Statutes, section 256F.10,
 612.31 subdivision 6, paragraph (b).

612.32 **Systems Modernization.** The following
 612.33 amounts are appropriated for transfer to

613.1 the state systems account authorized in
613.2 Minnesota Statutes, section 256.014:
613.3 (1) \$1,825,000 in fiscal year 2014 and
613.4 \$2,502,000 in fiscal year 2015 is for the
613.5 state share of Medicaid-allocated costs of
613.6 the health insurance exchange information
613.7 technology and operational structure. The
613.8 funding base is \$3,222,000 in fiscal year 2016
613.9 and \$3,037,000 in fiscal year 2017 but shall
613.10 not be included in the base thereafter; and
613.11 (2) \$9,344,000 in fiscal year 2014 and
613.12 \$3,660,000 in fiscal year 2015 are for the
613.13 modernization and streamlining of agency
613.14 eligibility and child support systems. The
613.15 funding base is \$5,921,000 in fiscal year
613.16 2016 and \$1,792,000 in fiscal year 2017 but
613.17 shall not be included in the base thereafter.
613.18 The unexpended balance of the \$9,344,000
613.19 appropriation in fiscal year 2014 and the
613.20 \$3,660,000 appropriation in fiscal year 2015
613.21 must be transferred from the Department of
613.22 Human Services state systems account to
613.23 the Office of Enterprise Technology when
613.24 the Office of Enterprise Technology has
613.25 negotiated a federally approved internal
613.26 service fund rates and billing process with
613.27 sufficient internal accounting controls to
613.28 properly maximize federal reimbursement
613.29 to Minnesota for human services system
613.30 modernization projects, but not later than
613.31 June 30, 2015.
613.32 If contingent funding is fully or partially
613.33 disbursed under article 15, section 3, and
613.34 transferred to the state systems account, the
613.35 unexpended balance of that appropriation

614.1 must be transferred to the Office of Enterprise
 614.2 Technology in accordance with this clause.
 614.3 Contingent funding must not exceed
 614.4 \$11,598,000 for the biennium.

614.5 **Base Adjustment.** The general fund base
 614.6 is increased by \$2,868,000 in fiscal year
 614.7 2016 and decreased by \$1,206,000 in fiscal
 614.8 year 2017. The health access fund base is
 614.9 decreased by \$551,000 in fiscal years 2016
 614.10 and 2017. The state government special
 614.11 revenue fund base is increased by \$4,000 in
 614.12 fiscal year 2016 and decreased by \$236,000
 614.13 in fiscal year 2017.

614.14 **(b) Children and Families**

614.15	<u>Appropriations by Fund</u>		
614.16	<u>General</u>	<u>8,023,000</u>	<u>8,015,000</u>
614.17	<u>Federal TANF</u>	<u>2,282,000</u>	<u>2,282,000</u>

614.18 **Financial Institution Data Match and**
 614.19 **Payment of Fees.** The commissioner is
 614.20 authorized to allocate up to \$310,000 each
 614.21 year in fiscal years 2014 and 2015 from the
 614.22 PRISM special revenue account to make
 614.23 payments to financial institutions in exchange
 614.24 for performing data matches between account
 614.25 information held by financial institutions
 614.26 and the public authority's database of child
 614.27 support obligors as authorized by Minnesota
 614.28 Statutes, section 13B.06, subdivision 7.

614.29 **Base Adjustment.** The general fund base is
 614.30 decreased by \$300,000 in fiscal years 2016
 614.31 and 2017. The TANF fund base is increased
 614.32 by \$300,000 in fiscal years 2016 and 2017.

614.33 **(c) Health Care**

615.1 Appropriations by Fund

615.2	<u>General</u>	<u>14,028,000</u>	<u>13,826,000</u>
615.3	<u>Health Care Access</u>	<u>28,442,000</u>	<u>31,137,000</u>

615.4 **Base Adjustment.** The general fund base
 615.5 is decreased by \$86,000 in fiscal year 2016
 615.6 and by \$86,000 in fiscal year 2017. The
 615.7 health care access fund base is increased
 615.8 by \$6,954,000 in fiscal year 2016 and by
 615.9 \$5,489,000 in fiscal year 2017.

615.10 **(d) Continuing Care**

615.11 Appropriations by Fund

615.12	<u>General</u>	<u>20,993,000</u>	<u>22,359,000</u>
615.13	<u>State Government</u>		
615.14	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

615.15 **Base Adjustment.** The general fund base is
 615.16 increased by \$1,690,000 in fiscal year 2016
 615.17 and by \$798,000 in fiscal year 2017.

615.18 **(e) Chemical and Mental Health**

615.19 Appropriations by Fund

615.20	<u>General</u>	<u>4,639,000</u>	<u>4,490,000</u>
615.21	<u>Lottery Prize Fund</u>	<u>157,000</u>	<u>157,000</u>

615.22 **Subd. 5. Forecasted Programs**

615.23 The amounts that may be spent from this
 615.24 appropriation for each purpose are as follows:

615.25 **(a) MFIP/DWP**

615.26 Appropriations by Fund

615.27	<u>General</u>	<u>72,583,000</u>	<u>76,927,000</u>
615.28	<u>Federal TANF</u>	<u>80,342,000</u>	<u>76,851,000</u>

615.29 **(b) MFIP Child Care Assistance** 61,701,000 69,294,000

615.30 **(c) General Assistance** 54,787,000 56,068,000

615.31 **General Assistance Standard.** The
 615.32 commissioner shall set the monthly standard
 615.33 of assistance for general assistance units
 615.34 consisting of an adult recipient who is

616.1 childless and unmarried or living apart
 616.2 from parents or a legal guardian at \$203.
 616.3 The commissioner may reduce this amount
 616.4 according to Laws 1997, chapter 85, article
 616.5 3, section 54.

616.6 **Emergency General Assistance.** The
 616.7 amount appropriated for emergency general
 616.8 assistance funds is limited to no more
 616.9 than \$6,729,812 in fiscal year 2014 and
 616.10 \$6,729,812 in fiscal year 2015. Funds
 616.11 to counties shall be allocated by the
 616.12 commissioner using the allocation method in
 616.13 Minnesota Statutes, section 256D.06.

616.14 <u>(d) MN Supplemental Assistance</u>	<u>38,646,000</u>	<u>39,821,000</u>
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616.15 <u>(e) Group Residential Housing</u>	<u>141,138,000</u>	<u>150,988,000</u>
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616.16 <u>(f) MinnesotaCare</u>	<u>297,707,000</u>	<u>247,284,000</u>
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616.17 This appropriation is from the health care
 616.18 access fund.

616.19 **(g) Medical Assistance**

	<u>Appropriations by Fund</u>	
616.20		
616.21 <u>General</u>	<u>4,443,768,000</u>	<u>4,431,612,000</u>
616.22 <u>Health Care Access</u>	<u>179,550,000</u>	<u>226,081,000</u>

616.23 **Spending to be apportioned.** The
 616.24 commissioner shall apportion expenditures
 616.25 under this paragraph consistent with the
 616.26 requirements of section 12.

616.27 **Support Services for Deaf and**
 616.28 **Hard-of-Hearing.** \$121,000 in fiscal
 616.29 year 2014 and \$141,000 in fiscal year 2015;
 616.30 and \$10,000 in fiscal year 2014 and \$13,000
 616.31 in fiscal year 2015 are from the health care
 616.32 access fund for the hospital reimbursement
 616.33 increase in Minnesota Statutes, section
 616.34 256.969, subdivision 29, paragraph (b).

617.1 **Disproportionate Share Payments.**
 617.2 Effective for services provided on or after
 617.3 July 1, 2011, through June 30, 2015, the
 617.4 commissioner of human services shall
 617.5 deposit, in the health care access fund,
 617.6 additional federal matching funds received
 617.7 under Minnesota Statutes, section 256B.199,
 617.8 paragraph (e), as disproportionate share
 617.9 hospital payments for inpatient hospital
 617.10 services provided under MinnesotaCare to
 617.11 lawfully present noncitizens who are not
 617.12 eligible for MinnesotaCare with federal
 617.13 financial participation due to immigration
 617.14 status. The amount deposited shall not exceed
 617.15 \$2,200,000 for the time period specified.

617.16 **Funding for Services Provided to EMA**
 617.17 **Recipients.** \$2,200,000 in fiscal year 2014 is
 617.18 from the health care access fund to provide
 617.19 services to emergency medical assistance
 617.20 recipients under Minnesota Statutes, section
 617.21 256B.06, subdivision 4, paragraph (l). This
 617.22 is a onetime appropriation and is available in
 617.23 either year of the biennium.

617.24 <u>(h) Alternative Care</u>	<u>50,776,000</u>	<u>54,922,000</u>
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617.25 **Alternative Care Transfer.** Any money
 617.26 allocated to the alternative care program that
 617.27 is not spent for the purposes indicated does
 617.28 not cancel but shall be transferred to the
 617.29 medical assistance account.

617.30 <u>(i) CD Treatment Fund</u>	<u>81,440,000</u>	<u>74,875,000</u>
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617.31 **Balance Transfer.** The commissioner must
 617.32 transfer \$18,188,000 from the consolidated
 617.33 chemical dependency treatment fund to the
 617.34 general fund by September 30, 2013.

618.1 **Subd. 6. Grant Programs**

618.2 The amounts that may be spent from this
 618.3 appropriation for each purpose are as follows:

618.4 **(a) Support Services Grants**

618.5	<u>Appropriations by Fund</u>		
618.6	<u>General</u>	<u>8,915,000</u>	<u>13,333,000</u>
618.7	<u>Federal TANF</u>	<u>94,611,000</u>	<u>94,611,000</u>

618.8 **Paid Work Experience. \$2,168,000**
 618.9 each year in fiscal years 2015 and 2016
 618.10 is from the general fund for paid work
 618.11 experience for long-term MFIP recipients.
 618.12 Paid work includes full and partial wage
 618.13 subsidies and other related services such as
 618.14 job development, marketing, preworksite
 618.15 training, job coaching, and postplacement
 618.16 services. These are onetime appropriations.
 618.17 Unexpended funds for fiscal year 2015 do not
 618.18 cancel, but are available to the commissioner
 618.19 for this purpose in fiscal year 2016.

618.20 **Work Study Funding for MFIP**
 618.21 **Participants. \$250,000 each year in fiscal**
 618.22 **years 2015 and 2016 is from the general fund**
 618.23 **to pilot work study jobs for MFIP recipients**
 618.24 **in approved postsecondary education**
 618.25 **programs. This is a onetime appropriation.**
 618.26 **Unexpended funds for fiscal year 2015 do**
 618.27 **not cancel, but are available for this purpose**
 618.28 **in fiscal year 2016.**

618.29 **Local Strategies to Reduce Disparities.**
 618.30 **\$2,000,000 each year in fiscal years 2015**
 618.31 **and 2016 is from the general fund for**
 618.32 **local projects that focus on services for**
 618.33 **subgroups within the MFIP caseload**
 618.34 **who are experiencing poor employment**
 618.35 **outcomes. These are onetime appropriations.**

619.1 Unexpended funds for fiscal year 2015 do not
 619.2 cancel, but are available to the commissioner
 619.3 for this purpose in fiscal year 2016.

619.4 **Home Visiting Collaborations for MFIP**
 619.5 **Teen Parents.** \$200,000 per year in fiscal
 619.6 years 2014 and 2015 is from the general fund
 619.7 and \$200,000 in fiscal year 2016 is from the
 619.8 federal TANF fund for technical assistance
 619.9 and training to support local collaborations
 619.10 that provide home visiting services for
 619.11 MFIP teen parents. The general fund
 619.12 appropriation is onetime. The federal TANF
 619.13 fund appropriation is added to the base.

619.14 **Performance Bonus Funds for Counties.**
 619.15 The TANF fund base is increased by
 619.16 \$1,500,000 each year in fiscal years 2016
 619.17 and 2017. The commissioner must allocate
 619.18 this amount each year to counties that exceed
 619.19 their expected range of performance on the
 619.20 annualized three-year self-support index
 619.21 as defined in Minnesota Statutes, section
 619.22 256J.751, subdivision 2, clause (6). This is a
 619.23 permanent base adjustment. Notwithstanding
 619.24 any contrary provisions in this article, this
 619.25 provision expires June 30, 2016.

619.26 **Base Adjustment.** The general fund base is
 619.27 decreased by \$200,000 in fiscal year 2016
 619.28 and \$4,618,000 in fiscal year 2017. The
 619.29 TANF fund base is increased by \$1,700,000
 619.30 in fiscal years 2016 and 2017.

619.31 <u>(b) Basic Sliding Fee Child Care Assistance</u>				
619.32 <u>Grants</u>			<u>36,836,000</u>	<u>42,318,000</u>

619.33 **Base Adjustment.** The general fund base is
 619.34 increased by \$3,778,000 in fiscal year 2016
 619.35 and by \$3,849,000 in fiscal year 2017.

620.1	<u>(c) Child Care Development Grants</u>	<u>1,612,000</u>	<u>1,737,000</u>
620.2	<u>(d) Child Support Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>

620.3 **Federal Child Support Demonstration**
 620.4 **Grants.** Federal administrative
 620.5 reimbursement resulting from the federal
 620.6 child support grant expenditures authorized
 620.7 under United States Code, title 42, section
 620.8 1315, is appropriated to the commissioner
 620.9 for this activity.

620.10 **(e) Children's Services Grants**

620.11	<u>Appropriations by Fund</u>		
620.12	<u>General</u>	<u>49,760,000</u>	<u>52,961,000</u>
620.13	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

620.14 **Adoption Assistance and Relative Custody**

620.15 **Assistance.** \$37,453,000 in fiscal year 2014
 620.16 and \$37,453,000 in fiscal year 2015 is for
 620.17 the adoption assistance and relative custody
 620.18 assistance programs. The commissioner
 620.19 shall determine with the commissioner of
 620.20 Minnesota Management and Budget the
 620.21 appropriation for Northstar Care for Children
 620.22 effective January 1, 2015. The commissioner
 620.23 may transfer appropriations for adoption
 620.24 assistance, relative custody assistance, and
 620.25 Northstar Care for Children between fiscal
 620.26 years and among programs to adjust for
 620.27 transfers across the programs.

620.28 **Title IV-E Adoption Assistance.** Additional
 620.29 federal reimbursements to the state as a result
 620.30 of the Fostering Connections to Success
 620.31 and Increasing Adoptions Act's expanded
 620.32 eligibility for Title IV-E adoption assistance
 620.33 are appropriated for postadoption services,
 620.34 including a parent-to-parent support network.

621.1 **Privatized Adoption Grants.** Federal
 621.2 reimbursement for privatized adoption grant
 621.3 and foster care recruitment grant expenditures
 621.4 is appropriated to the commissioner for
 621.5 adoption grants and foster care and adoption
 621.6 administrative purposes.

621.7 **Adoption Assistance Incentive Grants.**
 621.8 Federal funds available during fiscal years
 621.9 2014 and 2015 for adoption incentive grants
 621.10 are appropriated for postadoption services,
 621.11 including a parent-to-parent support network.

621.12 **Base Adjustment.** The general fund base is
 621.13 increased by \$5,913,000 in fiscal year 2016
 621.14 and by \$10,297,000 in fiscal year 2017.

621.15 <u>(f) Child and Community Service Grants</u>	<u>53,301,000</u>	<u>53,301,000</u>
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621.16 <u>(g) Child and Economic Support Grants</u>	<u>21,047,000</u>	<u>20,848,000</u>
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621.17 **Minnesota Food Assistance Program.**
 621.18 Unexpended funds for the Minnesota food
 621.19 assistance program for fiscal year 2014 do
 621.20 not cancel but are available for this purpose
 621.21 in fiscal year 2015.

621.22 **Transitional Housing.** \$250,000 each year
 621.23 is for the transitional housing programs under
 621.24 Minnesota Statutes, section 256E.33.

621.25 **Emergency Services.** \$250,000 each year
 621.26 is for emergency services grants under
 621.27 Minnesota Statutes, section 256E.36.

621.28 **Family Assets for Independence.** \$250,000
 621.29 each year is for the Family Assets for
 621.30 Independence Minnesota program. This
 621.31 appropriation is available in either year of the
 621.32 biennium and may be transferred between
 621.33 fiscal years.

622.1 **Food Shelf Programs.** \$375,000 in fiscal
 622.2 year 2014 and \$375,000 in fiscal year
 622.3 2015 are for food shelf programs under
 622.4 Minnesota Statutes, section 256E.34. If the
 622.5 appropriation for either year is insufficient,
 622.6 the appropriation for the other year is
 622.7 available for it. Notwithstanding Minnesota
 622.8 Statutes, section 256E.34, subdivision 4, no
 622.9 portion of this appropriation may be used
 622.10 by Hunger Solutions for its administrative
 622.11 expenses, including but not limited to rent
 622.12 and salaries.

622.13 **Homeless Youth Act.** \$2,000,000 in fiscal
 622.14 year 2014 and \$2,000,000 in fiscal year 2015
 622.15 is for purposes of Minnesota Statutes, section
 622.16 256K.45.

622.17 **Safe Harbor Shelter and Housing.**
 622.18 \$500,000 in fiscal year 2014 and \$500,000 in
 622.19 fiscal year 2015 is for a safe harbor shelter
 622.20 and housing fund for housing and supportive
 622.21 services for youth who are sexually exploited.

622.22 **(h) Health Care Grants**

622.23	<u>Appropriations by Fund</u>		
622.24	<u>General</u>	<u>190,000</u>	<u>190,000</u>
622.25	<u>Health Care Access</u>	<u>190,000</u>	<u>190,000</u>

622.26 **Emergency Medical Assistance Referral**
 622.27 **and Assistance Grants.** (a) The
 622.28 commissioner of human services shall
 622.29 award grants to nonprofit programs that
 622.30 provide immigration legal services based
 622.31 on indigency to provide legal services for
 622.32 immigration assistance to individuals with
 622.33 emergency medical conditions or complex
 622.34 and chronic health conditions who are not
 622.35 currently eligible for medical assistance

623.1 or other public health care programs, but
 623.2 who may meet eligibility requirements with
 623.3 immigration assistance.

623.4 (b) The grantees, in collaboration with
 623.5 hospitals and safety net providers, shall
 623.6 provide referral assistance to connect
 623.7 individuals identified in paragraph (a) with
 623.8 alternative resources and services to assist in
 623.9 meeting their health care needs. \$100,000
 623.10 is appropriated in fiscal year 2014 and
 623.11 \$100,000 in fiscal year 2015. This is a
 623.12 onetime appropriation.

623.13 **Base Adjustment.** The general fund is
 623.14 decreased by \$100,000 in fiscal year 2016
 623.15 and \$100,000 in fiscal year 2017.

623.16 <u>(i) Aging and Adult Services Grants</u>	<u>14,827,000</u>	<u>15,010,000</u>
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623.17 **Base Adjustment.** The general fund is
 623.18 increased by \$1,150,000 in fiscal year 2016
 623.19 and \$1,151,000 in fiscal year 2017.

623.20 **Community Service Development**

623.21 **Grants and Community Services Grants.**

623.22 Community service development grants and
 623.23 community services grants are reduced by
 623.24 \$1,150,000 each year. This is a onetime
 623.25 reduction.

623.26 <u>(j) Deaf and Hard-of-Hearing Grants</u>	<u>1,771,000</u>	<u>1,785,000</u>
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623.27 <u>(k) Disabilities Grants</u>	<u>18,605,000</u>	<u>18,823,000</u>
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623.28 **Advocating Change Together.** \$310,000 in
 623.29 fiscal year 2014 is for a grant to Advocating
 623.30 Change Together (ACT) to maintain and
 623.31 promote services for persons with intellectual
 623.32 and developmental disabilities throughout
 623.33 the state. This appropriation is onetime. Of
 623.34 this appropriation:

624.1 (1) \$120,000 is for direct costs associated
 624.2 with the delivery and evaluation of
 624.3 peer-to-peer training programs administered
 624.4 throughout the state, focusing on education,
 624.5 employment, housing, transportation, and
 624.6 voting;

624.7 (2) \$100,000 is for delivery of statewide
 624.8 conferences focusing on leadership and
 624.9 skill development within the disability
 624.10 community; and

624.11 (3) \$90,000 is for administrative and general
 624.12 operating costs associated with managing
 624.13 or maintaining facilities, program delivery,
 624.14 staff, and technology.

624.15 **Base Adjustment.** The general fund base
 624.16 is increased by \$535,000 in fiscal year 2016
 624.17 and by \$709,000 in fiscal year 2017.

624.18 **(I) Adult Mental Health Grants**

624.19	<u>Appropriations by Fund</u>		
624.20	<u>General</u>	<u>71,199,000</u>	<u>69,530,000</u>
624.21	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
624.22	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

624.23 **Problem Gambling.** \$225,000 in fiscal year
 624.24 2014 and \$225,000 in fiscal year 2015 is
 624.25 appropriated from the lottery prize fund for a
 624.26 grant to the state affiliate recognized by the
 624.27 National Council on Problem Gambling. The
 624.28 affiliate must provide services to increase
 624.29 public awareness of problem gambling,
 624.30 education and training for individuals and
 624.31 organizations providing effective treatment
 624.32 services to problem gamblers and their
 624.33 families, and research relating to problem
 624.34 gambling.

625.1 **Funding Usage.** Up to 75 percent of a fiscal
 625.2 year's appropriations for adult mental health
 625.3 grants may be used to fund allocations in that
 625.4 portion of the fiscal year ending December
 625.5 31.

625.6 **Base Adjustment.** The general fund base is
 625.7 decreased by \$4,427,000 in fiscal years 2016
 625.8 and 2017.

625.9 **Mental Health Pilot Project.** \$230,000
 625.10 each year is for a grant to the Zumbro
 625.11 Valley Mental Health Center. The grant
 625.12 shall be used to implement a pilot project
 625.13 to test an integrated behavioral health care
 625.14 coordination model. The grant recipient must
 625.15 report measurable outcomes and savings
 625.16 to the commissioner of human services
 625.17 by January 15, 2016. This is a onetime
 625.18 appropriation.

625.19 **High-risk adults.** \$200,000 in fiscal
 625.20 year 2014 is for a grant to the nonprofit
 625.21 organization selected to administer the
 625.22 demonstration project for high-risk adults
 625.23 under Laws 2007, chapter 54, article 1,
 625.24 section 19, in order to complete the project.
 625.25 This is a onetime appropriation.

625.26 (m) Child Mental Health Grants	<u>18,246,000</u>	<u>20,636,000</u>
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625.27 **Text Message Suicide Prevention**
 625.28 **Program.** \$625,000 in fiscal year 2014 and
 625.29 \$625,000 in fiscal year 2015 is for a grant
 625.30 to a nonprofit organization to establish and
 625.31 implement a statewide text message suicide
 625.32 prevention program. The program shall
 625.33 implement a suicide prevention counseling
 625.34 text line designed to use text messaging to
 625.35 connect with crisis counselors and to obtain

626.1 emergency information and referrals to
 626.2 local resources in the local community. The
 626.3 program shall include training within schools
 626.4 and communities to encourage the use of the
 626.5 program.

626.6 **Mental Health First Aid Training.** \$22,000
 626.7 in fiscal year 2014 and \$23,000 in fiscal
 626.8 year 2015 is to train teachers, social service
 626.9 personnel, law enforcement, and others who
 626.10 come into contact with children with mental
 626.11 illnesses, in children and adolescents mental
 626.12 health first aid training.

626.13 **Funding Usage.** Up to 75 percent of a fiscal
 626.14 year's appropriation for child mental health
 626.15 grants may be used to fund allocations in that
 626.16 portion of the fiscal year ending December
 626.17 31.

626.18 <u>(n) CD Treatment Support Grants</u>	<u>1,816,000</u>	<u>1,816,000</u>
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626.19 **SBIRT Training.** (1) \$300,000 each year is
 626.20 for grants to train primary care clinicians to
 626.21 provide substance abuse brief intervention
 626.22 and referral to treatment (SBIRT). This is a
 626.23 onetime appropriation. The commissioner of
 626.24 human services shall apply to SAMHSA for
 626.25 an SBIRT professional training grant.

626.26 (2) If the commissioner of human services
 626.27 receives a grant under clause (1) funds
 626.28 appropriated under this clause, equal to
 626.29 the grant amount, up to the available
 626.30 appropriation, shall be transferred to the
 626.31 Minnesota Organization on Fetal Alcohol
 626.32 Syndrome (MOFAS). MOFAS must use
 626.33 the funds for grants. Grant recipients must
 626.34 be selected from communities that are
 626.35 not currently served by federal Substance

627.1 Abuse Prevention and Treatment Block
 627.2 Grant funds. Grant money must be used to
 627.3 reduce the rates of fetal alcohol syndrome
 627.4 and fetal alcohol effects, and the number of
 627.5 drug-exposed infants. Grant money may be
 627.6 used for prevention and intervention services
 627.7 and programs, including, but not limited to,
 627.8 community grants, professional education,
 627.9 public awareness, and diagnosis.

627.10 **Fetal Alcohol Syndrome Grant. \$180,000**
 627.11 each year from the general fund is for a
 627.12 grant to the Minnesota Organization on Fetal
 627.13 Alcohol Syndrome (MOFAS) to support
 627.14 nonprofit Fetal Alcohol Spectrum Disorders
 627.15 (FASD) outreach prevention programs
 627.16 in Olmsted County. This is a onetime
 627.17 appropriation.

627.18 **Base Adjustment.** The general fund base is
 627.19 decreased by \$480,000 in fiscal year 2016
 627.20 and \$480,000 in fiscal year 2017.

627.21 **Subd. 7. State-Operated Services**

627.22 **Transfer Authority Related to**
 627.23 **State-Operated Services.** Money
 627.24 appropriated for state-operated services
 627.25 may be transferred between fiscal years
 627.26 of the biennium with the approval of the
 627.27 commissioner of management and budget.

627.28 The amounts that may be spent from the
 627.29 appropriation for each purpose are as follows:

627.30 <u>(a) SOS Mental Health</u>	<u>115,738,000</u>	<u>115,738,000</u>
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627.31 **Dedicated Receipts Available.** Of the
 627.32 revenue received under Minnesota Statutes,
 627.33 section 246.18, subdivision 8, paragraph
 627.34 (a), \$1,000,000 each year is available for

628.1 the purposes of paragraph (b), clause (1),
 628.2 of that subdivision, \$1,000,000 each year
 628.3 is available to transfer to the adult mental
 628.4 health budget activity for the purposes of
 628.5 paragraph (b), clause (2), of that subdivision,
 628.6 and up to \$2,713,000 each year is available
 628.7 for the purposes of paragraph (b), clause (3),
 628.8 of that subdivision.

628.9	<u>(b) SOS MN Security Hospital</u>	<u>69,582,000</u>	<u>69,582,000</u>
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628.10	<u>Subd. 8. Sex Offender Program</u>	<u>76,769,000</u>	<u>79,745,000</u>
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628.11 **Transfer Authority Related to Minnesota**
 628.12 **Sex Offender Program.** Money
 628.13 appropriated for the Minnesota sex offender
 628.14 program may be transferred between fiscal
 628.15 years of the biennium with the approval of the
 628.16 commissioner of management and budget.

628.17	<u>Subd. 9. Technical Activities</u>	<u>80,440,000</u>	<u>80,829,000</u>
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628.18 This appropriation is from the federal TANF
 628.19 fund.

628.20 **Base Adjustment.** The federal TANF fund
 628.21 base is increased by \$278,000 in fiscal year
 628.22 2016 and increased by \$651,000 in fiscal
 628.23 year 2017.

628.24 **Subd. 10. C.A.R.E.**

628.25 (a) Notwithstanding Minnesota Statutes,
 628.26 section 254B.06, subdivision 1, \$2,200,000
 628.27 is transferred from the consolidated chemical
 628.28 dependency treatment fund administrative
 628.29 account in the special revenue fund and
 628.30 deposited into the enterprise fund for the
 628.31 Community Addiction Recovery Enterprise
 628.32 in fiscal year 2013.

628.33 (b) Notwithstanding Minnesota Statutes,
 628.34 section 245.037, \$1,000,000 must be

630.1 **Statewide Health Improvement Program.**
630.2 \$17,500,000 in fiscal year 2014 and
630.3 \$17,500,000 in fiscal year 2015 is from the
630.4 health care access fund for the statewide
630.5 health improvement program under
630.6 Minnesota Statutes, section 145.986. Funds
630.7 appropriated under this paragraph are
630.8 available until expended. No more than 16
630.9 percent of the SHIP budget may be used
630.10 for administration, technical assistance,
630.11 and state-level evaluation costs. The
630.12 commissioner shall incorporate strategies
630.13 for improving health outcomes and reducing
630.14 health care costs in populations over age 60
630.15 to the menu of statewide health improvement
630.16 program strategies.

630.17 **Statewide Cancer Surveillance System. Of**
630.18 the general fund appropriation, \$350,000 in
630.19 fiscal year 2014 and \$350,000 in fiscal year
630.20 2015 is to develop and implement a new
630.21 cancer reporting system under Minnesota
630.22 Statutes, sections 144.671 to 144.69. Any
630.23 information technology development or
630.24 support costs necessary for the cancer
630.25 surveillance system must be incorporated
630.26 into the agency's service level agreement and
630.27 paid to the Office of Enterprise Technology.

630.28 **Minnesota Poison Information Center.**
630.29 \$500,000 in fiscal year 2014 and \$500,000
630.30 in fiscal year 2015 from the general fund
630.31 is for regional poison information centers
630.32 according to Minnesota Statutes, section
630.33 145.93.

630.34 **Support Services for Deaf and**
630.35 **Hard-of-Hearing. (a) \$365,000 in fiscal**

631.1 year 2014 and \$349,000 in fiscal year 2015
631.2 are for providing support services to families
631.3 as required under Minnesota Statutes, section
631.4 144.966, subdivision 3a.

631.5 (b) \$164,000 in fiscal year 2014 and \$156,000
631.6 in fiscal year 2015 are for home-based
631.7 education in American Sign Language for
631.8 families with children who are deaf or have
631.9 hearing loss, as required under Minnesota
631.10 Statutes, section 144.966, subdivision 3a.

631.11 **Reproductive Health Strategic Plan to**
631.12 **Reduce Health Disparities for Somali**
631.13 **Women.** To the extent funds are available
631.14 for fiscal years 2014 and 2015 for grants
631.15 provided pursuant to Minnesota Statutes,
631.16 section 145.928, the commissioner
631.17 shall provide a grant to a Somali-based
631.18 organization located in the metropolitan area
631.19 to develop a reproductive health strategic
631.20 plan to eliminate reproductive health
631.21 disparities for Somali women. The plan shall
631.22 develop initiatives to provide educational
631.23 and information resources to health care
631.24 providers, community organizations, and
631.25 Somali women to ensure effective interaction
631.26 with Somali culture and western medicine
631.27 and the delivery of appropriate health care
631.28 services, and the achievement of better health
631.29 outcomes for Somali women. The plan must
631.30 engage health care providers, the Somali
631.31 community, and Somali health-centered
631.32 organizations. The commissioner shall
631.33 submit a report to the chairs and ranking
631.34 minority members of the senate and house
631.35 committees with jurisdiction over health
631.36 policy on the strategic plan developed under

632.1 this grant for eliminating reproductive health
632.2 disparities for Somali women. The report
632.3 must be submitted by February 15, 2014.

632.4 **Sexual Violence Prevention.** Within
632.5 available appropriations, by January 15,
632.6 2015, the commissioner must report to the
632.7 legislature on its activities to prevent sexual
632.8 violence, including activities to promote
632.9 coordination of existing state programs and
632.10 services to achieve maximum impact on
632.11 addressing the root causes of sexual violence.

632.12 **Safe Harbor for Sexually Exploited**
632.13 **Youth.** (a) \$375,000 in fiscal year 2014 and
632.14 \$375,000 in fiscal year 2015 are for grants
632.15 to six regional navigators under Minnesota
632.16 Statutes, section 145.4717.

632.17 (b) \$100,000 in fiscal year 2014 and \$100,000
632.18 in fiscal year 2015 are for the director of
632.19 child sex trafficking prevention position.

632.20 (c) \$50,000 in fiscal year 2015 is for program
632.21 evaluation required under Minnesota
632.22 Statutes, section 145.4718.

632.23 **TANF Appropriations.** (1) \$1,156,000 of
632.24 the TANF funds is appropriated each year of
632.25 the biennium to the commissioner for family
632.26 planning grants under Minnesota Statutes,
632.27 section 145.925.

632.28 (2) \$3,579,000 of the TANF funds is
632.29 appropriated each year of the biennium to
632.30 the commissioner for home visiting and
632.31 nutritional services listed under Minnesota
632.32 Statutes, section 145.882, subdivision 7,
632.33 clauses (6) and (7). Funds must be distributed
632.34 to community health boards according to

633.1 Minnesota Statutes, section 145A.131,
 633.2 subdivision 1.
 633.3 (3) \$2,000,000 of the TANF funds is
 633.4 appropriated each year of the biennium to
 633.5 the commissioner for decreasing racial and
 633.6 ethnic disparities in infant mortality rates
 633.7 under Minnesota Statutes, section 145.928,
 633.8 subdivision 7.
 633.9 (4) \$4,978,000 of the TANF funds is
 633.10 appropriated each year of the biennium to the
 633.11 commissioner for the family home visiting
 633.12 grant program according to Minnesota
 633.13 Statutes, section 145A.17. \$4,000,000 of the
 633.14 funding must be distributed to community
 633.15 health boards according to Minnesota
 633.16 Statutes, section 145A.131, subdivision 1.
 633.17 \$978,000 of the funding must be distributed
 633.18 to tribal governments based on Minnesota
 633.19 Statutes, section 145A.14, subdivision 2a.
 633.20 (5) The commissioner may use up to 6.23
 633.21 percent of the funds appropriated each fiscal
 633.22 year to conduct the ongoing evaluations
 633.23 required under Minnesota Statutes, section
 633.24 145A.17, subdivision 7, and training and
 633.25 technical assistance as required under
 633.26 Minnesota Statutes, section 145A.17,
 633.27 subdivisions 4 and 5.
 633.28 **TANF Carryforward.** Any unexpended
 633.29 balance of the TANF appropriation in the
 633.30 first year of the biennium does not cancel but
 633.31 is available for the second year.

633.32 **Subd. 3. Policy Quality and Compliance**

633.33	<u>Appropriations by Fund</u>		
633.34	<u>General</u>	<u>9,391,000</u>	<u>9,391,000</u>

634.1	<u>State Government</u>		
634.2	<u>Special Revenue</u>	<u>14,428,000</u>	<u>16,450,000</u>
634.3	<u>Health Care Access</u>	<u>12,243,000</u>	<u>11,643,000</u>

634.4 The health care access fund appropriation
 634.5 includes the base appropriation for health
 634.6 care homes activities.

634.7 **Base Level Adjustment.** The health care
 634.8 access base shall be increased by \$600,000
 634.9 in fiscal year 2016.

634.10 **Criminal Background Checks.** The state
 634.11 government special revenue fund base for
 634.12 fiscal year 2017 includes \$111,000 for the
 634.13 implementation of criminal background
 634.14 checks for occupational therapy practitioners,
 634.15 speech-language pathologists, audiologists,
 634.16 and hearing aid dispensers, if the Sunset
 634.17 Advisory Commission under Minnesota
 634.18 Statutes, section 3D.03, is repealed before
 634.19 June 30, 2014.

634.20 **Subd. 4. Health Protection**

634.21		<u>Appropriations by Fund</u>	
634.22	<u>General</u>	<u>9,201,000</u>	<u>9,201,000</u>
634.23	<u>State Government</u>		
634.24	<u>Special Revenue</u>	<u>32,633,000</u>	<u>32,636,000</u>
634.25	<u>Special Revenue</u>	<u>300,000</u>	<u>300,000</u>

634.26 **Infectious Disease Laboratory.** Of the
 634.27 general fund appropriation, \$200,000 in
 634.28 fiscal year 2014 and \$200,000 in fiscal year
 634.29 2015 are to monitor infectious disease trends
 634.30 and investigate infectious disease outbreaks.

634.31 **Surveillance for Elevated Blood Lead**
 634.32 **Levels.** Of the general fund appropriation,
 634.33 \$100,000 in fiscal year 2014 and \$100,000
 634.34 in fiscal year 2015 are for the blood lead

635.1 surveillance system under Minnesota
 635.2 Statutes, section 144.9502.

635.3 **Base Level Adjustment.** The state
 635.4 government special revenue base is increased
 635.5 by \$6,000 in fiscal year 2016 and by \$13,000
 635.6 in fiscal year 2017.

635.7 **Subd. 5. Administrative Support Services** 8,020,000 8,020,000

635.8 The general fund appropriation includes the
 635.9 base appropriation for the Office of the State
 635.10 Epidemiologist.

635.11 **Regional Support for Local Public Health**

635.12 **Departments.** \$350,000 in fiscal year
 635.13 2014 and \$350,000 in fiscal year 2015 is
 635.14 for regional staff who provide specialized
 635.15 expertise to local public health departments.

635.16 **Sec. 4. HEALTH-RELATED BOARDS**

635.17 **Subdivision 1. Total Appropriation** \$ 20,040,000 \$ 18,446,000

635.18 This appropriation is from the state
 635.19 government special revenue fund.

635.20 The amounts that may be spent for each
 635.21 purpose are specified in the following
 635.22 subdivisions.

635.23 **Subd. 2. Board of Chiropractic Examiners** 508,000 490,000

635.24 This appropriation includes \$10,000
 635.25 for information technology hardware
 635.26 to streamline board operations. This
 635.27 is a onetime appropriation. \$15,000 is
 635.28 for a LEAN evaluation. This is a onetime
 635.29 appropriation. \$2,000 in fiscal years 2014 and
 635.30 2015 is for rental of additional storage space.

635.31 **Subd. 3. Board of Dentistry** 2,059,000 2,056,000

636.1 This appropriation includes \$843,000 in fiscal
 636.2 year 2014 and \$837,000 in fiscal year 2015
 636.3 for the health professional services program.
 636.4 \$15,000 in fiscal year 2014 is for repairs,
 636.5 maintenance, furnishings, and ergonomic
 636.6 upgrades. This is a onetime appropriation.
 636.7 \$35,000 in fiscal years 2014 and 2015 is for
 636.8 additional staff to implement new regulatory
 636.9 activity. \$20,000 in fiscal years 2014 and
 636.10 2015 is for database upgrades for regulatory
 636.11 and licensing activities. \$10,000 in fiscal
 636.12 years 2014 and 2015 is for professional and
 636.13 technical contracts for expert consultants
 636.14 to review complex complaints, advise on
 636.15 specialty dentistry areas, and to serve as
 636.16 expert witnesses in contested case matters.

636.17 <u>Subd. 4. Board of Dietetic and Nutrition</u>		
636.18 <u>Practice</u>	<u>111,000</u>	<u>111,000</u>

636.19 <u>Subd. 5. Board of Marriage and Family</u>		
636.20 <u>Therapy</u>	<u>254,000</u>	<u>226,000</u>

636.21 This appropriation includes \$25,000 in fiscal
 636.22 year 2014 for rulemaking. This is a onetime
 636.23 appropriation. \$31,000 in fiscal year 2014
 636.24 and \$27,000 in fiscal year 2015 are for
 636.25 additional staff to improve licensing and
 636.26 licensing renewal activities. \$30,000 in fiscal
 636.27 year 2014 and \$31,000 in fiscal year 2015
 636.28 are to increase the executive director to a
 636.29 full-time position.

636.30 The remaining balance of the state
 636.31 government special revenue fund
 636.32 appropriation in Laws 2011, First Special
 636.33 Session chapter 9, article 10, section 8,
 636.34 subdivision 5, for Board of Marriage and
 636.35 Family Therapy rulemaking, estimated to

637.1	<u>be \$25,000, is canceled. This paragraph is</u>		
637.2	<u>effective the day following final enactment.</u>		
637.3	<u>Subd. 6. Board of Medical Practice</u>	<u>3,867,000</u>	<u>3,867,000</u>
637.4	<u>Subd. 7. Board of Nursing</u>	<u>3,637,000</u>	<u>3,637,000</u>
637.5	<u>Subd. 8. Board of Nursing Home</u>		
637.6	<u>Administrators</u>	<u>3,742,000</u>	<u>2,252,000</u>
637.7	<u>Administrative Services Unit - Operating</u>		
637.8	<u>Costs. Of this appropriation, \$676,000</u>		
637.9	<u>in fiscal year 2014 and \$626,000 in</u>		
637.10	<u>fiscal year 2015 are for operating costs</u>		
637.11	<u>of the administrative services unit. The</u>		
637.12	<u>administrative services unit may receive</u>		
637.13	<u>and expend reimbursements for services</u>		
637.14	<u>performed by other agencies.</u>		
637.15	<u>Administrative Services Unit - Volunteer</u>		
637.16	<u>Health Care Provider Program. Of this</u>		
637.17	<u>appropriation, \$150,000 in fiscal year 2014</u>		
637.18	<u>and \$150,000 in fiscal year 2015 are to pay</u>		
637.19	<u>for medical professional liability coverage</u>		
637.20	<u>required under Minnesota Statutes, section</u>		
637.21	<u>214.40.</u>		
637.22	<u>Administrative Services Unit - Contested</u>		
637.23	<u>Cases and Other Legal Proceedings. Of</u>		
637.24	<u>this appropriation, \$200,000 in fiscal year</u>		
637.25	<u>2014 and \$200,000 in fiscal year 2015 are</u>		
637.26	<u>for costs of contested case hearings and other</u>		
637.27	<u>unanticipated costs of legal proceedings</u>		
637.28	<u>involving health-related boards funded</u>		
637.29	<u>under this section. Upon certification of a</u>		
637.30	<u>health-related board to the administrative</u>		
637.31	<u>services unit that the costs will be incurred</u>		
637.32	<u>and that there is insufficient money available</u>		
637.33	<u>to pay for the costs out of money currently</u>		
637.34	<u>available to that board, the administrative</u>		
637.35	<u>services unit is authorized to transfer money</u>		

638.1 from this appropriation to the board for
638.2 payment of those costs with the approval
638.3 of the commissioner of management and
638.4 budget.

638.5 This appropriation includes \$44,000 in
638.6 fiscal year 2014 for rulemaking. This is
638.7 a onetime appropriation. \$1,441,000 in
638.8 fiscal year 2014 and \$420,000 in fiscal year
638.9 2015 are for the development of a shared
638.10 disciplinary, regulatory, licensing, and
638.11 information management system. \$391,000
638.12 in fiscal year 2014 is a onetime appropriation
638.13 for retirement costs in the health-related
638.14 boards. This funding may be transferred to
638.15 the health boards incurring retirement costs.
638.16 These funds are available either year of the
638.17 biennium.

638.18 This appropriation includes \$16,000 in fiscal
638.19 years 2014 and 2015 for evening security,
638.20 \$2,000 in fiscal years 2014 and 2015 for a
638.21 state vehicle lease, and \$18,000 in fiscal
638.22 years 2014 and 2015 for shared office space
638.23 and administrative support. \$205,000 in
638.24 fiscal year 2014 and \$221,000 in fiscal year
638.25 2015 are for shared information technology
638.26 services, equipment, and maintenance.

638.27 The remaining balance of the state
638.28 government special revenue fund
638.29 appropriation in Laws 2011, First Special
638.30 Session chapter 9, article 10, section 8,
638.31 subdivision 8, for Board of Nursing Home
638.32 Administrators rulemaking, estimated to
638.33 be \$44,000, is canceled, and the remaining
638.34 balance of the state government special
638.35 revenue fund appropriation in Laws 2011,

639.1 First Special Session chapter 9, article 10,
 639.2 section 8, subdivision 8, for electronic
 639.3 licensing system adaptors, estimated to be
 639.4 \$761,000, and for the development and
 639.5 implementation of a disciplinary, regulatory,
 639.6 licensing, and information management
 639.7 system, estimated to be \$1,100,000, are
 639.8 canceled. This paragraph is effective the day
 639.9 following final enactment.

639.10 **Base Adjustment.** The base is decreased by
 639.11 \$370,000 in fiscal years 2016 and 2017.

639.12	<u>Subd. 9. Board of Optometry</u>	<u>107,000</u>	<u>107,000</u>
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639.13	<u>Subd. 10. Board of Pharmacy</u>	<u>2,555,000</u>	<u>2,555,000</u>
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639.14 **Prescription Electronic Reporting.** Of
 639.15 this appropriation, \$356,000 in fiscal year
 639.16 2014 and \$356,000 in fiscal year 2015 from
 639.17 the state government special revenue fund
 639.18 are to the board to operate the prescription
 639.19 monitoring program in Minnesota Statutes,
 639.20 section 152.126.

639.21	<u>Subd. 11. Board of Physical Therapy</u>	<u>390,000</u>	<u>346,000</u>
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639.22 This appropriation includes \$44,000 in fiscal
 639.23 year 2014 for rulemaking. This is a onetime
 639.24 appropriation.

639.25 The remaining balance of the state
 639.26 government special revenue fund
 639.27 appropriation in Laws 2011, First Special
 639.28 Session chapter 9, article 10, section 8,
 639.29 subdivision 11, for Board of Physical
 639.30 Therapy rulemaking, estimated to be
 639.31 \$44,000, is canceled. This paragraph is
 639.32 effective the day following final enactment.

639.33	<u>Subd. 12. Board of Podiatry</u>	<u>76,000</u>	<u>76,000</u>
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639.34	<u>Subd. 13. Board of Psychology</u>	<u>892,000</u>	<u>892,000</u>
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640.1 This appropriation includes \$15,000 in
 640.2 fiscal years 2014 and 2015 for continuing
 640.3 educational programming. \$5,000 in fiscal
 640.4 years 2014 and 2015 are for a public
 640.5 education program. \$25,000 in fiscal years
 640.6 2014 and 2015 are for development of
 640.7 educational materials. This is a onetime
 640.8 appropriation.

640.9 **Base Adjustment.** The base is decreased by
 640.10 \$45,000 in fiscal years 2016 and 2017.

640.11 <u>Subd. 14. Board of Social Work</u>	<u>1,109,000</u>	<u>1,110,000</u>
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640.12 This appropriation includes \$55,000 in fiscal
 640.13 year 2014 and \$56,000 in fiscal year 2015
 640.14 for additional staff to enhance the board's
 640.15 complaint resolution process.

640.16 <u>Subd. 15. Board of Veterinary Medicine</u>	<u>262,000</u>	<u>256,000</u>
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640.17 This appropriation includes \$32,000 in fiscal
 640.18 year 2014 and \$26,000 in fiscal year 2015
 640.19 for additional staff to improve the board's
 640.20 complaint resolution process.

640.21 <u>Subd. 16. Board of Behavioral Health and</u> 640.22 <u>Therapy</u>	<u>471,000</u>	<u>465,000</u>
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640.23 This appropriation includes \$56,000 in fiscal
 640.24 year 2014 and \$50,000 in fiscal year 2015 for
 640.25 additional staff to enhance the licensing and
 640.26 complaint resolution processes of the board.

640.27 <u>Sec. 5. EMERGENCY MEDICAL SERVICES</u> 640.28 <u>REGULATORY BOARD</u>	<u>\$ 2,741,000</u>	<u>\$ 2,741,000</u>
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640.29 **Regional Grants.** \$585,000 in fiscal year
 640.30 2014 and \$585,000 in fiscal year 2015 are
 640.31 for regional emergency medical services
 640.32 programs, to be distributed equally to the
 640.33 eight emergency medical service regions.

641.1 **Cooper/Sams Volunteer Ambulance**
 641.2 **Program.** \$700,000 in fiscal year 2014 and
 641.3 \$700,000 in fiscal year 2015 are for the
 641.4 Cooper/Sams volunteer ambulance program
 641.5 under Minnesota Statutes, section 144E.40.
 641.6 (a) Of this amount, \$611,000 in fiscal year
 641.7 2014 and \$611,000 in fiscal year 2015
 641.8 are for the ambulance service personnel
 641.9 longevity award and incentive program under
 641.10 Minnesota Statutes, section 144E.40.
 641.11 (b) Of this amount, \$89,000 in fiscal year
 641.12 2014 and \$89,000 in fiscal year 2015 are
 641.13 for the operations of the ambulance service
 641.14 personnel longevity award and incentive
 641.15 program under Minnesota Statutes, section
 641.16 144E.40.
 641.17 **Ambulance Training Grant.** \$361,000 in
 641.18 fiscal year 2014 and \$361,000 in fiscal year
 641.19 2015 are for training grants.
 641.20 **EMSRB Board Operations.** \$1,095,000 in
 641.21 fiscal year 2014 and \$1,095,000 in fiscal year
 641.22 2015 are for operations.

641.23	Sec. 6. <u>COUNCIL ON DISABILITY</u>	<u>\$</u>	<u>614,000</u>	<u>\$</u>	<u>614,000</u>
641.24	Sec. 7. <u>OMBUDSMAN FOR MENTAL</u>				
641.25	<u>HEALTH AND DEVELOPMENTAL</u>				
641.26	<u>DISABILITIES</u>	<u>\$</u>	<u>1,654,000</u>	<u>\$</u>	<u>1,654,000</u>
641.27	Sec. 8. <u>OMBUDSPERSON FOR FAMILIES</u>	<u>\$</u>	<u>333,000</u>	<u>\$</u>	<u>334,000</u>

641.28 Sec. 9. Minnesota Statutes 2012, section 256.01, subdivision 34, is amended to read:
 641.29 Subd. 34. **Federal administrative reimbursement dedicated.** Federal
 641.30 administrative reimbursement resulting from the following activities is appropriated to the
 641.31 commissioner for the designated purposes:
 641.32 (1) reimbursement for the Minnesota senior health options project; and

642.1 (2) reimbursement related to prior authorization and inpatient admission certification
642.2 by a professional review organization. A portion of these funds must be used for activities
642.3 to decrease unnecessary pharmaceutical costs in medical assistance; and

642.4 (3) reimbursement resulting from the federal child support grant expenditures
642.5 authorized under United States Code, title 42, section 1315.

642.6 Sec. 10. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
642.7 to read:

642.8 Subd. 35. **Federal reimbursement for privatized adoption grants.** Federal
642.9 reimbursement for privatized adoption grant and foster care recruitment grant expenditures
642.10 is appropriated to the commissioner for adoption grants and foster care and adoption
642.11 administrative purposes.

642.12 Sec. 11. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
642.13 to read:

642.14 Subd. 36. **DHS receipt center accounting.** The commissioner may transfer
642.15 appropriations to, and account for DHS receipt center operations in, the special revenue
642.16 fund.

642.17 Sec. 12. **APPROPRIATION ADJUSTMENTS.**

642.18 (a) The general fund appropriation in section 2, subdivision 5, paragraph (g),
642.19 includes up to \$53,391,000 in fiscal year 2014; \$216,637,000 in fiscal year 2015;
642.20 \$261,660,000 in fiscal year 2016; and \$279,984,000 in fiscal year 2017, for medical
642.21 assistance eligibility and administration changes related to:

642.22 (1) eligibility for children age two to 18 with income up to 275 percent of the federal
642.23 poverty guidelines;

642.24 (2) eligibility for pregnant women with income up to 275 percent of the federal
642.25 poverty guidelines;

642.26 (3) Affordable Care Act enrollment and renewal processes, including elimination
642.27 of six-month renewals, ex parte eligibility reviews, preprinted renewal forms, changes
642.28 in verification requirements, and other changes in the eligibility determination and
642.29 enrollment and renewal process;

642.30 (4) automatic eligibility for children who turn 18 in foster care until they reach age 26;

642.31 (5) eligibility related to spousal impoverishment provisions for waiver recipients; and

642.32 (6) presumptive eligibility determinations by hospitals.

643.1 (b) The commissioner of human services shall determine the difference between the
643.2 actual or forecasted costs to the medical assistance program attributable to the program
643.3 changes in paragraph (a), clauses (1) to (6), and the costs of paragraph (a), clauses (1) to
643.4 (6), that were estimated during the 2013 legislative session based on data from the 2013
643.5 February forecast. The costs in this paragraph must be calculated between January 1,
643.6 2014, and June 30, 2017.

643.7 (c) For each fiscal year from 2014 to 2017, the commissioner of human services
643.8 shall certify the actual or forecasted cost differences to the medical assistance program
643.9 determined under paragraph (b), and report the difference in costs to the commissioner of
643.10 management and budget at least four weeks prior to a forecast under Minnesota Statutes,
643.11 section 16A.103. No later than three weeks before the release of the forecast under
643.12 Minnesota Statutes, section 16A.103, the commissioner of management and budget shall
643.13 reduce the health care access fund appropriation in section 2, subdivision 5, paragraph (g),
643.14 by the cumulative difference in costs determined in paragraph (b). If for any fiscal year,
643.15 the amount of the cumulative cost differences determined under paragraph (b) is positive,
643.16 no adjustment shall be made to the health care access fund appropriation. If for any fiscal
643.17 year, the amount of the cumulative cost differences determined under paragraph (b) is less
643.18 than the original appropriation, the appropriation for that fiscal year is zero.

643.19 (d) This section expires on January 1, 2018.

643.20 Sec. 13. **TRANSFERS.**

643.21 Subdivision 1. **Grants.** The commissioner of human services, with the approval of
643.22 the commissioner of management and budget, may transfer unencumbered appropriation
643.23 balances for the biennium ending June 30, 2015, within fiscal years among the MFIP,
643.24 general assistance, general assistance medical care under Minnesota Statutes 2009
643.25 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP
643.26 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental
643.27 aid, group residential housing programs, the entitlement portion of the chemical
643.28 dependency consolidated treatment fund, and between fiscal years of the biennium. The
643.29 commissioner shall inform the chairs and ranking minority members of the senate Health
643.30 and Human Services Finance Division and the house of representatives Health and Human
643.31 Services Finance Committee quarterly about transfers made under this provision.

643.32 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
643.33 money may be transferred within the Departments of Human Services and Health as the
643.34 commissioners consider necessary, with the advance approval of the commissioner of
643.35 management and budget. The commissioner shall inform the chairs and ranking minority

645.1	<u>(a) Operations</u>	<u>2,909,000</u>	<u>8,957,000</u>
645.2	<u>Base Adjustment.</u> The general fund base is		
645.3	decreased by \$8,916,000 in fiscal year 2016		
645.4	and \$8,916,000 in fiscal year 2017.		
645.5	<u>(b) Children and Families</u>	<u>109,000</u>	<u>206,000</u>
645.6	<u>(c) Continuing Care</u>	<u>2,849,000</u>	<u>3,574,000</u>
645.7	<u>Base Adjustment.</u> The general fund base is		
645.8	decreased by \$2,000 in fiscal year 2016 and		
645.9	by \$27,000 in fiscal year 2017.		
645.10	<u>(d) Group Residential Housing</u>	<u>(1,166,000)</u>	<u>(8,602,000)</u>
645.11	<u>(e) Medical Assistance</u>	<u>(3,950,000)</u>	<u>(6,420,000)</u>
645.12	<u>(f) Alternative Care</u>	<u>(7,386,000)</u>	<u>(6,851,000)</u>
645.13	<u>(g) Child and Community Service Grants</u>	<u>3,000,000</u>	<u>3,000,000</u>
645.14	<u>(h) Aging and Adult Services Grants</u>	<u>5,365,000</u>	<u>5,936,000</u>
645.15	<u>Gaps Analysis.</u> In fiscal year 2014, and		
645.16	in each even-numbered year thereafter,		
645.17	\$435,000 is appropriated to conduct an		
645.18	analysis of gaps in long-term care services		
645.19	under Minnesota Statutes, section 144A.351.		
645.20	This is a biennial appropriation. The base is		
645.21	increased by \$435,000 in fiscal year 2016.		
645.22	Notwithstanding any contrary provisions in		
645.23	this article, this provision does not expire.		
645.24	<u>Base Adjustment.</u> The general fund base is		
645.25	increased by \$498,000 in fiscal year 2016,		
645.26	and decreased by \$124,000 in fiscal year		
645.27	2017.		
645.28	<u>(i) Disabilities Grants</u>	<u>414,000</u>	<u>414,000</u>

645.29 **Sec. 3. FEDERAL APPROVAL.**

645.30 **(a) The implementation of this article and article 2 is contingent on federal approval.**

647.1	<u>Appropriations by Fund</u>	
647.2	<u>2013</u>	
647.3	<u>General Fund</u>	<u>(158,668,000)</u>
647.4	<u>Health Care Access</u>	<u>(7,179,000)</u>
647.5	<u>TANF</u>	<u>4,816,000</u>
647.6	<u>Subd. 2. Forecasted Programs</u>	
647.7	<u>(a) MFIP/DWP Grants</u>	
647.8	<u>Appropriations by Fund</u>	
647.9	<u>General Fund</u>	<u>(8,211,000)</u>
647.10	<u>TANF</u>	<u>4,399,000</u>
647.11	<u>(b) MFIP Child Care Assistance Grants</u>	<u>10,113,000</u>
647.12	<u>(c) General Assistance Grants</u>	<u>3,230,000</u>
647.13	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>(1,008,000)</u>
647.14	<u>(e) Group Residential Housing Grants</u>	<u>(5,423,000)</u>
647.15	<u>(f) MinnesotaCare Grants</u>	<u>(7,179,000)</u>
647.16	<u>This appropriation is from the health care</u>	
647.17	<u>access fund.</u>	
647.18	<u>(g) Medical Assistance Grants</u>	<u>(159,733,000)</u>
647.19	<u>(h) Alternative Care Grants</u>	<u>-0-</u>
647.20	<u>(i) CD Entitlement Grants</u>	<u>2,364,000</u>
647.21	<u>Subd. 3. Technical Activities</u>	<u>417,000</u>
647.22	<u>This appropriation is from the TANF fund.</u>	

647.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

647.24 **ARTICLE 17**

647.25 **NORTHSTAR CARE FOR CHILDREN**

647.26 Section 1. Minnesota Statutes 2012, section 256.0112, is amended by adding a
647.27 subdivision to read:

647.28 **Subd. 10. Contracts for child foster care services.** When local agencies negotiate
647.29 lead county contracts or purchase of service contracts for child foster care services, the
647.30 foster care maintenance payment made on behalf of the child shall follow the provisions of
647.31 Northstar Care for Children, chapter 256N. Foster care maintenance payments as defined

648.1 in section 256N.02, subdivision 15, represent costs for activities similar in nature to those
648.2 expected of parents and do not cover services rendered by the licensed or tribally approved
648.3 foster parent, facility, or administrative costs or fees. Payments made to foster parents
648.4 must follow the requirements of section 256N.26, subdivision 15. The legally responsible
648.5 agency must provide foster parents with the assessment and notice as specified in section
648.6 256N.24. The financially responsible agency is permitted to make additional payments for
648.7 specific services provided by the foster parents or facility, as permitted in section 256N.21,
648.8 subdivision 5. These additional payments are not considered foster care maintenance.

648.9 Sec. 2. Minnesota Statutes 2012, section 256.82, subdivision 2, is amended to read:

648.10 Subd. 2. **Foster care maintenance payments.** ~~Beginning January 1, 1986,~~ For the
648.11 purpose of foster care maintenance payments under title IV-E of the Social Security Act,
648.12 United States Code, title 42, sections 670 to 676, the county paying the maintenance
648.13 costs must be reimbursed for the costs from the federal money available for the purpose.
648.14 Beginning July 1, 1997, for the purposes of determining a child's eligibility under title
648.15 IV-E of the Social Security Act, the placing agency shall use AFDC requirements in
648.16 effect on July 16, 1996.

648.17 Sec. 3. Minnesota Statutes 2012, section 256.82, subdivision 3, is amended to read:

648.18 Subd. 3. **Setting foster care standard rates.** (a) The commissioner shall annually
648.19 establish minimum ~~standard maintenance~~ rates for foster care maintenance and including
648.20 supplemental difficulty of care payments for all children ~~in foster care~~ eligible for
648.21 Northstar Care for Children under chapter 256N.

648.22 (b) All children entering foster care on or after January 1, 2015, are eligible for
648.23 Northstar Care for Children under chapter 256N. Any increase in rates shall in no case
648.24 exceed three percent per annum.

648.25 (c) All children in foster care on December 31, 2014, must remain in the
648.26 pre-Northstar Care for Children foster care program under sections 256N.21, subdivision
648.27 6, and 260C.4411, subdivision 1. The rates for the pre-Northstar Care for Children foster
648.28 care program shall remain those in effect on January 1, 2013.

648.29 Sec. 4. **[256N.001] CITATION.**

648.30 Sections 256N.001 to 256N.28 may be cited as the "Northstar Care for Children Act."
648.31 Sections 256N.001 to 256N.28 establish Northstar Care for Children, which authorizes
648.32 certain benefits to support a child in need who is served by the Minnesota child welfare
648.33 system and who is the responsibility of the state, local county social service agencies, or

649.1 tribal social service agencies authorized under section 256.01, subdivision 14b, or are
649.2 otherwise eligible for federal adoption assistance. A child eligible under this chapter
649.3 has experienced a child welfare intervention that has resulted in the child being placed
649.4 away from the child's parents' care and is receiving foster care services consistent with
649.5 chapter 260B, 260C, or 260D, or is in the permanent care of relatives through a transfer of
649.6 permanent legal and physical custody, or in the permanent care of adoptive parents.

649.7 **Sec. 5. [256N.01] PUBLIC POLICY.**

649.8 (a) The legislature declares that the public policy of this state is to keep children safe
649.9 from harm and to ensure that when children suffer harmful or injurious experiences in
649.10 their lives, appropriate services are immediately available to keep them safe.

649.11 (b) Children do best in permanent, safe, nurturing homes where they can maintain
649.12 lifelong relationships with adults. Whenever safely possible, children are best served
649.13 when they can be nurtured and raised by their parents. Where services cannot be provided
649.14 to allow a child to remain safely at home, an out-of-home placement may be required.
649.15 When this occurs, reunification should be sought if it can be accomplished safely. When
649.16 it is not possible for parents to provide safety and permanency for their children, an
649.17 alternative permanent home must quickly be made available to the child, drawing from
649.18 kinship sources whenever possible.

649.19 (c) Minnesota understands the importance of having a comprehensive approach to
649.20 temporary out-of-home care and to permanent homes for children who cannot be reunited
649.21 with their families. It is critical that stable benefits be available to caregivers to ensure
649.22 that the child's needs can be met whether the child's situation and best interests call for
649.23 temporary foster care, transfer of permanent legal and physical custody to a relative, or
649.24 adoption. Northstar Care for Children focuses on the child's needs and strengths, and
649.25 the actual level of care provided by the caregiver, without consideration for the type of
649.26 placement setting. In this way caregivers are not faced with the burden of making specific
649.27 long-term decisions based upon competing financial incentives.

649.28 **Sec. 6. [256N.02] DEFINITIONS.**

649.29 Subdivision 1. **Scope.** For the purposes of sections 256N.001 to 256N.28, the terms
649.30 defined in this section have the meanings given them.

649.31 Subd. 2. **Adoption assistance.** "Adoption assistance" means medical coverage as
649.32 allowable under section 256B.055 and reimbursement of nonrecurring expenses associated
649.33 with adoption and may include financial support provided under agreement with the
649.34 financially responsible agency, the commissioner, and the parents of an adoptive child

650.1 whose special needs would otherwise make it difficult to place the child for adoption to
650.2 assist with the cost of caring for the child. Financial support may include a basic rate
650.3 payment and a supplemental difficulty of care rate.

650.4 Subd. 3. **Assessment.** "Assessment" means the process under section 256N.24 that
650.5 determines the benefits an eligible child may receive under section 256N.26.

650.6 Subd. 4. **At-risk child.** "At-risk child" means a child who does not have a
650.7 documented disability but who is at risk of developing a physical, mental, emotional, or
650.8 behavioral disability based on being related within the first or second degree to persons
650.9 who have an inheritable physical, mental, emotional, or behavioral disabling condition,
650.10 or from a background which has the potential to cause the child to develop a physical,
650.11 mental, emotional, or behavioral disability that the child is at risk of developing. The
650.12 disability must manifest during childhood.

650.13 Subd. 5. **Basic rate.** "Basic rate" means the maintenance payment made on behalf
650.14 of a child to support the costs caregivers incur to provide for a child's needs consistent with
650.15 the care parents customarily provide, including: food, clothing, shelter, daily supervision,
650.16 school supplies, and a child's personal incidentals. It also supports typical travel to the
650.17 child's home for visitation, and reasonable travel for the child to remain in the school in
650.18 which the child is enrolled at the time of placement.

650.19 Subd. 6. **Caregiver.** "Caregiver" means the foster parent or parents of a child in
650.20 foster care who meet the requirements of emergency relative placement, licensed foster
650.21 parents under chapter 245A, or foster parents licensed or approved by a tribe; the relative
650.22 custodian or custodians; or the adoptive parent or parents who have legally adopted a child.

650.23 Subd. 7. **Commissioner.** "Commissioner" means the commissioner of human
650.24 services or any employee of the Department of Human Services to whom the
650.25 commissioner has delegated appropriate authority.

650.26 Subd. 8. **County board.** "County board" means the board of county commissioners
650.27 in each county.

650.28 Subd. 9. **Disability.** "Disability" means a physical, mental, emotional, or behavioral
650.29 impairment that substantially limits one or more major life activities. Major life activities
650.30 include, but are not limited to: thinking, walking, hearing, breathing, working, seeing,
650.31 speaking, communicating, learning, developing and maintaining healthy relationships,
650.32 safely caring for oneself, and performing manual tasks. The nature, duration, and severity
650.33 of the impairment must be considered in determining if the limitation is substantial.

650.34 Subd. 10. **Financially responsible agency.** "Financially responsible agency" means
650.35 the agency that is financially responsible for a child. These agencies include both local
650.36 social service agencies under section 393.07 and tribal social service agencies authorized

651.1 in section 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative,
651.2 and Minnesota tribes who assume financial responsibility of children from other states.
651.3 Under Northstar Care for Children, the agency that is financially responsible at the time of
651.4 placement for foster care continues to be responsible under section 256N.27 for the local
651.5 share of any maintenance payments, even after finalization of the adoption of transfer of
651.6 permanent legal and physical custody of a child.

651.7 Subd. 11. **Guardianship assistance.** "Guardianship assistance" means medical
651.8 coverage, as allowable under section 256B.055, and reimbursement of nonrecurring
651.9 expenses associated with obtaining permanent legal and physical custody of a child, and
651.10 may include financial support provided under agreement with the financially responsible
651.11 agency, the commissioner, and the relative who has received a transfer of permanent legal
651.12 and physical custody of a child. Financial support may include a basic rate payment and a
651.13 supplemental difficulty of care rate to assist with the cost of caring for the child.

651.14 Subd. 12. **Human services board.** "Human services board" means a board
651.15 established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

651.16 Subd. 13. **Initial assessment.** "Initial assessment" means the assessment conducted
651.17 within the first 30 days of a child's initial placement into foster care under section
651.18 256N.24, subdivisions 4 and 5.

651.19 Subd. 14. **Legally responsible agency.** "Legally responsible agency" means the
651.20 Minnesota agency that is assigned responsibility for placement, care, and supervision
651.21 of the child through a court order, voluntary placement agreement, or voluntary
651.22 relinquishment. These agencies include local social service agencies under section 393.07,
651.23 tribal social service agencies authorized in section 256.01, subdivision 14b, and Minnesota
651.24 tribes that assume court jurisdiction when legal responsibility is transferred to the tribal
651.25 social service agency through a Minnesota district court order. A Minnesota local social
651.26 service agency is otherwise financially responsible.

651.27 Subd. 15. **Maintenance payments.** "Maintenance payments" means the basic
651.28 rate plus any supplemental difficulty of care rate under Northstar Care for Children. It
651.29 specifically does not include the cost of initial clothing allowance, payment for social
651.30 services, or administrative payments to a child-placing agency. Payments are paid
651.31 consistent with section 256N.26.

651.32 Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical
651.33 custody" means a transfer of permanent legal and physical custody to a relative ordered by
651.34 a Minnesota juvenile court under section 260C.515, subdivision 4, or for a child under
651.35 jurisdiction of a tribal court, a judicial determination under a similar provision in tribal
651.36 code which means that a relative will assume the duty and authority to provide care,

652.1 control, and protection of a child who is residing in foster care, and to make decisions
652.2 regarding the child's education, health care, and general welfare until adulthood.

652.3 Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment
652.4 through the process under section 256N.24 for a child who has been continuously eligible
652.5 for Northstar Care for Children, or when a child identified as an at-risk child (Level A)
652.6 under guardianship or adoption assistance has manifested the disability upon which
652.7 eligibility for the agreement was based according to section 256N.25, subdivision 3,
652.8 paragraph (b). A reassessment may be used to update an initial assessment, a special
652.9 assessment, or a previous reassessment.

652.10 Subd. 18. **Relative.** "Relative," as described in section 260C.007, subdivision 27,
652.11 means a person related to the child by blood, marriage, or adoption, or an individual who
652.12 is an important friend with whom the child has resided or had significant contact. For an
652.13 Indian child, relative includes members of the extended family as defined by the law or
652.14 custom of the Indian child's tribe or, in the absence of law or custom, nieces, nephews,
652.15 or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United
652.16 States Code, title 25, section 1903.

652.17 Subd. 19. **Relative custodian.** "Relative custodian" means a person to whom
652.18 permanent legal and physical custody of a child has been transferred under section
652.19 260C.515, subdivision 4, or for a child under jurisdiction of a tribal court, a judicial
652.20 determination under a similar provision in tribal code, which means that a relative will
652.21 assume the duty and authority to provide care, control, and protection of a child who is
652.22 residing in foster care, and to make decisions regarding the child's education, health
652.23 care, and general welfare until adulthood.

652.24 Subd. 20. **Special assessment.** "Special assessment" means an assessment
652.25 performed under section 256N.24 that determines the benefits that an eligible child may
652.26 receive under section 256N.26 at the time when a special assessment is required. A
652.27 special assessment is used when a child's status within Northstar Care is shifted from a
652.28 pre-Northstar Care program into Northstar Care for Children and when the commissioner
652.29 determines that a special assessment is appropriate instead of assigning the transition child
652.30 to a level under section 256N.28.

652.31 Subd. 21. **Supplemental difficulty of care rate.** "Supplemental difficulty of care
652.32 rate" means the supplemental payment under section 256N.26, if any, as determined by
652.33 the financially responsible agency or the state, based upon an assessment under section
652.34 256N.24. The rate must support activities consistent with the care a parent provides a child
652.35 with special needs and not the equivalent of a purchased service. The rate must consider
652.36 the capacity and intensity of the activities associated with parenting duties provided in

653.1 the home to nurture the child, preserve the child's connections, and support the child's
653.2 functioning in the home and community.

653.3 **Sec. 7. [256N.20] NORTHSTAR CARE FOR CHILDREN; GENERALLY.**

653.4 **Subdivision 1. Eligibility.** A child is eligible for Northstar Care for Children if
653.5 the child is eligible for:

653.6 (1) foster care under section 256N.21;

653.7 (2) guardianship assistance under section 256N.22; or

653.8 (3) adoption assistance under section 256N.23.

653.9 **Subd. 2. Assessments.** Except as otherwise specified, a child eligible for Northstar
653.10 Care for Children shall receive an assessment under section 256N.24.

653.11 **Subd. 3. Agreements.** When a child is eligible for guardianship assistance or
653.12 adoption assistance, negotiations with caregivers and the development of a written,
653.13 binding agreement must be conducted under section 256N.25.

653.14 **Subd. 4. Benefits and payments.** A child eligible for Northstar Care for Children is
653.15 entitled to benefits specified in section 256N.26, based primarily on assessments under
653.16 section 256N.24, and, if appropriate, negotiations and agreements under section 256N.25.
653.17 Although paid to the caregiver, these benefits must be considered benefits of the child
653.18 rather than of the caregiver.

653.19 **Subd. 5. Federal, state, and local shares.** The cost of Northstar Care for Children
653.20 must be shared among the federal government, state, counties of financial responsibility,
653.21 and certain tribes as specified in section 256N.27.

653.22 **Subd. 6. Administration and appeals.** The commissioner and financially
653.23 responsible agency, or other agency designated by the commissioner, shall administer
653.24 Northstar Care for Children according to section 256N.28. The notification and fair
653.25 hearing process applicable to this chapter is defined in section 256N.28.

653.26 **Subd. 7. Transition.** A child in foster care, relative custody assistance, or adoption
653.27 assistance prior to January 1, 2015, who remains with the same caregivers continues
653.28 to receive benefits under programs preceding Northstar Care for Children, unless the
653.29 child moves to a new foster care placement, permanency is obtained for the child, or the
653.30 commissioner initiates transition of a child receiving pre-Northstar Care for Children
653.31 relative custody assistance, guardianship assistance, or adoption assistance under this
653.32 chapter. Provisions for the transition to Northstar Care for Children for certain children in
653.33 preceding programs are specified in section 256N.28, subdivisions 2 and 7. Additional
653.34 provisions for children in: foster care are specified in section 256N.21, subdivision
653.35 6; relative custody assistance under section 257.85 are specified in section 256N.22,

654.1 subdivision 12; and adoption assistance under chapter 259A are specified in section
654.2 256N.23, subdivision 13.

654.3 **Sec. 8. [256N.21] ELIGIBILITY FOR FOSTER CARE BENEFITS.**

654.4 Subdivision 1. **General eligibility requirements.** (a) A child is eligible for foster
654.5 care benefits under this section if the child meets the requirements of subdivision 2 on
654.6 or after January 1, 2015.

654.7 (b) The financially responsible agency shall make a title IV-E eligibility determination
654.8 for all foster children meeting the requirements of subdivision 2, provided the agency has
654.9 such authority under the state title IV-E plan. To be eligible for title IV-E foster care, a child
654.10 must also meet any additional criteria specified in section 472 of the Social Security Act.

654.11 (c) Except as provided under section 256N.26, subdivision 1 or 6, the foster care
654.12 benefit to the child under this section must be determined under sections 256N.24 and
654.13 256N.26 through an individual assessment. Information from this assessment must be
654.14 used to determine a potential future benefit under guardianship assistance or adoption
654.15 assistance, if needed.

654.16 (d) When a child is eligible for additional services, subdivisions 3 and 4 govern
654.17 the co-occurrence of program eligibility.

654.18 Subd. 2. **Placement in foster care.** To be eligible for foster care benefits under this
654.19 section, the child must be in placement away from the child's legal parent or guardian and
654.20 all of the following criteria must be met:

654.21 (1) the legally responsible agency must have placement authority and care
654.22 responsibility, including for a child 18 years old or older and under age 21, who maintains
654.23 eligibility for foster care consistent with section 260C.451;

654.24 (2) the legally responsible agency must have authority to place the child with a
654.25 voluntary placement agreement or a court order, consistent with sections 260B.198,
654.26 260C.001, 260D.01, or continued eligibility consistent with section 260C.451; and

654.27 (3) the child must be placed in an emergency relative placement under section
654.28 245A.035, a licensed foster family setting, foster residence setting, or treatment foster
654.29 care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, a family
654.30 foster home licensed or approved by a tribal agency or, for a child 18 years old or older
654.31 and under age 21, an unlicensed supervised independent living setting approved by the
654.32 agency responsible for the youth's care.

654.33 Subd. 3. **Minor parent.** A child who is a minor parent in placement with the minor
654.34 parent's child in the same home is eligible for foster care benefits under this section. The

655.1 foster care benefit is limited to the minor parent, unless the legally responsible agency has
655.2 separate legal authority for placement of the minor parent's child.

655.3 Subd. 4. **Foster children ages 18 up to 21 placed in an unlicensed supervised**
655.4 **independent living setting.** A foster child 18 years old or older and under age 21 who
655.5 maintains eligibility consistent with section 260C.451 and who is placed in an unlicensed
655.6 supervised independent living setting shall receive the level of benefit under section
655.7 256N.26.

655.8 Subd. 5. **Excluded activities.** The basic and supplemental difficulty of care
655.9 payment represents costs for activities similar in nature to those expected of parents,
655.10 and does not cover services rendered by the licensed or tribally approved foster parent,
655.11 facility, or administrative costs or fees. The financially responsible agency may pay an
655.12 additional fee for specific services provided by the licensed foster parent or facility. A
655.13 foster parent or residence setting must distinguish such a service from the daily care of the
655.14 child as assessed through the process under section 256N.24.

655.15 Subd. 6. **Transition from pre-Northstar Care for Children program.** (a) Section
655.16 256.82 establishes the pre-Northstar Care for Children foster care program for all children
655.17 residing in family foster care on December 31, 2014. Unless transitioned under paragraph
655.18 (b), a child in foster care with the same caregiver receives benefits under this pre-Northstar
655.19 Care for Children foster care program.

655.20 (b) Transition from the pre-Northstar Care for Children foster care program to
655.21 Northstar Care for Children takes place on or after January 1, 2015, when the child:

655.22 (1) moves to a different foster home or unlicensed supervised independent living
655.23 setting;

655.24 (2) has permanent legal and physical custody transferred and, if applicable, meets
655.25 eligibility requirements in section 256N.22;

655.26 (3) is adopted and, if applicable, meets eligibility requirements in section 256N.23; or

655.27 (4) re-enters foster care after reunification or a trial home visit.

655.28 (c) Upon becoming eligible, a foster child must be assessed according to section
655.29 256N.24 and then transitioned into Northstar Care for Children according to section
655.30 256N.28.

655.31 Sec. 9. **[256N.22] GUARDIANSHIP ASSISTANCE ELIGIBILITY.**

655.32 Subdivision 1. **General eligibility requirements.** (a) To be eligible for guardianship
655.33 assistance under this section, there must be a judicial determination under section
655.34 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to a
655.35 relative is in the child's best interest. For a child under jurisdiction of a tribal court, a

656.1 judicial determination under a similar provision in tribal code indicating that a relative
656.2 will assume the duty and authority to provide care, control, and protection of a child who
656.3 is residing in foster care, and to make decisions regarding the child's education, health
656.4 care, and general welfare until adulthood, and that this is in the child's best interest is
656.5 considered equivalent. Additionally, a child must:

656.6 (1) have been removed from the child's home pursuant to a voluntary placement
656.7 agreement or court order;

656.8 (2)(i) have resided in foster care for at least six consecutive months in the home
656.9 of the prospective relative custodian; or

656.10 (ii) have received an exemption from the requirement in item (i) from the court
656.11 based on a determination that:

656.12 (A) an expedited move to permanency is in the child's best interest;

656.13 (B) expedited permanency cannot be completed without provision of guardianship
656.14 assistance; and

656.15 (C) the prospective relative custodian is uniquely qualified to meet the child's needs
656.16 on a permanent basis;

656.17 (3) meet the agency determinations regarding permanency requirements in
656.18 subdivision 2;

656.19 (4) meet the applicable citizenship and immigration requirements in subdivision 3;

656.20 (5) have been consulted regarding the proposed transfer of permanent legal and
656.21 physical custody to a relative, if the child is at least 14 years of age or is expected to attain
656.22 14 years of age prior to the transfer of permanent legal and physical custody; and

656.23 (6) have a written, binding agreement under section 256N.25 among the caregiver or
656.24 caregivers, the financially responsible agency, and the commissioner established prior to
656.25 transfer of permanent legal and physical custody.

656.26 (b) In addition to the requirements in paragraph (a), the child's prospective relative
656.27 custodian or custodians must meet the applicable background study requirements in
656.28 subdivision 4.

656.29 (c) To be eligible for title IV-E guardianship assistance, a child must also meet any
656.30 additional criteria in section 473(d) of the Social Security Act. The sibling of a child
656.31 who meets the criteria for title IV-E guardianship assistance in section 473(d) of the
656.32 Social Security Act is eligible for title IV-E guardianship assistance if the child and
656.33 sibling are placed with the same prospective relative custodian or custodians, and the
656.34 legally responsible agency, relatives, and commissioner agree on the appropriateness of
656.35 the arrangement for the sibling. A child who meets all eligibility criteria except those

657.1 specific to title IV-E guardianship assistance is entitled to guardianship assistance paid
657.2 through funds other than title IV-E.

657.3 Subd. 2. **Agency determinations regarding permanency.** (a) To be eligible for
657.4 guardianship assistance, the legally responsible agency must complete the following
657.5 determinations regarding permanency for the child prior to the transfer of permanent
657.6 legal and physical custody:

657.7 (1) a determination that reunification and adoption are not appropriate permanency
657.8 options for the child; and

657.9 (2) a determination that the child demonstrates a strong attachment to the prospective
657.10 relative custodian and the prospective relative custodian has a strong commitment to
657.11 caring permanently for the child.

657.12 (b) The legally responsible agency shall document the determinations in paragraph
657.13 (a) and the supporting information for completing each determination in the case file and
657.14 make them available for review as requested by the financially responsible agency and the
657.15 commissioner during the guardianship assistance eligibility determination process.

657.16 Subd. 3. **Citizenship and immigration status.** A child must be a citizen of the
657.17 United States or otherwise be eligible for federal public benefits according to the Personal
657.18 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order
657.19 to be eligible for guardianship assistance.

657.20 Subd. 4. **Background study.** (a) A background study under section 245C.33 must
657.21 be completed on each prospective relative custodian and any other adult residing in the
657.22 home of the prospective relative custodian. A background study on the prospective
657.23 relative custodian or adult residing in the household previously completed under section
657.24 245C.04 for the purposes of foster care licensure may be used for the purposes of this
657.25 section, provided that the background study is current at the time of the application for
657.26 guardianship assistance.

657.27 (b) If the background study reveals:

657.28 (1) a felony conviction at any time for:

657.29 (i) child abuse or neglect;

657.30 (ii) spousal abuse;

657.31 (iii) a crime against a child, including child pornography; or

657.32 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not
657.33 including other physical assault or battery; or

657.34 (2) a felony conviction within the past five years for:

657.35 (i) physical assault;

657.36 (ii) battery; or

658.1 (iii) a drug-related offense;
658.2 the prospective relative custodian is prohibited from receiving guardianship assistance
658.3 on behalf of an otherwise eligible child.

658.4 **Subd. 5. Responsibility for determining guardianship assistance eligibility.** The
658.5 commissioner shall determine eligibility for:

658.6 (1) a child under the legal custody or responsibility of a Minnesota county social
658.7 service agency who would otherwise remain in foster care;

658.8 (2) a Minnesota child under tribal court jurisdiction who would otherwise remain
658.9 in foster care; and

658.10 (3) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
658.11 in section 473(d) of the Social Security Act. The agency or entity assuming responsibility
658.12 for the child is responsible for the nonfederal share of the guardianship assistance payment.

658.13 **Subd. 6. Exclusions.** (a) A child with a guardianship assistance agreement under
658.14 Northstar Care for Children is not eligible for the Minnesota family investment program
658.15 child-only grant under chapter 256J.

658.16 (b) The commissioner shall not enter into a guardianship assistance agreement with:

658.17 (1) a child's biological parent;

658.18 (2) an individual assuming permanent legal and physical custody of a child or the
658.19 equivalent under tribal code without involvement of the child welfare system; or

658.20 (3) an individual assuming permanent legal and physical custody of a child who was
658.21 placed in Minnesota by another state or a tribe outside of Minnesota.

658.22 **Subd. 7. Guardianship assistance eligibility determination.** The financially
658.23 responsible agency shall prepare a guardianship assistance eligibility determination
658.24 for review and final approval by the commissioner. The eligibility determination must
658.25 be completed according to requirements and procedures and on forms prescribed by
658.26 the commissioner. Supporting documentation for the eligibility determination must be
658.27 provided to the commissioner. The financially responsible agency and the commissioner
658.28 must make every effort to establish a child's eligibility for title IV-E guardianship
658.29 assistance. A child who is determined to be eligible for guardianship assistance must
658.30 have a guardianship assistance agreement negotiated on the child's behalf according to
658.31 section 256N.25.

658.32 **Subd. 8. Termination of agreement.** (a) A guardianship assistance agreement must
658.33 be terminated in any of the following circumstances:

658.34 (1) the child has attained the age of 18, or up to age 21 when the child meets a
658.35 condition for extension in subdivision 11;

659.1 (2) the child has not attained the age of 18 years of age, but the commissioner
659.2 determines the relative custodian is no longer legally responsible for support of the child;

659.3 (3) the commissioner determines the relative custodian is no longer providing
659.4 financial support to the child up to age 21;

659.5 (4) the death of the child; or

659.6 (5) the relative custodian requests in writing termination of the guardianship
659.7 assistance agreement.

659.8 (b) A relative custodian is considered no longer legally responsible for support of
659.9 the child in any of the following circumstances:

659.10 (1) permanent legal and physical custody or guardianship of the child is transferred
659.11 to another individual;

659.12 (2) the death of the relative custodian under subdivision 9;

659.13 (3) the child enlists in the military;

659.14 (4) the child gets married; or

659.15 (5) the child is determined an emancipated minor through legal action.

659.16 Subd. 9. **Death of relative custodian or dissolution of custody.** The guardianship
659.17 assistance agreement ends upon death or dissolution of permanent legal and physical
659.18 custody of both relative custodians in the case of assignment of custody to two individuals,
659.19 or the sole relative custodian in the case of assignment of custody to one individual.
659.20 Guardianship assistance eligibility may be continued according to subdivision 10.

659.21 Subd. 10. **Assigning a child's guardianship assistance to a court-appointed**
659.22 **guardian or custodian.** (a) Guardianship assistance may be continued with the written
659.23 consent of the commissioner to an individual who is a guardian or custodian appointed by
659.24 a court for the child upon the death of both relative custodians in the case of assignment
659.25 of custody to two individuals, or the sole relative custodian in the case of assignment
659.26 of custody to one individual, unless the child is under the custody of a county, tribal,
659.27 or child-placing agency.

659.28 (b) Temporary assignment of guardianship assistance may be approved for a
659.29 maximum of six consecutive months from the death of the relative custodian or custodians
659.30 as provided in paragraph (a) and must adhere to the policies and procedures prescribed by
659.31 the commissioner. If a court has not appointed a permanent legal guardian or custodian
659.32 within six months, the guardianship assistance must terminate and must not be resumed.

659.33 (c) Upon assignment of assistance payments under this subdivision, assistance must
659.34 be provided from funds other than title IV-E.

659.35 Subd. 11. **Extension of guardianship assistance after age 18.** (a) Under the
659.36 circumstances outlined in paragraph (e), a child may qualify for extension of the

660.1 guardianship assistance agreement beyond the date the child attains age 18, up to the
660.2 date the child attains the age of 21.

660.3 (b) A request for extension of the guardianship assistance agreement must be
660.4 completed in writing and submitted, including all supporting documentation, by the
660.5 relative custodian to the commissioner at least 60 calendar days prior to the date that the
660.6 current agreement will terminate.

660.7 (c) A signed amendment to the current guardianship assistance agreement must be
660.8 fully executed between the relative custodian and the commissioner at least ten business
660.9 days prior to the termination of the current agreement. The request for extension and
660.10 the fully executed amendment must be made according to requirements and procedures
660.11 prescribed by the commissioner, including documentation of eligibility, and on forms
660.12 prescribed by the commissioner.

660.13 (d) If an agency is certifying a child for guardianship assistance and the child will
660.14 attain the age of 18 within 60 calendar days of submission, the request for extension must
660.15 be completed in writing and submitted, including all supporting documentation, with
660.16 the guardianship assistance application.

660.17 (e) A child who has attained the age of 16 prior to the effective date of the
660.18 guardianship assistance agreement is eligible for extension of the agreement up to the
660.19 date the child attains age 21 if the child:

660.20 (1) is dependent on the relative custodian for care and financial support; and

660.21 (2) meets at least one of the following conditions:

660.22 (i) is completing a secondary education program or a program leading to an
660.23 equivalent credential;

660.24 (ii) is enrolled in an institution which provides postsecondary or vocational education;

660.25 (iii) is participating in a program or activity designed to promote or remove barriers
660.26 to employment;

660.27 (iv) is employed for at least 80 hours per month; or

660.28 (v) is incapable of doing any of the activities described in items (i) to (iv) due to
660.29 a medical condition where incapability is supported by professional documentation
660.30 according to the requirements and procedures prescribed by the commissioner.

660.31 (f) A child who has not attained the age of 16 prior to the effective date of the
660.32 guardianship assistance agreement is eligible for extension of the guardianship assistance
660.33 agreement up to the date the child attains the age of 21 if the child is:

660.34 (1) dependent on the relative custodian for care and financial support; and

661.1 (2) possesses a physical or mental disability which impairs the capacity for
661.2 independent living and warrants continuation of financial assistance, as determined by
661.3 the commissioner.

661.4 Subd. 12. **Beginning guardianship assistance component of Northstar Care for**
661.5 **Children.** Effective November 27, 2014, a child who meets the eligibility criteria for
661.6 guardianship assistance in subdivision 1 may have a guardianship assistance agreement
661.7 negotiated on the child's behalf according to section 256N.25. The effective date of the
661.8 agreement must be January 1, 2015, or the date of the court order transferring permanent
661.9 legal and physical custody, whichever is later. Except as provided under section 256N.26,
661.10 subdivision 1, paragraph (c), the rate schedule for an agreement under this subdivision
661.11 is determined under section 256N.26 based on the age of the child on the date that the
661.12 prospective relative custodian signs the agreement.

661.13 Subd. 13. **Transition to guardianship assistance under Northstar Care for**
661.14 **Children.** The commissioner may execute guardianship assistance agreements for a child
661.15 with a relative custody agreement under section 257.85 executed on the child's behalf
661.16 on or before November 26, 2014, in accordance with the priorities outlined in section
661.17 256N.28, subdivision 7, paragraph (b). To facilitate transition into the guardianship
661.18 assistance program, the commissioner may waive any guardianship assistance eligibility
661.19 requirements for a child with a relative custody agreement under section 257.85 executed
661.20 on the child's behalf on or before November 26, 2014. Agreements negotiated under
661.21 this subdivision must be done according to the process outlined in section 256N.28,
661.22 subdivision 7. The maximum rate used in the negotiation process for an agreement under
661.23 this subdivision must be as outlined in section 256N.28, subdivision 7.

661.24 Sec. 10. **[256N.23] ADOPTION ASSISTANCE ELIGIBILITY.**

661.25 Subdivision 1. **General eligibility requirements.** (a) To be eligible for adoption
661.26 assistance under this section, a child must:

- 661.27 (1) be determined to be a child with special needs under subdivision 2;
661.28 (2) meet the applicable citizenship and immigration requirements in subdivision 3;
661.29 (3)(i) meet the criteria in section 473 of the Social Security Act; or
661.30 (ii) have had foster care payments paid on the child's behalf while in out-of-home
661.31 placement through the county or tribe and be either under the guardianship of the
661.32 commissioner or under the jurisdiction of a Minnesota tribe and adoption, according to
661.33 tribal law, is in the child's documented permanency plan; and
661.34 (4) have a written, binding agreement under section 256N.25 among the adoptive
661.35 parent, the financially responsible agency, or if there is no financially responsible agency,

662.1 the agency designated by the commissioner, and the commissioner established prior to
662.2 finalization of the adoption.

662.3 (b) In addition to the requirements in paragraph (a), an eligible child's adoptive parent
662.4 or parents must meet the applicable background study requirements in subdivision 4.

662.5 (c) A child who meets all eligibility criteria except those specific to title IV-E adoption
662.6 assistance shall receive adoption assistance paid through funds other than title IV-E.

662.7 Subd. 2. **Special needs determination.** (a) A child is considered a child with
662.8 special needs under this section if the requirements in paragraphs (b) to (g) are met.

662.9 (b) There must be a determination that the child must not or should not be returned
662.10 to the home of the child's parents as evidenced by:

662.11 (1) a court-ordered termination of parental rights;

662.12 (2) a petition to terminate parental rights;

662.13 (3) consent of parent to adoption accepted by the court under chapter 260C;

662.14 (4) in circumstances when tribal law permits the child to be adopted without a

662.15 termination of parental rights, a judicial determination by a tribal court indicating the valid
662.16 reason why the child cannot or should not return home;

662.17 (5) a voluntary relinquishment under section 259.25 or 259.47 or, if relinquishment
662.18 occurred in another state, the applicable laws in that state; or

662.19 (6) the death of the legal parent or parents if the child has two legal parents.

662.20 (c) There exists a specific factor or condition of which it is reasonable to conclude
662.21 that the child cannot be placed with adoptive parents without providing adoption
662.22 assistance as evidenced by:

662.23 (1) a determination by the Social Security Administration that the child meets all
662.24 medical or disability requirements of title XVI of the Social Security Act with respect to
662.25 eligibility for Supplemental Security Income benefits;

662.26 (2) a documented physical, mental, emotional, or behavioral disability not covered
662.27 under clause (1);

662.28 (3) a member of a sibling group being adopted at the same time by the same parent;

662.29 (4) an adoptive placement in the home of a parent who previously adopted a sibling
662.30 for whom they receive adoption assistance; or

662.31 (5) documentation that the child is an at-risk child.

662.32 (d) A reasonable but unsuccessful effort must have been made to place the child
662.33 with adoptive parents without providing adoption assistance as evidenced by:

662.34 (1) a documented search for an appropriate adoptive placement; or

662.35 (2) a determination by the commissioner that a search under clause (1) is not in the
662.36 best interests of the child.

663.1 (e) The requirement for a documented search for an appropriate adoptive placement
663.2 under paragraph (d), including the registration of the child with the state adoption
663.3 exchange and other recruitment methods under paragraph (f), must be waived if:

663.4 (1) the child is being adopted by a relative and it is determined by the child-placing
663.5 agency that adoption by the relative is in the best interests of the child;

663.6 (2) the child is being adopted by a foster parent with whom the child has developed
663.7 significant emotional ties while in the foster parent's care as a foster child and it is
663.8 determined by the child-placing agency that adoption by the foster parent is in the best
663.9 interests of the child; or

663.10 (3) the child is being adopted by a parent that previously adopted a sibling of the
663.11 child, and it is determined by the child-placing agency that adoption by this parent is
663.12 in the best interests of the child.

663.13 For an Indian child covered by the Indian Child Welfare Act, a waiver must not be
663.14 granted unless the child-placing agency has complied with the placement preferences
663.15 required by the Indian Child Welfare Act, United States Code, title 25, section 1915(a).

663.16 (f) To meet the requirement of a documented search for an appropriate adoptive
663.17 placement under paragraph (d), clause (1), the child-placing agency minimally must:

663.18 (1) conduct a relative search as required by section 260C.221 and give consideration
663.19 to placement with a relative, as required by section 260C.212, subdivision 2;

663.20 (2) comply with the placement preferences required by the Indian Child Welfare Act
663.21 when the Indian Child Welfare Act, United States Code, title 25, section 1915(a), applies;

663.22 (3) locate prospective adoptive families by registering the child on the state adoption
663.23 exchange, as required under section 259.75; and

663.24 (4) if registration with the state adoption exchange does not result in the identification
663.25 of an appropriate adoptive placement, the agency must employ additional recruitment
663.26 methods prescribed by the commissioner.

663.27 (g) Once the legally responsible agency has determined that placement with an
663.28 identified parent is in the child's best interests and made full written disclosure about the
663.29 child's social and medical history, the agency must ask the prospective adoptive parent if
663.30 the prospective adoptive parent is willing to adopt the child without receiving adoption
663.31 assistance under this section. If the identified parent is either unwilling or unable to
663.32 adopt the child without adoption assistance, the legally responsible agency must provide
663.33 documentation as prescribed by the commissioner to fulfill the requirement to make a
663.34 reasonable effort to place the child without adoption assistance. If the identified parent is
663.35 willing to adopt the child without adoption assistance, the parent must provide a written
663.36 statement to this effect to the legally responsible agency and the statement must be

664.1 maintained in the permanent adoption record of the legally responsible agency. For children
664.2 under guardianship of the commissioner, the legally responsible agency shall submit a copy
664.3 of this statement to the commissioner to be maintained in the permanent adoption record.

664.4 Subd. 3. **Citizenship and immigration status.** (a) A child must be a citizen of the
664.5 United States or otherwise eligible for federal public benefits according to the Personal
664.6 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to
664.7 be eligible for the title IV-E adoption assistance program.

664.8 (b) A child must be a citizen of the United States or meet the qualified alien
664.9 requirements as defined in the Personal Responsibility and Work Opportunity
664.10 Reconciliation Act of 1996, as amended, in order to be eligible for adoption assistance
664.11 paid through funds other than title IV-E.

664.12 Subd. 4. **Background study.** A background study under section 259.41 must be
664.13 completed on each prospective adoptive parent. If the background study reveals:

664.14 (1) a felony conviction at any time for:

664.15 (i) child abuse or neglect;

664.16 (ii) spousal abuse;

664.17 (iii) a crime against a child, including child pornography; or

664.18 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not
664.19 including other physical assault or battery; or

664.20 (2) a felony conviction within the past five years for:

664.21 (i) physical assault;

664.22 (ii) battery; or

664.23 (iii) a drug-related offense;

664.24 the adoptive parent is prohibited from receiving adoption assistance on behalf of an
664.25 otherwise eligible child.

664.26 Subd. 5. **Responsibility for determining adoption assistance eligibility.** The
664.27 commissioner must determine eligibility for:

664.28 (1) a child under the guardianship of the commissioner who would otherwise remain
664.29 in foster care;

664.30 (2) a child who is not under the guardianship of the commissioner who meets title
664.31 IV-E eligibility defined in section 473 of the Social Security Act and no state agency has
664.32 legal responsibility for placement and care of the child;

664.33 (3) a Minnesota child under tribal jurisdiction who would otherwise remain in foster
664.34 care; and

665.1 (4) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
665.2 in section 473 of the Social Security Act. The agency or entity assuming responsibility for
665.3 the child is responsible for the nonfederal share of the adoption assistance payment.

665.4 Subd. 6. **Exclusions.** The commissioner must not enter into an adoption assistance
665.5 agreement with the following individuals:

665.6 (1) a child's biological parent or stepparent;

665.7 (2) a child's relative under section 260C.007, subdivision 27, with whom the child
665.8 resided immediately prior to child welfare involvement unless:

665.9 (i) the child was in the custody of a Minnesota county or tribal agency pursuant to
665.10 an order under chapter 260C or equivalent provisions of tribal code and the agency had
665.11 placement and care responsibility for permanency planning for the child; and

665.12 (ii) the child is under guardianship of the commissioner of human services according
665.13 to the requirements of section 260C.325, subdivision 1 or 3, or is a ward of a Minnesota
665.14 tribal court after termination of parental rights, suspension of parental rights, or a finding
665.15 by the tribal court that the child cannot safely return to the care of the parent;

665.16 (3) an individual adopting a child who is the subject of a direct adoptive placement
665.17 under section 259.47 or the equivalent in tribal code;

665.18 (4) a child's legal custodian or guardian who is now adopting the child; or

665.19 (5) an individual who is adopting a child who is not a citizen or resident of the
665.20 United States and was either adopted in another country or brought to the United States
665.21 for the purposes of adoption.

665.22 Subd. 7. **Adoption assistance eligibility determination.** (a) The financially
665.23 responsible agency shall prepare an adoption assistance eligibility determination for
665.24 review and final approval by the commissioner. When there is no financially responsible
665.25 agency, the adoption assistance eligibility determination must be completed by the
665.26 agency designated by the commissioner. The eligibility determination must be completed
665.27 according to requirements and procedures and on forms prescribed by the commissioner.
665.28 The financially responsible agency and the commissioner shall make every effort to
665.29 establish a child's eligibility for title IV-E adoption assistance. Documentation from a
665.30 qualified expert for the eligibility determination must be provided to the commissioner
665.31 to verify that a child meets the special needs criteria in subdivision 2. A child who
665.32 is determined to be eligible for adoption assistance must have an adoption assistance
665.33 agreement negotiated on the child's behalf according to section 256N.25.

665.34 (b) Documentation from a qualified expert of a disability is limited to evidence
665.35 deemed appropriate by the commissioner and must be submitted to the commissioner with
665.36 the eligibility determination. Examples of appropriate documentation include, but are not

666.1 limited to, medical records, psychological assessments, educational or early childhood
666.2 evaluations, court findings, and social and medical history.

666.3 (c) Documentation that the child is at risk of developing physical, mental, emotional,
666.4 or behavioral disabilities must be submitted according to policies and procedures
666.5 prescribed by the commissioner.

666.6 Subd. 8. **Termination of agreement.** (a) An adoption assistance agreement must
666.7 terminate in any of the following circumstances:

666.8 (1) the child has attained the age of 18, or up to age 21 when the child meets a
666.9 condition for extension in subdivision 12;

666.10 (2) the child has not attained the age of 18, but the commissioner determines the
666.11 adoptive parent is no longer legally responsible for support of the child;

666.12 (3) the commissioner determines the adoptive parent is no longer providing financial
666.13 support to the child up to age 21;

666.14 (4) the death of the child; or

666.15 (5) the adoptive parent requests in writing the termination of the adoption assistance
666.16 agreement.

666.17 (b) An adoptive parent is considered no longer legally responsible for support of the
666.18 child in any of the following circumstances:

666.19 (1) parental rights to the child are legally terminated or a court accepted the parent's
666.20 consent to adoption under chapter 260C;

666.21 (2) permanent legal and physical custody or guardianship of the child is transferred
666.22 to another individual;

666.23 (3) death of the adoptive parent under subdivision 9;

666.24 (4) the child enlists in the military;

666.25 (5) the child gets married; or

666.26 (6) the child is determined an emancipated minor through legal action.

666.27 Subd. 9. **Death of adoptive parent or adoption dissolution.** The adoption
666.28 assistance agreement ends upon death or termination of parental rights of both adoptive
666.29 parents in the case of a two-parent adoption, or the sole adoptive parent in the case of
666.30 a single-parent adoption. The child's adoption assistance eligibility may be continued
666.31 according to subdivision 10.

666.32 Subd. 10. **Continuing a child's title IV-E adoption assistance in a subsequent**
666.33 **adoption.** (a) The child maintains eligibility for title IV-E adoption assistance in a
666.34 subsequent adoption if the following criteria are met:

666.35 (1) the child is determined to be a child with special needs as outlined in subdivision
666.36 2; and

667.1 (2) the subsequent adoptive parent resides in Minnesota.

667.2 (b) If a child had a title IV-E adoption assistance agreement in effect prior to the
667.3 death of the adoptive parent or dissolution of the adoption, and the subsequent adoptive
667.4 parent resides outside of Minnesota, the commissioner is not responsible for determining
667.5 whether the child meets the definition of special needs, entering into the adoption
667.6 assistance agreement, and making any adoption assistance payments outlined in the new
667.7 agreement unless a state agency in Minnesota has responsibility for placement and care of
667.8 the child at the time of the subsequent adoption. If there is no state agency in Minnesota
667.9 that has responsibility for placement and care of the child at the time of the subsequent
667.10 adoption, the public child welfare agency in the subsequent adoptive parent's residence is
667.11 responsible for determining whether the child meets the definition of special needs and
667.12 entering into the adoption assistance agreement.

667.13 Subd. 11. **Assigning a child's adoption assistance to a court-appointed guardian**
667.14 **or custodian.** (a) State-funded adoption assistance may be continued with the written
667.15 consent of the commissioner to an individual who is a guardian appointed by a court for
667.16 the child upon the death of both the adoptive parents in the case of a two-parent adoption,
667.17 or the sole adoptive parent in the case of a single-parent adoption, unless the child is
667.18 under the custody of a state agency.

667.19 (b) Temporary assignment of adoption assistance may be approved by the
667.20 commissioner for a maximum of six consecutive months from the death of the adoptive
667.21 parent or parents under subdivision 9 and must adhere to the requirements and procedures
667.22 prescribed by the commissioner. If, within six months, the child has not been adopted by a
667.23 person agreed upon by the commissioner, or a court has not appointed a permanent legal
667.24 guardian under section 260C.325, 525.5-313, or similar law of another jurisdiction, the
667.25 adoption assistance must terminate.

667.26 (c) Upon assignment of payments under this subdivision, assistance must be from
667.27 funds other than title IV-E.

667.28 Subd. 12. **Extension of adoption assistance agreement.** (a) Under certain limited
667.29 circumstances a child may qualify for extension of the adoption assistance agreement
667.30 beyond the date the child attains age 18, up to the date the child attains the age of 21.

667.31 (b) A request for extension of the adoption assistance agreement must be completed
667.32 in writing and submitted, including all supporting documentation, by the adoptive parent
667.33 to the commissioner at least 60 calendar days prior to the date that the current agreement
667.34 will terminate.

667.35 (c) A signed amendment to the current adoption assistance agreement must be
667.36 fully executed between the adoptive parent and the commissioner at least ten business

668.1 days prior to the termination of the current agreement. The request for extension and the
668.2 fully executed amendment must be made according to the requirements and procedures
668.3 prescribed by the commissioner, including documentation of eligibility, on forms
668.4 prescribed by the commissioner.

668.5 (d) If an agency is certifying a child for adoption assistance and the child will attain
668.6 the age of 18 within 60 calendar days of submission, the request for extension must be
668.7 completed in writing and submitted, including all supporting documentation, with the
668.8 adoption assistance application.

668.9 (e) A child who has attained the age of 16 prior to the finalization of the child's
668.10 adoption is eligible for extension of the adoption assistance agreement up to the date the
668.11 child attains age 21 if the child is:

668.12 (1) dependent on the adoptive parent for care and financial support; and

668.13 (2)(i) completing a secondary education program or a program leading to an
668.14 equivalent credential;

668.15 (ii) enrolled in an institution that provides postsecondary or vocational education;

668.16 (iii) participating in a program or activity designed to promote or remove barriers to
668.17 employment;

668.18 (iv) employed for at least 80 hours per month; or

668.19 (v) incapable of doing any of the activities described in items (i) to (iv) due to
668.20 a medical condition where incapability is supported by documentation from an expert
668.21 according to the requirements and procedures prescribed by the commissioner.

668.22 (f) A child who has not attained the age of 16 prior to finalization of the child's
668.23 adoption is eligible for extension of the adoption assistance agreement up to the date the
668.24 child attains the age of 21 if the child is:

668.25 (1) dependent on the adoptive parent for care and financial support; and

668.26 (2)(i) enrolled in a secondary education program or a program leading to the
668.27 equivalent; or

668.28 (ii) possesses a physical or mental disability that impairs the capacity for independent
668.29 living and warrants continuation of financial assistance as determined by the commissioner.

668.30 **Subd. 13. Beginning adoption assistance under Northstar Care for Children.**

668.31 Effective November 27, 2014, a child who meets the eligibility criteria for adoption
668.32 assistance in subdivision 1, may have an adoption assistance agreement negotiated on
668.33 the child's behalf according to section 256N.25, and the effective date of the agreement
668.34 must be January 1, 2015, or the date of the court order finalizing the adoption, whichever
668.35 is later. Except as provided under section 256N.26, subdivision 1, paragraph (c), the
668.36 maximum rate schedule for the agreement must be determined according to section

669.1 256N.26 based on the age of the child on the date that the prospective adoptive parent or
669.2 parents sign the agreement.

669.3 **Subd. 14. Transition to adoption assistance under Northstar Care for Children.**

669.4 The commissioner may offer adoption assistance agreements under this chapter to a
669.5 child with an adoption assistance agreement under chapter 259A executed on the child's
669.6 behalf on or before November 26, 2014, according to the priorities outlined in section
669.7 256N.28, subdivision 7, paragraph (b). To facilitate transition into the Northstar Care for
669.8 Children adoption assistance program, the commissioner has the authority to waive any
669.9 Northstar Care for Children adoption assistance eligibility requirements for a child with
669.10 an adoption assistance agreement under chapter 259A executed on the child's behalf on
669.11 or before November 26, 2014. Agreements negotiated under this subdivision must be in
669.12 accordance with the process in section 256N.28, subdivision 7. The maximum rate used in
669.13 the negotiation process for an agreement under this subdivision must be as outlined in
669.14 section 256N.28, subdivision 7.

669.15 **Sec. 11. [256N.24] ASSESSMENTS.**

669.16 **Subdivision 1. Assessment.** (a) Each child eligible under sections 256N.21,
669.17 256N.22, and 256N.23, must be assessed to determine the benefits the child may receive
669.18 under section 256N.26, in accordance with the assessment tool, process, and requirements
669.19 specified in subdivision 2.

669.20 (b) If an agency applies the emergency foster care rate for initial placement under
669.21 section 256N.26, the agency may wait up to 30 days to complete the initial assessment.

669.22 (c) Unless otherwise specified in paragraph (d), a child must be assessed at the basic
669.23 level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

669.24 (d) An assessment must not be completed for:

669.25 (1) a child eligible for guardianship assistance under section 256N.22 or adoption
669.26 assistance under section 256N.23 who is determined to be an at-risk child. A child under
669.27 this clause must be assigned level A under section 256N.26, subdivision 1; and

669.28 (2) a child transitioning into Northstar Care for Children under section 256N.28,
669.29 subdivision 7, unless the commissioner determines an assessment is appropriate.

669.30 **Subd. 2. Establishment of assessment tool, process, and requirements.** Consistent
669.31 with sections 256N.001 to 256N.28, the commissioner shall establish an assessment tool
669.32 to determine the basic and supplemental difficulty of care, and shall establish the process
669.33 to be followed and other requirements, including appropriate documentation, when
669.34 conducting the initial assessment of a child entering Northstar Care for Children or when
669.35 the special assessment and reassessments may be needed for children continuing in the

670.1 program. The assessment tool must take into consideration the strengths and needs of the
670.2 child and the extra parenting provided by the caregiver to meet the child's needs.

670.3 Subd. 3. **Child care allowance portion of assessment.** (a) The assessment tool
670.4 established under subdivision 2 must include consideration of the caregiver's need for
670.5 child care under this subdivision, with greater consideration for children of younger ages.

670.6 (b) The child's assessment must include consideration of the caregiver's need for
670.7 child care if the following criteria are met:

670.8 (1) the child is under age 13;

670.9 (2) all available adult caregivers are employed or attending educational or vocational
670.10 training programs; and

670.11 (3) the caregiver does not receive child care assistance for the child under chapter
670.12 119B.

670.13 (c) For children younger than seven years of age, the level determined by the
670.14 non-child care portions of the assessment must be adjusted based on the average number
670.15 of hours child care is needed each week due to employment or attending a training or
670.16 educational program as follows:

670.17 (1) fewer than ten hours or if the caregiver is participating in the child care assistance
670.18 program under chapter 119B, no adjustment;

670.19 (2) ten to 19 hours or if needed during school summer vacation or equivalent only,
670.20 increase one level;

670.21 (3) 20 to 29 hours, increase two levels;

670.22 (4) 30 to 39 hours, increase three levels; and

670.23 (5) 40 or more hours, increase four levels.

670.24 (d) For children at least seven years of age but younger than 13, the level determined
670.25 by the non-child care portions of the assessment must be adjusted based on the average
670.26 number of hours child care is needed each week due to employment or attending a training
670.27 or educational program as follows:

670.28 (1) fewer than 20 hours, needed during school summer vacation or equivalent only,
670.29 or if the caregiver is participating in the child care assistance program under chapter
670.30 119B, no adjustment;

670.31 (2) 20 to 39 hours, increase one level; and

670.32 (3) 40 or more hours, increase two levels.

670.33 (e) When the child attains the age of seven, the child care allowance must be reduced
670.34 by reducing the level to that available under paragraph (d). For children in foster care,
670.35 benefits under section 256N.26 must be automatically reduced when the child turns seven.
670.36 For children who receive guardianship assistance or adoption assistance, agreements must

671.1 include similar provisions to ensure that the benefit provided to these children does not
671.2 exceed the benefit provided to children in foster care.

671.3 (f) When the child attains the age of 13, the child care allowance must be eliminated
671.4 by reducing the level to that available prior to any consideration of the caregiver's need
671.5 for child care. For children in foster care, benefits under section 256N.26 must be
671.6 automatically reduced when the child attains the age of 13. For children who receive
671.7 guardianship assistance or adoption assistance, agreements must include similar provisions
671.8 to ensure that the benefit provided to these children does not exceed the benefit provided
671.9 to children in foster care.

671.10 (g) The child care allowance under this subdivision is not available to caregivers
671.11 who receive the child care assistance under chapter 119B. A caregiver receiving a child
671.12 care allowance under this subdivision must notify the commissioner if the caregiver
671.13 subsequently receives the child care assistance program under chapter 119B, and the
671.14 level must be reduced to that available prior to any consideration of the caregiver's need
671.15 for child care.

671.16 (h) In establishing the assessment tool under subdivision 2, the commissioner must
671.17 design the tool so that the levels applicable to the non-child care portions of the assessment
671.18 at a given age accommodate the requirements of this subdivision.

671.19 Subd. 4. **Extraordinary levels.** (a) The assessment tool established under
671.20 subdivision 2 must provide a mechanism through which up to five levels can be added
671.21 to the supplemental difficulty of care for a particular child under section 256N.26,
671.22 subdivision 4. In establishing the assessment tool, the commissioner must design the tool
671.23 so that the levels applicable to the portions of the assessment other than the extraordinary
671.24 levels can accommodate the requirements of this subdivision.

671.25 (b) These extraordinary levels are available when all of the following circumstances
671.26 apply:

671.27 (1) the child has extraordinary needs as determined by the assessment tool provided
671.28 for under subdivision 2, and the child meets other requirements established by the
671.29 commissioner, such as a minimum score on the assessment tool;

671.30 (2) the child's extraordinary needs require extraordinary care and intense supervision
671.31 that is provided by the child's caregiver as part of the parental duties as described in the
671.32 supplemental difficulty of care rate, section 256N.02, subdivision 21. This extraordinary
671.33 care provided by the caregiver is required so that the child can be safely cared for in the
671.34 home and community, and prevents residential placement;

672.1 (3) the child is physically living in a foster family setting, as defined in Minnesota
672.2 Rules, part 2960.3010, subpart 23, or physically living in the home with the adoptive
672.3 parent or relative custodian; and

672.4 (4) the child is receiving the services for which the child is eligible through medical
672.5 assistance programs or other programs that provide necessary services for children with
672.6 disabilities or other medical and behavioral conditions to live with the child's family, but
672.7 the agency with caregiver's input has identified a specific support gap that cannot be met
672.8 through home and community support waivers or other programs that are designed to
672.9 provide support for children with special needs.

672.10 (c) The agency completing an assessment, under subdivision 2, that suggests an
672.11 extraordinary level must document as part of the assessment, the following:

672.12 (1) the assessment tool that determined that the child's needs or disabilities require
672.13 extraordinary care and intense supervision;

672.14 (2) a summary of the extraordinary care and intense supervision that is provided by
672.15 the caregiver as part of the parental duties as described in the supplemental difficulty of
672.16 care rate, section 256N.02, subdivision 21;

672.17 (3) confirmation that the child is currently physically residing in the foster family
672.18 setting or in the home with the adoptive parent or relative custodian;

672.19 (4) the efforts of the agency, caregiver, parents, and others to request support services
672.20 in the home and community that would ease the degree of parental duties provided by the
672.21 caregiver for the care and supervision of the child. This would include documentation of
672.22 the services provided for the child's needs or disabilities, and the services that were denied
672.23 or not available from the local social service agency, community agency, the local school
672.24 district, local public health department, the parent or child's medical insurance provider;

672.25 (5) the specific support gap identified that places the child's safety and well-being at
672.26 risk in the home or community and is necessary to prevent residential placement; and

672.27 (6) the extraordinary care and intense supervision provided by the foster, adoptive,
672.28 or guardianship caregivers to maintain the child safely in the child's home and prevent
672.29 residential placement that cannot be supported by medical assistance or other programs
672.30 that provide services, necessary care for children with disabilities, or other medical or
672.31 behavioral conditions in the home or community.

672.32 (d) An agency completing an assessment under subdivision 2 that suggests
672.33 an extraordinary level is appropriate must forward the assessment and required
672.34 documentation to the commissioner. If the commissioner approves, the extraordinary
672.35 levels must be retroactive to the date the assessment was forwarded.

673.1 Subd. 5. **Timing of initial assessment.** For a child entering Northstar Care for
673.2 Children under section 256N.21, the initial assessment must be completed within 30
673.3 days after the child is placed in foster care.

673.4 Subd. 6. **Completion of initial assessment.** (a) The assessment must be completed
673.5 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
673.6 required to complete the assessment.

673.7 (b) Initial assessments are completed for foster children, eligible under section
673.8 256N.21.

673.9 (c) The initial assessment must be completed by the financially responsible agency,
673.10 in consultation with the legally responsible agency if different, within 30 days of the
673.11 child's placement in foster care.

673.12 (d) If the foster parent is unable or unwilling to cooperate with the assessment process,
673.13 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3.

673.14 (e) Notice to the foster parent shall be provided as specified in subdivision 12.

673.15 Subd. 7. **Timing of special assessment.** (a) A special assessment is required as part
673.16 of the negotiation of the guardianship assistance agreement under section 256N.22 if:

673.17 (1) the child was not placed in foster care with the prospective relative custodian
673.18 or custodians prior to the negotiation of the guardianship assistance agreement under
673.19 section 256N.25; or

673.20 (2) any requirement for reassessment under subdivision 8 is met.

673.21 (b) A special assessment is required as part of the negotiation of the adoption
673.22 assistance agreement under section 256N.23 if:

673.23 (1) the child was not placed in foster care with the prospective adoptive parent
673.24 or parents prior to the negotiation of the adoption assistance agreement under section
673.25 256N.25; or

673.26 (2) any requirement for reassessment under subdivision 8 is met.

673.27 (c) A special assessment is required when a child transitions from a pre-Northstar
673.28 Care for Children program into Northstar Care for Children if the commissioner
673.29 determines that a special assessment is appropriate instead of assigning the transition child
673.30 to a level under section 256N.28.

673.31 (d) The special assessment must be completed prior to the establishment of a
673.32 guardianship assistance or adoption assistance agreement on behalf of the child.

673.33 Subd. 8. **Completing the special assessment.** (a) The special assessment must
673.34 be completed in consultation with the child's caregiver. Face-to-face contact with the
673.35 caregiver is not required to complete the special assessment.

674.1 (b) If a new special assessment is required prior to the effective date of the
674.2 guardianship assistance agreement, it must be completed by the financially responsible
674.3 agency, in consultation with the legally responsible agency if different. If the prospective
674.4 relative custodian is unable or unwilling to cooperate with the special assessment process,
674.5 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3,
674.6 unless the child is known to be an at-risk child, in which case, the child shall be assigned
674.7 level A under section 256N.26, subdivision 1.

674.8 (c) If a special assessment is required prior to the effective date of the adoption
674.9 assistance agreement, it must be completed by the financially responsible agency, in
674.10 consultation with the legally responsible agency if different. If there is no financially
674.11 responsible agency, the special assessment must be completed by the agency designated by
674.12 the commissioner. If the prospective adoptive parent is unable or unwilling to cooperate
674.13 with the special assessment process, the child must be assigned the basic level, level B
674.14 under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in
674.15 which case, the child shall be assigned level A under section 256N.26, subdivision 1.

674.16 (d) Notice to the prospective relative custodians or prospective adoptive parents
674.17 must be provided as specified in subdivision 12.

674.18 Subd. 9. **Timing of and requests for reassessments.** Reassessments for an eligible
674.19 child must be completed within 30 days of any of the following events:

674.20 (1) for a child in continuous foster care, when six months have elapsed since
674.21 completion of the last assessment;

674.22 (2) for a child in continuous foster care, change of placement location;

674.23 (3) for a child in foster care, at the request of the financially responsible agency or
674.24 legally responsible agency;

674.25 (4) at the request of the commissioner; or

674.26 (5) at the request of the caregiver under subdivision 9.

674.27 Subd. 10. **Caregiver requests for reassessments.** (a) A caregiver may initiate
674.28 a reassessment request for an eligible child in writing to the financially responsible
674.29 agency or, if there is no financially responsible agency, the agency designated by the
674.30 commissioner. The written request must include the reason for the request and the
674.31 name, address, and contact information of the caregivers. For an eligible child with a
674.32 guardianship assistance or adoption assistance agreement, the caregiver may request a
674.33 reassessment if at least six months have elapsed since any previously requested review.
674.34 For an eligible foster child, a foster parent may request reassessment in less than six
674.35 months with written documentation that there have been significant changes in the child's
674.36 needs that necessitate an earlier reassessment.

675.1 (b) A caregiver may request a reassessment of an at-risk child for whom a
675.2 guardianship assistance or adoption assistance agreement has been executed if the
675.3 caregiver has satisfied the commissioner with written documentation from a qualified
675.4 expert that the potential disability upon which eligibility for the agreement was based has
675.5 manifested itself, consistent with section 256N.25, subdivision 3, paragraph (b).

675.6 (c) If the reassessment cannot be completed within 30 days of the caregiver's request,
675.7 the agency responsible for reassessment must notify the caregiver of the reason for the
675.8 delay and a reasonable estimate of when the reassessment can be completed.

675.9 Subd. 11. **Completion of reassessment.** (a) The reassessment must be completed
675.10 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
675.11 required to complete the reassessment.

675.12 (b) For foster children eligible under section 256N.21, reassessments must be
675.13 completed by the financially responsible agency, in consultation with the legally
675.14 responsible agency if different.

675.15 (c) If reassessment is required after the effective date of the guardianship assistance
675.16 agreement, the reassessment must be completed by the financially responsible agency.

675.17 (d) If a reassessment is required after the effective date of the adoption assistance
675.18 agreement, it must be completed by the financially responsible agency or, if there is no
675.19 financially responsible agency, the agency designated by the commissioner.

675.20 (e) If the child's caregiver is unable or unwilling to cooperate with the reassessment,
675.21 the child must be assessed at level B under section 256N.26, subdivision 3, unless the
675.22 child has an adoption assistance or guardianship assistance agreement in place and is
675.23 known to be an at-risk child, in which case the child must be assessed at level A under
675.24 section 256N.26, subdivision 1.

675.25 Subd. 12. **Approval of initial assessments, special assessments, and**
675.26 **reassessments.** (a) Any agency completing initial assessments, special assessments, or
675.27 reassessments must designate one or more supervisors or other staff to examine and approve
675.28 assessments completed by others in the agency under subdivision 2. The person approving
675.29 an assessment must not be the case manager or staff member completing that assessment.

675.30 (b) In cases where a special assessment or reassessment for guardian assistance
675.31 and adoption assistance is required under subdivision 7 or 10, the commissioner shall
675.32 review and approve the assessment as part of the eligibility determination process outlined
675.33 in section 256N.22, subdivision 7, for guardianship assistance, or section 256N.23,
675.34 subdivision 7, for adoption assistance. The assessment determines the maximum for the
675.35 negotiated agreement amount under section 256N.25.

676.1 (c) The new rate is effective the calendar month that the assessment is approved,
676.2 or the effective date of the agreement, whichever is later.

676.3 Subd. 13. **Notice for caregiver.** (a) The agency as defined in subdivision 5 or 10
676.4 that is responsible for completing the initial assessment or reassessment must provide the
676.5 child's caregiver with written notice of the initial assessment or reassessment.

676.6 (b) Initial assessment notices must be sent within 15 days of completion of the initial
676.7 assessment and must minimally include the following:

676.8 (1) a summary of the child's completed individual assessment used to determine the
676.9 initial rating;

676.10 (2) statement of rating and benefit level;

676.11 (3) statement of the circumstances under which the agency must reassess the child;

676.12 (4) procedure to seek reassessment;

676.13 (5) notice that the caregiver has the right to a fair hearing review of the assessment
676.14 and how to request a fair hearing, consistent with section 256.045, subdivision 3; and

676.15 (6) the name, telephone number, and e-mail, if available, of a contact person at the
676.16 agency completing the assessment.

676.17 (c) Reassessment notices must be sent within 15 days after the completion of the
676.18 reassessment and must minimally include the following:

676.19 (1) a summary of the child's individual assessment used to determine the new rating;

676.20 (2) any change in rating and its effective date;

676.21 (3) procedure to seek reassessment;

676.22 (4) notice that if a change in rating results in a reduction of benefits, the caregiver
676.23 has the right to a fair hearing review of the assessment and how to request a fair hearing
676.24 consistent with section 256.045, subdivision 3;

676.25 (5) notice that a caregiver who requests a fair hearing of the reassessed rating within
676.26 ten days may continue at the current rate pending the hearing, but the agency may recover
676.27 any overpayment; and

676.28 (6) name, telephone number, and e-mail, if available, of a contact person at the
676.29 agency completing the reassessment.

676.30 (d) Notice is not required for special assessments since the notice is part of the
676.31 guardianship assistance or adoption assistance negotiated agreement completed according
676.32 to section 256N.25.

676.33 Subd. 14. **Assessment tool determines rate of benefits.** The assessment tool
676.34 established by the commissioner in subdivision 2 determines the monthly benefit level
676.35 for children in foster care. The monthly payment for guardian assistance or adoption

677.1 assistance may be negotiated up to the monthly benefit level under foster care for those
677.2 children eligible for a payment under section 256N.26, subdivision 1.

677.3 Sec. 12. **[256N.25] AGREEMENTS.**

677.4 Subdivision 1. **Agreement; guardianship assistance; adoption assistance.** (a)
677.5 In order to receive guardianship assistance or adoption assistance benefits on behalf of
677.6 an eligible child, a written, binding agreement between the caregiver or caregivers, the
677.7 financially responsible agency, or, if there is no financially responsible agency, the agency
677.8 designated by the commissioner, and the commissioner must be established prior to
677.9 finalization of the adoption or a transfer of permanent legal and physical custody. The
677.10 agreement must be negotiated with the caregiver or caregivers under subdivision 2.

677.11 (b) The agreement must be on a form approved by the commissioner and must
677.12 specify the following:

677.13 (1) duration of the agreement;

677.14 (2) the nature and amount of any payment, services, and assistance to be provided
677.15 under such agreement;

677.16 (3) the child's eligibility for Medicaid services;

677.17 (4) the terms of the payment, including any child care portion as specified in section
677.18 256N.24, subdivision 3;

677.19 (5) eligibility for reimbursement of nonrecurring expenses associated with adopting
677.20 or obtaining permanent legal and physical custody of the child, to the extent that the
677.21 total cost does not exceed \$2,000 per child;

677.22 (6) that the agreement must remain in effect regardless of the state of which the
677.23 adoptive parents or relative custodians are residents at any given time;

677.24 (7) provisions for modification of the terms of the agreement, including renegotiation
677.25 of the agreement; and

677.26 (8) the effective date of the agreement.

677.27 (c) The caregivers, the commissioner, and the financially responsible agency, or, if
677.28 there is no financially responsible agency, the agency designated by the commissioner, must
677.29 sign the agreement. A copy of the signed agreement must be given to each party. Once
677.30 signed by all parties, the commissioner shall maintain the official record of the agreement.

677.31 (d) The effective date of the guardianship assistance agreement must be the date of the
677.32 court order that transfers permanent legal and physical custody to the relative. The effective
677.33 date of the adoption assistance agreement is the date of the finalized adoption decree.

677.34 (e) Termination or disruption of the preadoptive placement or the foster care
677.35 placement prior to assignment of custody makes the agreement with that caregiver void.

678.1 Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible
678.2 for guardianship assistance or adoption assistance, the financially responsible agency, or,
678.3 if there is no financially responsible agency, the agency designated by the commissioner,
678.4 must negotiate with the caregiver to develop an agreement under subdivision 1. If and when
678.5 the caregiver and agency reach concurrence as to the terms of the agreement, both parties
678.6 shall sign the agreement. The agency must submit the agreement, along with the eligibility
678.7 determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to
678.8 the commissioner for final review, approval, and signature according to subdivision 1.

678.9 (b) A monthly payment is provided as part of the adoption assistance or guardianship
678.10 assistance agreement to support the care of children unless the child is determined to be an
678.11 at-risk child, in which case the special at-risk monthly payment under section 256N.26,
678.12 subdivision 7, must be made until the caregiver obtains written documentation from a
678.13 qualified expert that the potential disability upon which eligibility for the agreement
678.14 was based has manifested itself.

678.15 (1) The amount of the payment made on behalf of a child eligible for guardianship
678.16 assistance or adoption assistance is determined through agreement between the prospective
678.17 relative custodian or the adoptive parent and the financially responsible agency, or, if there
678.18 is no financially responsible agency, the agency designated by the commissioner, using
678.19 the assessment tool established by the commissioner in section 256N.24, subdivision 2,
678.20 and the associated benefit and payments outlined in section 256N.26. Except as provided
678.21 under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes
678.22 the monthly benefit level for a child under foster care. The monthly payment under a
678.23 guardianship assistance agreement or adoption assistance agreement may be negotiated up
678.24 to the monthly benefit level under foster care. In no case may the amount of the payment
678.25 under a guardianship assistance agreement or adoption assistance agreement exceed the
678.26 foster care maintenance payment which would have been paid during the month if the
678.27 child with respect to whom the guardianship assistance or adoption assistance payment is
678.28 made had been in a foster family home in the state.

678.29 (2) The rate schedule for the agreement is determined based on the age of the
678.30 child on the date that the prospective adoptive parent or parents or relative custodian or
678.31 custodians sign the agreement.

678.32 (3) The income of the relative custodian or custodians or adoptive parent or parents
678.33 must not be taken into consideration when determining eligibility for guardianship
678.34 assistance or adoption assistance or the amount of the payments under section 256N.26.

678.35 (4) With the concurrence of the relative custodian or adoptive parent, the amount of
678.36 the payment may be adjusted periodically using the assessment tool established by the

679.1 commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under
679.2 subdivision 3 when there is a change in the child's needs or the family's circumstances.

679.3 (5) The guardianship assistance or adoption assistance agreement of a child who is
679.4 identified as at-risk receives the special at-risk monthly payment under section 256N.26,
679.5 subdivision 7, unless and until the potential disability manifests itself, as documented by
679.6 an appropriate professional, and the commissioner authorizes commencement of payment
679.7 by modifying the agreement accordingly. A relative custodian or adoptive parent of an
679.8 at-risk child with a guardianship assistance or adoption assistance agreement may request
679.9 a reassessment of the child under section 256N.24, subdivision 9, and renegotiation of
679.10 the guardianship assistance or adoption assistance agreement under subdivision 3 to
679.11 include a monthly payment, if the caregiver has written documentation from a qualified
679.12 expert that the potential disability upon which eligibility for the agreement was based has
679.13 manifested itself. Documentation of the disability must be limited to evidence deemed
679.14 appropriate by the commissioner.

679.15 (c) For guardianship assistance agreements:

679.16 (1) the initial amount of the monthly guardianship assistance payment must be
679.17 equivalent to the foster care rate in effect at the time that the agreement is signed less any
679.18 offsets under section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to
679.19 by the prospective relative custodian and specified in that agreement, unless the child is
679.20 identified as at-risk or the guardianship assistance agreement is entered into when a child
679.21 is under the age of six;

679.22 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
679.23 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
679.24 and until the potential disability manifests itself, as documented by a qualified expert, and
679.25 the commissioner authorizes commencement of payment by modifying the agreement
679.26 accordingly; and

679.27 (3) the amount of the monthly payment for a guardianship assistance agreement for
679.28 a child, other than an at-risk child, who is under the age of six must be as specified in
679.29 section 256N.26, subdivision 5.

679.30 (d) For adoption assistance agreements:

679.31 (1) for a child in foster care with the prospective adoptive parent immediately prior
679.32 to adoptive placement, the initial amount of the monthly adoption assistance payment
679.33 must be equivalent to the foster care rate in effect at the time that the agreement is signed
679.34 less any offsets in section 256N.26, subdivision 11, or a lesser negotiated amount if agreed
679.35 to by the prospective adoptive parents and specified in that agreement, unless the child is

680.1 identified as at-risk or the adoption assistance agreement is entered into when a child is
680.2 under the age of six;

680.3 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
680.4 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
680.5 and until the potential disability manifests itself, as documented by an appropriate
680.6 professional, and the commissioner authorizes commencement of payment by modifying
680.7 the agreement accordingly;

680.8 (3) the amount of the monthly payment for an adoption assistance agreement for
680.9 a child under the age of six, other than an at-risk child, must be as specified in section
680.10 256N.26, subdivision 5;

680.11 (4) for a child who is in the guardianship assistance program immediately prior
680.12 to adoptive placement, the initial amount of the adoption assistance payment must be
680.13 equivalent to the guardianship assistance payment in effect at the time that the adoption
680.14 assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive
680.15 parent and specified in that agreement; and

680.16 (5) for a child who is not in foster care placement or the guardianship assistance
680.17 program immediately prior to adoptive placement or negotiation of the adoption assistance
680.18 agreement, the initial amount of the adoption assistance agreement must be determined
680.19 using the assessment tool and process in this section and the corresponding payment
680.20 amount outlined in section 256N.26.

680.21 Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive
680.22 parent of a child with a guardianship assistance or adoption assistance agreement may
680.23 request renegotiation of the agreement when there is a change in the needs of the child
680.24 or in the family's circumstances. When a relative custodian or adoptive parent requests
680.25 renegotiation of the agreement, a reassessment of the child must be completed consistent
680.26 with section 256N.24, subdivisions 9 and 10. If the reassessment indicates that the
680.27 child's level has changed, the financially responsible agency or, if there is no financially
680.28 responsible agency, the agency designated by the commissioner or the commissioner's
680.29 designee, and the caregiver must renegotiate the agreement to include a payment with
680.30 the level determined through the reassessment process. The agreement must not be
680.31 renegotiated unless the commissioner, the financially responsible agency, and the caregiver
680.32 mutually agree to the changes. The effective date of any renegotiated agreement must be
680.33 determined by the commissioner.

680.34 (b) A relative custodian or adoptive parent of an at-risk child with a guardianship
680.35 assistance or adoption assistance agreement may request renegotiation of the agreement to
680.36 include a monthly payment higher than the special at-risk monthly payment under section

681.1 256N.26, subdivision 7, if the caregiver has written documentation from a qualified
 681.2 expert that the potential disability upon which eligibility for the agreement was based has
 681.3 manifested itself. Documentation of the disability must be limited to evidence deemed
 681.4 appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment
 681.5 of the child must be conducted as outlined in section 256N.24, subdivision 9. The
 681.6 reassessment must be used to renegotiate the agreement to include an appropriate monthly
 681.7 payment. The agreement must not be renegotiated unless the commissioner, the financially
 681.8 responsible agency, and the caregiver mutually agree to the changes. The effective date of
 681.9 any renegotiated agreement must be determined by the commissioner.

681.10 (c) Renegotiation of a guardianship assistance or adoption assistance agreement is
 681.11 required when one of the circumstances outlined in section 256N.26, subdivision 13,
 681.12 occurs.

681.13 Sec. 13. **[256N.26] BENEFITS AND PAYMENTS.**

681.14 Subdivision 1. **Benefits.** (a) There are three benefits under Northstar Care for
 681.15 Children: medical assistance, basic payment, and supplemental difficulty of care payment.

681.16 (b) A child is eligible for medical assistance under subdivision 2.

681.17 (c) A child is eligible for the basic payment under subdivision 3, except for a child
 681.18 assigned level A under section 256N.24, subdivision 1, because the child is determined to
 681.19 be an at-risk child receiving guardianship assistance or adoption assistance.

681.20 (d) A child, including a foster child age 18 to 21, is eligible for an additional
 681.21 supplemental difficulty of care payment under subdivision 4, as determined by the
 681.22 assessment under section 256N.24.

681.23 (e) An eligible child entering guardianship assistance or adoption assistance under
 681.24 the age of six receives a basic payment and supplemental difficulty of care payment as
 681.25 specified in subdivision 5.

681.26 (f) A child transitioning in from a pre-Northstar Care for Children program under
 681.27 section 256N.28, subdivision 7, shall receive basic and difficulty of care supplemental
 681.28 payments according to those provisions.

681.29 Subd. 2. **Medical assistance.** Eligibility for medical assistance under this chapter
 681.30 must be determined according to section 256B.055.

681.31 Subd. 3. **Basic monthly rate.** From January 1, 2015, to June 30, 2016, the basic
 681.32 monthly rate must be according to the following schedule:

681.33	<u>Ages 0-5</u>	<u>\$565 per month</u>
681.34	<u>Ages 6-12</u>	<u>\$670 per month</u>
681.35	<u>Ages 13 and older</u>	<u>\$790 per month</u>

682.1 Subd. 4. **Difficulty of care supplemental monthly rate.** From January 1, 2015,
 682.2 to June 30, 2016, the supplemental difficulty of care monthly rate is determined by the
 682.3 following schedule:

682.4	<u>Level A</u>	<u>none (special rate under subdivision 7</u>
682.5		<u>applies)</u>
682.6	<u>Level B</u>	<u>none (basic under subdivision 3 only)</u>
682.7	<u>Level C</u>	<u>\$100 per month</u>
682.8	<u>Level D</u>	<u>\$200 per month</u>
682.9	<u>Level E</u>	<u>\$300 per month</u>
682.10	<u>Level F</u>	<u>\$400 per month</u>
682.11	<u>Level G</u>	<u>\$500 per month</u>
682.12	<u>Level H</u>	<u>\$600 per month</u>
682.13	<u>Level I</u>	<u>\$700 per month</u>
682.14	<u>Level J</u>	<u>\$800 per month</u>
682.15	<u>Level K</u>	<u>\$900 per month</u>
682.16	<u>Level L</u>	<u>\$1,000 per month</u>
682.17	<u>Level M</u>	<u>\$1,100 per month</u>
682.18	<u>Level N</u>	<u>\$1,200 per month</u>
682.19	<u>Level O</u>	<u>\$1,300 per month</u>
682.20	<u>Level P</u>	<u>\$1,400 per month</u>
682.21	<u>Level Q</u>	<u>\$1,500 per month</u>

682.22 A child assigned level A is not eligible for either the basic or supplemental difficulty
 682.23 of care payment, while a child assigned level B is not eligible for the supplemental
 682.24 difficulty of care payment but is eligible for the basic monthly rate under subdivision 3.

682.25 Subd. 5. **Alternate rates for preschool entry and certain transitioned children.**

682.26 A child who entered the guardianship assistance or adoption assistance components
 682.27 of Northstar Care for Children while under the age of six shall receive 50 percent of
 682.28 the amount the child would otherwise be entitled to under subdivisions 3 and 4. The
 682.29 commissioner may also use the 50 percent rate for a child who was transitioned into those
 682.30 components through declaration of the commissioner under section 256N.28, subdivision 7.

682.31 Subd. 6. **Emergency foster care rate for initial placement.** (a) A child who enters
 682.32 foster care due to immediate custody by a police officer or court order, consistent with
 682.33 section 260C.175, subdivisions 1 and 2, or equivalent provision under tribal code, shall
 682.34 receive the emergency foster care rate for up to 30 days. The emergency foster care rate
 682.35 cannot be extended beyond 30 days of the child's placement.

682.36 (b) For this payment rate to be applied, at least one of three conditions must apply:

682.37 (1) the child's initial placement must be in foster care in Minnesota;

682.38 (2) the child's previous placement was more than two years ago; or

683.1 (3) the child's previous placement was for fewer than 30 days and an assessment
683.2 under section 256N.24 was not completed by an agency under section 256N.24.

683.3 (c) The emergency foster care rate consists of the appropriate basic monthly rate
683.4 under subdivision 3 plus a difficulty of care supplemental monthly rate of level D under
683.5 subdivision 4.

683.6 (d) The emergency foster care rate ends under any of three conditions:

683.7 (1) when an assessment under section 256N.24 is completed;

683.8 (2) when the placement ends; or

683.9 (3) after 30 days have elapsed.

683.10 (e) The financially responsible agency, in consultation with the legally responsible
683.11 agency, if different, may replace the emergency foster care rate at any time by completing
683.12 an initial assessment on which a revised difficulty of care supplemental monthly rate
683.13 would be based. Consistent with section 256N.24, subdivision 9, the caregiver may
683.14 request a reassessment in writing for an initial assessment to replace the emergency foster
683.15 care rate. This written request would initiate an initial assessment under section 256N.24,
683.16 subdivision 5. If the revised difficulty of care supplemental level based on the initial
683.17 assessment is higher than level D, then the revised higher rate shall apply retroactively to
683.18 the beginning of the placement. If the revised level is lower, the lower rate shall apply on
683.19 the date the initial assessment was completed.

683.20 (f) If a child remains in foster care placement for more than 30 days, the emergency
683.21 foster care rate ends after the 30th day of placement and an assessment under section
683.22 256N.26 must be completed.

683.23 Subd. 7. **Special at-risk monthly payment for at-risk children in guardianship**
683.24 **assistance and adoption assistance.** A child eligible for guardianship assistance under
683.25 section 256N.22 or adoption assistance under section 256N.23 who is determined to be
683.26 an at-risk child shall receive a special at-risk monthly payment of \$1 per month basic,
683.27 unless and until the potential disability manifests itself and the agreement is renegotiated
683.28 to include reimbursement. Such an at-risk child shall receive neither a supplemental
683.29 difficulty of care monthly rate under subdivision 4 nor home and vehicle modifications
683.30 under subdivision 10, but must be considered for medical assistance under subdivision 2.

683.31 Subd. 8. **Daily rates.** (a) The commissioner shall establish prorated daily rates to
683.32 the nearest cent for the monthly rates under subdivisions 3 to 7. Daily rates must be
683.33 routinely used when a partial month is involved for foster care, guardianship assistance, or
683.34 adoption assistance.

684.1 (b) A full month payment is permitted if a foster child is temporarily absent from
684.2 the foster home if the brief absence does not exceed 14 days and the child's placement
684.3 continues with the same caregiver.

684.4 Subd. 9. **Revision.** By April 1, 2016, for fiscal year 2017, and by each succeeding
684.5 April 1 for the subsequent fiscal year, the commissioner shall review and revise the rates
684.6 under subdivisions 3 to 7 based on the United States Department of Agriculture, Estimates
684.7 of the Cost of Raising a Child, published by the United States Department of Agriculture,
684.8 Agricultural Resources Service, Publication 1411. The revision shall be the average
684.9 percentage by which costs increase for the age ranges represented in the United States
684.10 Department of Agriculture, Estimates of the Cost of Raising a Child, except that in no
684.11 instance must the increase be more than three percent per annum. The monthly rates must
684.12 be revised to the nearest dollar and the daily rates to the nearest cent.

684.13 Subd. 10. **Home and vehicle modifications.** (a) Except for a child assigned level A
684.14 under section 256N.24, subdivision 1, paragraph (d), clause (1), a child who is eligible
684.15 for an adoption assistance agreement may have reimbursement of home and vehicle
684.16 modifications necessary to accommodate the child's special needs upon which eligibility
684.17 for adoption assistance was based and included as part of the negotiation of the agreement
684.18 under section 256N.25, subdivision 2. Reimbursement of home and vehicle modifications
684.19 must not be available for a child who is assessed at level A under subdivision 1, unless
684.20 and until the potential disability manifests itself and the agreement is renegotiated to
684.21 include reimbursement.

684.22 (b) Application for and reimbursement of modifications must be completed
684.23 according to a process specified by the commissioner. The type and cost of each
684.24 modification must be preapproved by the commissioner. The type of home and vehicle
684.25 modifications must be limited to those specified by the commissioner.

684.26 (c) Reimbursement for home modifications as outlined in this subdivision is limited
684.27 to once every five years per child. Reimbursement for vehicle modifications as outlined in
684.28 this subdivision is limited to once every five years per family.

684.29 Subd. 11. **Child income or income attributable to the child.** (a) A monthly
684.30 guardianship assistance or adoption assistance payment must be considered as income
684.31 and resources attributable to the child. Guardianship assistance and adoption assistance
684.32 are exempt from garnishment, except as permissible under the laws of the state where the
684.33 child resides.

684.34 (b) When a child is placed into foster care, any income and resources attributable
684.35 to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as
684.36 applicable to the child being placed.

685.1 (c) Consideration of income and resources attributable to the child must be part of
685.2 the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances,
685.3 the receipt of other income on behalf of the child may impact the amount of the monthly
685.4 payment received by the relative custodian or adoptive parent on behalf of the child
685.5 through Northstar Care for Children. Supplemental Security Income (SSI), retirement
685.6 survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and
685.7 black lung benefits are considered income and resources attributable to the child.

685.8 Subd. 12. **Treatment of Supplemental Security Income.** If a child placed in foster
685.9 care receives benefits through Supplemental Security Income (SSI) at the time of foster
685.10 care placement or subsequent to placement in foster care, the financially responsible
685.11 agency may apply to be the payee for the child for the duration of the child's placement in
685.12 foster care. If a child continues to be eligible for SSI after finalization of the adoption or
685.13 transfer of permanent legal and physical custody and is determined to be eligible for a
685.14 payment under Northstar Care for Children, a permanent caregiver may choose to receive
685.15 payment from both programs simultaneously. The permanent caregiver is responsible
685.16 to report the amount of the payment to the Social Security Administration and the SSI
685.17 payment will be reduced as required by the Social Security Administration.

685.18 Subd. 13. **Treatment of retirement survivor's disability insurance, veteran's**
685.19 **benefits, railroad retirement benefits, and black lung benefits.** (a) If a child placed
685.20 in foster care receives retirement survivor's disability insurance, veteran's benefits,
685.21 railroad retirement benefits, or black lung benefits at the time of foster care placement or
685.22 subsequent to placement in foster care, the financially responsible agency may apply to
685.23 be the payee for the child for the duration of the child's placement in foster care. If it is
685.24 anticipated that a child will be eligible to receive retirement survivor's disability insurance,
685.25 veteran's benefits, railroad retirement benefits, or black lung benefits after finalization
685.26 of the adoption or assignment of permanent legal and physical custody, the permanent
685.27 caregiver shall apply to be the payee of those benefits on the child's behalf. The monthly
685.28 amount of the other benefits must be considered an offset to the amount of the payment
685.29 the child is determined eligible for under Northstar Care for Children.

685.30 (b) If a child becomes eligible for retirement survivor's disability insurance, veteran's
685.31 benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the
685.32 payment under Northstar Care for Children is finalized, the permanent caregiver shall
685.33 contact the commissioner to redetermine the payment under Northstar Care for Children.
685.34 The monthly amount of the other benefits must be considered an offset to the amount of
685.35 the payment the child is determined eligible for under Northstar Care for Children.

686.1 (c) If a child ceases to be eligible for retirement survivor's disability insurance,
686.2 veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount
686.3 of the payment under Northstar Care for Children is finalized, the permanent caregiver
686.4 shall contact the commissioner to redetermine the payment under Northstar Care for
686.5 Children. The monthly amount of the payment under Northstar Care for Children must be
686.6 the amount the child was determined to be eligible for prior to consideration of any offset.

686.7 (d) If the monthly payment received on behalf of the child under retirement survivor's
686.8 disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits
686.9 changes after the adoption assistance or guardianship assistance agreement is finalized,
686.10 the permanent caregiver shall notify the commissioner as to the new monthly payment
686.11 amount, regardless of the amount of the change in payment. If the monthly payment
686.12 changes by \$75 or more, even if the change occurs incrementally over the duration of
686.13 the term of the adoption assistance or guardianship assistance agreement, the monthly
686.14 payment under Northstar Care for Children must be adjusted without further consent
686.15 to reflect the amount of the increase or decrease in the offset amount. Any subsequent
686.16 change to the payment must be reported and handled in the same manner. A change of
686.17 monthly payments of less than \$75 is not a permissible reason to renegotiate the adoption
686.18 assistance or guardianship assistance agreement under section 256N.25, subdivision 3.
686.19 The commissioner shall review and revise the limit at which the adoption assistance or
686.20 guardian assistance agreement must be renegotiated in accordance with subdivision 9.

686.21 Subd. 14. **Treatment of child support and Minnesota family investment**
686.22 **program.** (a) If a child placed in foster care receives child support, the child support
686.23 payment may be redirected to the financially responsible agency for the duration of the
686.24 child's placement in foster care. In cases where the child qualifies for Northstar Care
686.25 for Children by meeting the adoption assistance eligibility criteria or the guardianship
686.26 assistance eligibility criteria, any court-ordered child support must not be considered
686.27 income attributable to the child and must have no impact on the monthly payment.

686.28 (b) Consistent with section 256J.24, a child eligible for Northstar Care for Children
686.29 whose caregiver receives a payment on the child's behalf is excluded from a Minnesota
686.30 family investment program assistance unit.

686.31 Subd. 15. **Payments.** (a) Payments to caregivers under Northstar Care for Children
686.32 must be made monthly. Consistent with section 256N.24, subdivision 12, the financially
686.33 responsible agency must send the caregiver the required written notice within 15 days of
686.34 a completed assessment or reassessment.

686.35 (b) Unless paragraph (c) or (d) applies, the financially responsible agency shall pay
686.36 foster parents directly for eligible children in foster care.

687.1 (c) When the legally responsible agency is different than the financially responsible
687.2 agency, the legally responsible agency may make the payments to the caregiver, provided
687.3 payments are made on a timely basis. The financially responsible agency must pay
687.4 the legally responsible agency on a timely basis. Caregivers must have access to the
687.5 financially and legally responsible agencies' records of the transaction, consistent with
687.6 the retention schedule for the payments.

687.7 (d) For eligible children in foster care, the financially responsible agency may pay
687.8 the foster parent's payment for a licensed child-placing agency instead of paying the foster
687.9 parents directly. The licensed child-placing agency must timely pay the foster parents
687.10 and maintain records of the transaction. Caregivers must have access to the financially
687.11 responsible agency's records of the transaction and the child-placing agency's records of
687.12 the transaction, consistent with the retention schedule for the payments.

687.13 Subd. 16. **Effect of benefit on other aid.** Payments received under this section
687.14 must not be considered as income for child care assistance under chapter 119B or any
687.15 other financial benefit. Consistent with section 256J.24, a child receiving a maintenance
687.16 payment under Northstar Care for Children is excluded from any Minnesota family
687.17 investment program assistance unit.

687.18 Subd. 17. **Home and community-based services waiver for persons with**
687.19 **disabilities.** A child in foster care may qualify for home and community-based waived
687.20 services, consistent with section 256B.092 for developmental disabilities, or section
687.21 256B.49 for community alternative care, community alternatives for disabled individuals,
687.22 or traumatic brain injury waivers. A waiver service must not be substituted for the foster
687.23 care program. When the child is simultaneously eligible for waived services and for
687.24 benefits under Northstar Care for Children, the financially responsible agency must
687.25 assess and provide basic and supplemental difficulty of care rates as determined by the
687.26 assessment according to section 256N.24. If it is determined that additional services are
687.27 needed to meet the child's needs in the home that is not or cannot be met by the foster care
687.28 program, the need would be referred to the local waived service program.

687.29 Subd. 18. **Overpayments.** The commissioner has the authority to collect any
687.30 amount of foster care payment, adoption assistance, or guardianship assistance paid
687.31 to a caregiver in excess of the payment due. Payments covered by this subdivision
687.32 include basic maintenance needs payments, supplemental difficulty of care payments, and
687.33 reimbursement of home and vehicle modifications under subdivision 10. Prior to any
687.34 collection, the commissioner or the commissioner's designee shall notify the caregiver in
687.35 writing, including:

687.36 (1) the amount of the overpayment and an explanation of the cause of overpayment;

- 688.1 (2) clarification of the corrected amount;
688.2 (3) a statement of the legal authority for the decision;
688.3 (4) information about how the caregiver can correct the overpayment;
688.4 (5) if repayment is required, when the payment is due and a person to contact to
688.5 review a repayment plan;
688.6 (6) a statement that the caregiver has a right to a fair hearing review by the
688.7 department; and
688.8 (7) the procedure for seeking a fair hearing review by the department.

688.9 Subd. 19. **Payee.** For adoption assistance and guardianship assistance cases, the
688.10 payment must only be made to the adoptive parent or relative custodian specified on the
688.11 agreement. If there is more than one adoptive parent or relative custodian, both parties will
688.12 be listed as the payee unless otherwise specified in writing according to policies outlined
688.13 by the commissioner. In the event of divorce or separation of the caregivers, a change of
688.14 payee must be made in writing according to policies outlined by the commissioner. If both
688.15 caregivers are in agreement as to the change, it may be made according to a process outlined
688.16 by the commissioner. If there is not agreement as to the change, a court order indicating
688.17 the party who is to receive the payment is needed before a change can be processed. If the
688.18 change of payee is disputed, the commissioner may withhold the payment until agreement
688.19 is reached. A noncustodial caregiver may request notice in writing of review, modification,
688.20 or termination of the adoption assistance or guardianship assistance agreement. In the
688.21 event of the death of a payee, a change of payee consistent with sections 256N.22 and
688.22 256N.23 may be made in writing according to policies outlined by the commissioner.

688.23 Subd. 20. **Notification of change.** (a) A caregiver who has an adoption assistance
688.24 agreement or guardianship assistance agreement in place shall keep the agency
688.25 administering the program informed of changes in status or circumstances which would
688.26 make the child ineligible for the payments or eligible for payments in a different amount.

- 688.27 (b) For the duration of the agreement, the caregiver agrees to notify the agency
688.28 administering the program in writing within 30 days of any of the following:
688.29 (1) a change in the child's or caregiver's legal name;
688.30 (2) a change in the family's address;
688.31 (3) a change in the child's legal custody status;
688.32 (4) the child's completion of high school, if this occurs after the child attains age 18;
688.33 (5) the end of the caregiver's legal responsibility to support the child based on
688.34 termination of parental rights of the caregiver, transfer of guardianship to another person,
688.35 or transfer of permanent legal and physical custody to another person;
688.36 (6) the end of the caregiver's financial support of the child;

- 689.1 (7) the death of the child;
 689.2 (8) the death of the caregiver;
 689.3 (9) the child enlists in the military;
 689.4 (10) the child gets married;
 689.5 (11) the child becomes an emancipated minor through legal action;
 689.6 (12) the caregiver separates or divorces; and
 689.7 (13) the child is residing outside the caregiver's home for a period of more than
 689.8 30 consecutive days.

689.9 Subd. 21. **Correct and true information.** The caregiver must be investigated for
 689.10 fraud if the caregiver reports information the caregiver knows is untrue, the caregiver
 689.11 fails to notify the commissioner of changes that may affect eligibility, or the agency
 689.12 administering the program receives relevant information that the caregiver did not report.

689.13 Subd. 22. **Termination notice for caregiver.** The agency that issues the
 689.14 maintenance payment shall provide the child's caregiver with written notice of termination
 689.15 of payment. Termination notices must be sent at least 15 days before the final payment or,
 689.16 in the case of an unplanned termination, the notice is sent within three days of the end of
 689.17 the payment. The written notice must minimally include the following:

- 689.18 (1) the date payment will end;
 689.19 (2) the reason payments will end and the event that is the basis to terminate payment;
 689.20 (3) a statement that the provider has a right to a fair hearing review by the department
 689.21 consistent with section 256.045, subdivision 3;
 689.22 (4) the procedure to request a fair hearing; and
 689.23 (5) the name, telephone number, and e-mail address of a contact person at the agency.

689.24 **Sec. 14. [256N.27] FEDERAL, STATE, AND LOCAL SHARES.**

689.25 Subdivision 1. **Federal share.** For the purposes of determining a child's eligibility
 689.26 under title IV-E of the Social Security Act for a child in foster care, the financially
 689.27 responsible agency shall use the eligibility requirements outlined in section 472 of the
 689.28 Social Security Act. For a child who qualifies for guardianship assistance or adoption
 689.29 assistance, the financially responsible agency and the commissioner shall use the
 689.30 eligibility requirements outlined in section 473 of the Social Security Act. In each case,
 689.31 the agency paying the maintenance payments must be reimbursed for the costs from the
 689.32 federal money available for this purpose.

689.33 Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance
 689.34 payments as determined under subdivision 4, and an identical share of the pre-Northstar
 689.35 Care foster care program under section 260C.4411, subdivision 1, the relative custody

690.1 assistance program under section 257.85, and the pre-Northstar Care for Children adoption
690.2 assistance program under chapter 259A. The commissioner may transfer funds into the
690.3 account if a deficit occurs.

690.4 Subd. 3. **Local share.** (a) The financially responsible agency at the time of
690.5 placement for foster care or finalization of the agreement for guardianship assistance or
690.6 adoption assistance shall pay the local share of the maintenance payments as determined
690.7 under subdivision 4, and an identical share of the pre-Northstar Care for Children foster
690.8 care program under section 260C.4411, subdivision 1, the relative custody assistance
690.9 program under section 257.85, and the pre-Northstar Care for Children adoption assistance
690.10 program under chapter 259A.

690.11 (b) The financially responsible agency shall pay the entire cost of any initial clothing
690.12 allowance, administrative payments to child caring agencies specified in section 317A.907,
690.13 or other support services it authorizes, except as provided under other provisions of law.

690.14 (c) In cases of federally required adoption assistance where there is no financially
690.15 responsible agency as provided in section 256N.24, subdivision 5, the commissioner
690.16 shall pay the local share.

690.17 (d) When an Indian child being placed in Minnesota meets title IV-E eligibility
690.18 defined in section 473(d) of the Social Security Act and is receiving guardianship
690.19 assistance or adoption assistance, the agency or entity assuming responsibility for the
690.20 child is responsible for the nonfederal share of the payment.

690.21 Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share
690.22 of the maintenance payments, reduced by federal reimbursements under title IV-E of the
690.23 Social Security Act, to be paid by the state and to be paid by the financially responsible
690.24 agency.

690.25 (b) These state and local shares must initially be calculated based on the ratio of the
690.26 average appropriate expenditures made by the state and all financially responsible agencies
690.27 during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation,
690.28 appropriate expenditures for the financially responsible agencies must include basic and
690.29 difficulty of care payments for foster care reduced by federal reimbursements, but not
690.30 including any initial clothing allowance, administrative payments to child care agencies
690.31 specified in section 317A.907, child care, or other support or ancillary expenditures. For
690.32 purposes of this calculation, appropriate expenditures for the state shall include adoption
690.33 assistance and relative custody assistance, reduced by federal reimbursements.

690.34 (c) For each of the periods January 1, 2015, to June 30, 2016, and fiscal years 2017,
690.35 2018, and 2019, the commissioner shall adjust this initial percentage of state and local
690.36 shares to reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and

691.1 2014, taking into account appropriations for Northstar Care for Children and the turnover
691.2 rates of the components. In making these adjustments, the commissioner's goal shall be to
691.3 make these state and local expenditures other than the appropriations for Northstar Care for
691.4 Children to be the same as they would have been had Northstar Care for Children not been
691.5 implemented, or if that is not possible, proportionally higher or lower, as appropriate. The
691.6 state and local share percentages for fiscal year 2019 must be used for all subsequent years.

691.7 Subd. 5. **Adjustments for proportionate shares among financially responsible**
691.8 **agencies.** (a) The commissioner shall adjust the expenditures under subdivision 4 by each
691.9 financially responsible agency so that its relative share is proportional to its foster care
691.10 expenditures, with the goal of making the local share similar to what the county or tribe
691.11 would have spent had Northstar Care for Children not been enacted.

691.12 (b) For the period January 1, 2015, to June 30, 2016, the relative shares must be as
691.13 determined under subdivision 4 for calendar years 2011, 2012, 2013, and 2014 compared
691.14 with similar costs of all financially responsible agencies.

691.15 (c) For subsequent fiscal years, the commissioner shall update the relative shares
691.16 based on actual utilization of Northstar Care for Children by the financially responsible
691.17 agencies during the previous period, so that those using relatively more than they did
691.18 historically are adjusted upward and those using less are adjusted downward.

691.19 (d) The commissioner must ensure that the adjustments are not unduly influenced by
691.20 onetime events, anomalies, small changes that appear large compared to a narrow historic
691.21 base, or fluctuations that are the results of the transfer of responsibilities to tribal social
691.22 service agencies authorized in section 256.01, subdivision 14b, as part of the American
691.23 Indian Child Welfare Initiative.

691.24 Sec. 15. **[256N.28] ADMINISTRATION AND APPEALS.**

691.25 Subdivision 1. **Responsibilities.** (a) The financially responsible agency shall
691.26 determine the eligibility for Northstar Care for Children for children in foster care under
691.27 section 256N.21, and for those children determined eligible, shall further determine each
691.28 child's eligibility for title IV-E of the Social Security Act, provided the agency has such
691.29 authority under the state title IV-E plan.

691.30 (b) Subject to commissioner review and approval, the financially responsible agency
691.31 shall prepare the eligibility determination for Northstar Care for Children for children in
691.32 guardianship assistance under section 256N.22 and children in adoption assistance under
691.33 section 256N.23. The AFDC relatedness determination, when necessary to determine a
691.34 child's eligibility for title IV-E funding, shall be made only by an authorized agency
691.35 according to policies and procedures prescribed by the commissioner.

692.1 (c) The financially responsible agency is responsible for the administration of
692.2 Northstar Care for Children for children in foster care. The agency designated by the
692.3 commissioner is responsible for assisting the commissioner with the administration of
692.4 Northstar Care for Children for children in guardianship assistance and adoption assistance
692.5 by conducting assessments, reassessments, negotiations, and other activities as specified
692.6 by the commissioner under subdivision 2.

692.7 Subd. 2. **Procedures, requirements, and deadlines.** The commissioner shall
692.8 specify procedures, requirements, and deadlines for the administration of Northstar Care
692.9 for Children in accordance with sections 256N.001 to 256N.28, including for children
692.10 transitioning into Northstar Care for Children under subdivision 7. The commissioner
692.11 shall periodically review all procedures, requirements, and deadlines, including the
692.12 assessment tool and process under section 256N.24, in consultation with counties, tribes,
692.13 and representatives of caregivers, and may alter them as needed.

692.14 Subd. 3. **Administration of title IV-E programs.** The title IV-E foster care,
692.15 guardianship assistance, and adoption assistance programs must operate within the
692.16 statutes, rules, and policies set forth by the federal government in the Social Security Act.

692.17 Subd. 4. **Reporting.** The commissioner shall specify required fiscal and statistical
692.18 reports under section 256.01, subdivision 2, paragraph (q), and other reports as necessary.

692.19 Subd. 5. **Promotion of programs.** Families who adopt a child under the
692.20 commissioner's guardianship must be informed as to the adoption tax credit. The
692.21 commissioner shall actively seek ways to promote the guardianship assistance and
692.22 adoption assistance programs, including informing prospective caregivers of eligible
692.23 children of the availability of guardianship assistance and adoption assistance.

692.24 Subd. 6. **Appeals and fair hearings.** (a) A caregiver has the right to appeal to the
692.25 commissioner under section 256.045 when eligibility for Northstar Care for Children is
692.26 denied, and when payment or the agreement for an eligible child is modified or terminated.

692.27 (b) A relative custodian or adoptive parent has additional rights to appeal to the
692.28 commissioner pursuant to section 256.045. These rights include when the commissioner
692.29 terminates or modifies the guardianship assistance or adoption assistance agreement or
692.30 when the commissioner denies an application for guardianship assistance or adoption
692.31 assistance. A prospective relative custodian or adoptive parent who disagrees with a
692.32 decision by the commissioner before transfer of permanent legal and physical custody or
692.33 finalization of the adoption may request review of the decision by the commissioner or
692.34 may appeal the decision under section 256.045. A guardianship assistance or adoption
692.35 assistance agreement must be signed and in effect before the court order that transfers
692.36 permanent legal and physical custody or the adoption finalization; however, in some cases,

693.1 there may be extenuating circumstances as to why an agreement was not entered into
693.2 before finalization of permanency for the child. Caregivers who believe that extenuating
693.3 circumstances exist in the case of their child may request a fair hearing. Caregivers have the
693.4 responsibility of proving that extenuating circumstances exist. Caregivers must be required
693.5 to provide written documentation of each eligibility criterion at the fair hearing. Examples
693.6 of extenuating circumstances include: relevant facts regarding the child were known by
693.7 the placing agency and not presented to the caregivers before transfer of permanent legal
693.8 and physical custody or finalization of the adoption, or failure by the commissioner or a
693.9 designee to advise potential caregivers about the availability of guardianship assistance or
693.10 adoption assistance for children in the state foster care system. If an appeals judge finds
693.11 through the fair hearing process that extenuating circumstances existed and that the child
693.12 met all eligibility criteria at the time the transfer of permanent legal and physical custody
693.13 was ordered or the adoption was finalized, the effective date and any associated federal
693.14 financial participation shall be retroactive from the date of the request for a fair hearing.

693.15 Subd. 7. **Transitions from pre-Northstar Care for Children programs.** (a) A child
693.16 in foster care who remains with the same caregiver shall continue to receive benefits under
693.17 the pre-Northstar Care for Children foster care program under section 256.82. Transitions
693.18 to Northstar Care for Children must occur as provided in section 256N.21, subdivision 6.

693.19 (b) The commissioner may seek to transition into Northstar Care for Children a child
693.20 who is in pre-Northstar Care for Children relative custody assistance under section 257.85
693.21 or pre-Northstar Care for Children adoption assistance under chapter 259A, in accordance
693.22 with these priorities, in order of priority:

693.23 (1) financial and budgetary constraints;

693.24 (2) complying with federal regulations;

693.25 (3) converting pre-Northstar Care for Children relative custody assistance under
693.26 section 257.85 to the guardianship assistance component of Northstar Care for Children;

693.27 (4) improving permanency for a child or children;

693.28 (5) maintaining permanency for a child or children;

693.29 (6) accessing additional federal funds; and

693.30 (7) administrative simplification.

693.31 (c) Transitions shall be accomplished according to procedures, deadlines, and
693.32 requirements specified by the commissioner under subdivision 2.

693.33 (d) The commissioner may accomplish a transition of a child from pre-Northstar
693.34 Care for Children relative custody assistance under section 257.85 to the guardianship
693.35 assistance component of Northstar Care for Children by declaration and appropriate notice
693.36 to the caregiver, provided that the benefit for a child under this paragraph is not reduced.

694.1 (e) The commissioner may offer a transition of a child from pre-Northstar Care for
694.2 Children adoption assistance under chapter 259A to the adoption assistance component
694.3 of Northstar Care for Children by contacting the caregiver with an offer. The transition
694.4 must be accomplished only when the caregiver agrees to the offer. The caregiver shall
694.5 have a maximum of 90 days to review and accept the commissioner's offer. If the
694.6 commissioner's offer is not accepted within 90 days, the pre-Northstar Care for Children
694.7 adoption assistance agreement remains in effect until it terminates or a subsequent offer is
694.8 made by the commissioner.

694.9 (f) For a child transitioning into Northstar Care for Children, the commissioner shall
694.10 assign an equivalent assessment level based on the most recently completed supplemental
694.11 difficulty of care level assessment, unless the commissioner determines that arranging
694.12 for a new assessment under section 256N.24 would be more appropriate based on the
694.13 priorities specified in paragraph (b).

694.14 (g) For a child transitioning into Northstar Care for Children, regardless of the age
694.15 of the child, the commissioner shall use the rates under section 256N.26, subdivision 5,
694.16 unless the rates under section 256N.26, subdivisions 3 and 4, are more appropriate based
694.17 on the priorities specified in paragraph (b), as determined by the commissioner.

694.18 Subd. 8. **Purchase of child-specific adoption services.** The commissioner may
694.19 reimburse the placing agency for appropriate adoption services for children eligible
694.20 under section 259A.75.

694.21 Sec. 16. Minnesota Statutes 2012, section 257.85, subdivision 2, is amended to read:

694.22 Subd. 2. **Scope.** The provisions of this section apply to those situations in which
694.23 the legal and physical custody of a child is established with a relative or important friend
694.24 with whom the child has resided or had significant contact according to section 260C.515,
694.25 subdivision 4, by a district court order issued on or after July 1, 1997, but on or before
694.26 November 26, 2014, or a tribal court order issued on or after July 1, 2005, but on or
694.27 before November 26, 2014, when the child has been removed from the care of the parent
694.28 by previous district or tribal court order.

694.29 Sec. 17. Minnesota Statutes 2012, section 257.85, subdivision 5, is amended to read:

694.30 Subd. 5. **Relative custody assistance agreement.** (a) A relative custody assistance
694.31 agreement will not be effective, unless it is signed by the local agency and the relative
694.32 custodian no later than 30 days after the date of the order establishing permanent legal and
694.33 physical custody, and on or before November 26, 2014, except that a local agency may
694.34 enter into a relative custody assistance agreement with a relative custodian more than 30

695.1 days after the date of the order if it certifies that the delay in entering the agreement was
695.2 through no fault of the relative custodian and the agreement is signed and in effect on or
695.3 before November 26, 2014. There must be a separate agreement for each child for whom
695.4 the relative custodian is receiving relative custody assistance.

695.5 (b) Regardless of when the relative custody assistance agreement is signed by the
695.6 local agency and relative custodian, the effective date of the agreement shall be the date of
695.7 the order establishing permanent legal and physical custody.

695.8 (c) If MFIP is not the applicable program for a child at the time that a relative
695.9 custody assistance agreement is entered on behalf of the child, when MFIP becomes
695.10 the applicable program, if the relative custodian had been receiving custody assistance
695.11 payments calculated based upon a different program, the amount of relative custody
695.12 assistance payment under subdivision 7 shall be recalculated under the Minnesota family
695.13 investment program.

695.14 (d) The relative custody assistance agreement shall be in a form specified by the
695.15 commissioner and shall include provisions relating to the following:

695.16 (1) the responsibilities of all parties to the agreement;

695.17 (2) the payment terms, including the financial circumstances of the relative
695.18 custodian, the needs of the child, the amount and calculation of the relative custody
695.19 assistance payments, and that the amount of the payments shall be reevaluated annually;

695.20 (3) the effective date of the agreement, which shall also be the anniversary date for
695.21 the purpose of submitting the annual affidavit under subdivision 8;

695.22 (4) that failure to submit the affidavit as required by subdivision 8 will be grounds
695.23 for terminating the agreement;

695.24 (5) the agreement's expected duration, which shall not extend beyond the child's
695.25 eighteenth birthday;

695.26 (6) any specific known circumstances that could cause the agreement or payments
695.27 to be modified, reduced, or terminated and the relative custodian's appeal rights under
695.28 subdivision 9;

695.29 (7) that the relative custodian must notify the local agency within 30 days of any of
695.30 the following:

695.31 (i) a change in the child's status;

695.32 (ii) a change in the relationship between the relative custodian and the child;

695.33 (iii) a change in composition or level of income of the relative custodian's family;

695.34 (iv) a change in eligibility or receipt of benefits under MFIP, or other assistance
695.35 program; and

696.1 (v) any other change that could affect eligibility for or amount of relative custody
696.2 assistance;

696.3 (8) that failure to provide notice of a change as required by clause (7) will be
696.4 grounds for terminating the agreement;

696.5 (9) that the amount of relative custody assistance is subject to the availability of state
696.6 funds to reimburse the local agency making the payments;

696.7 (10) that the relative custodian may choose to temporarily stop receiving payments
696.8 under the agreement at any time by providing 30 days' notice to the local agency and may
696.9 choose to begin receiving payments again by providing the same notice but any payments
696.10 the relative custodian chooses not to receive are forfeit; and

696.11 (11) that the local agency will continue to be responsible for making relative custody
696.12 assistance payments under the agreement regardless of the relative custodian's place of
696.13 residence.

696.14 Sec. 18. Minnesota Statutes 2012, section 257.85, subdivision 6, is amended to read:

696.15 Subd. 6. **Eligibility criteria.** (a) A local agency shall enter into a relative custody
696.16 assistance agreement under subdivision 5 if it certifies that the following criteria are met:

696.17 (1) the juvenile court has determined or is expected to determine that the child,
696.18 under the former or current custody of the local agency, cannot return to the home of
696.19 the child's parents;

696.20 (2) the court, upon determining that it is in the child's best interests, has issued
696.21 or is expected to issue an order transferring permanent legal and physical custody of
696.22 the child; and

696.23 (3) the child either:

696.24 (i) is a member of a sibling group to be placed together; or

696.25 (ii) has a physical, mental, emotional, or behavioral disability that will require
696.26 financial support.

696.27 When the local agency bases its certification that the criteria in clause (1) or (2) are
696.28 met upon the expectation that the juvenile court will take a certain action, the relative
696.29 custody assistance agreement does not become effective until and unless the court acts as
696.30 expected.

696.31 (b) After November 26, 2014, new relative custody assistance agreements must not
696.32 be executed. Agreements that were signed by all parties on or before November 26, 2014,
696.33 and were not in effect because the proposed transfer of permanent legal and physical
696.34 custody of the child did not occur on or before November 26, 2014, must be renegotiated
696.35 under the terms of Northstar Care for Children in chapter 256N.

697.1 Sec. 19. **[259A.12] NO NEW EXECUTION OF ADOPTION ASSISTANCE**
697.2 **AGREEMENTS.**

697.3 After November 26, 2014, new adoption assistance agreements must not be executed
697.4 under this section. Agreements that were signed on or before November 26, 2014, and
697.5 were not in effect because the adoption finalization of the child did not occur on or before
697.6 November 26, 2014, must be renegotiated according to the terms of Northstar Care for
697.7 Children under chapter 256N. Agreements signed and in effect on or before November 26,
697.8 2014, must continue according to the terms of this section and applicable rules for the
697.9 duration of the agreement, unless the commissioner and the adoptive parents choose to
697.10 renegotiated the agreements under Northstar Care for Children consistent with section
697.11 256N.28, subdivision 7. After November 26, 2014, this section and associated rules must
697.12 be referred to as the pre-Northstar Care for Children adoption assistance program and
697.13 shall apply to children whose adoption assistance agreements were in effect on or before
697.14 November 26, 2014, and whose adoptive parents have not renegotiated their agreements
697.15 according to the terms of Northstar Care for Children.

697.16 Sec. 20. **[260C.4411] PRE-NORTHSTAR CARE FOR CHILDREN FOSTER**
697.17 **CARE PROGRAM.**

697.18 Subdivision 1. **Pre-Northstar Care for Children foster care program.** (a) For a
697.19 child placed in family foster care on or before December 31, 2014, the county of financial
697.20 responsibility under section 256G.02 or tribal agency authorized under section 256.01,
697.21 subdivision 14b, shall pay the local share under section 256N.27, subdivision 3, for foster
697.22 care maintenance including any difficulty of care as defined in Minnesota Rules, part
697.23 9560.0521, subparts 7 and 10. Family foster care includes:

697.24 (1) emergency relative placement under section 245A.035;

697.25 (2) licensed foster family settings, foster residence settings, or treatment foster care
697.26 settings, licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and served by
697.27 a public or private child care agency authorized by Minnesota Rules, parts 9545.0755
697.28 to 9545.0845;

697.29 (3) family foster care homes approved by a tribal agency; and

697.30 (4) unlicensed supervised settings for foster youth ages 18 to 21.

697.31 (b) The county of financial responsibility under section 256G.02 or tribal social
697.32 services agency authorized in section 256.01, subdivision 14b, shall pay the entire cost of
697.33 any initial clothing allowance, administrative payments to child care agencies specified
697.34 in section 317A.907, or any other support services it authorizes, except as otherwise
697.35 provided by law.

698.1 (c) The rates for the pre-Northstar Care for Children foster care program remain
698.2 those in effect on January 1, 2013, continuing the preexisting rate structure for foster
698.3 children who remain with the same caregivers and do not transition into Northstar Care for
698.4 Children under section 256N.21, subdivision 6.

698.5 (d) Difficulty of care payments must be maintained consistent with Minnesota Rules,
698.6 parts 9560.0652 and 9560.0653, using the established reassessment tool in Minnesota
698.7 Rules, part 9560.0654. The preexisting rate structure for the pre-Northstar Care for
698.8 Children foster care program must be maintained, provided that when the number of
698.9 foster children in the program is less than ten percent of the population in 2012, the
698.10 commissioner may apply the same assessment tool to both the pre-Northstar Care for
698.11 Children foster care program and Northstar Care for Children under the authority granted
698.12 in section 256N.24, subdivision 2.

698.13 (e) The county of financial responsibility under section 256G.02 or tribal agency
698.14 authorized under section 256.01, subdivision 14b, shall document the determined
698.15 pre-Northstar Care for Children foster care rate in the case record, including a description
698.16 of each condition on which the difficulty of care assessment is based. The difficulty
698.17 of care rate is reassessed:

698.18 (1) every 12 months;

698.19 (2) at the request of the foster parent; or

698.20 (3) if the child's level of need changes in the current foster home.

698.21 (f) The pre-Northstar Care for Children foster care program must maintain the
698.22 following existing program features:

698.23 (1) monthly payments must be made to the family foster home provider;

698.24 (2) notice and appeal procedures must be consistent with Minnesota Rules, part
698.25 9560.0665; and

698.26 (3) medical assistance eligibility for foster children must continue to be determined
698.27 according to section 256B.055.

698.28 (g) The county of financial responsibility under section 256G.02 or tribal agency
698.29 authorized under section 256.01, subdivision 14b, may continue existing program features,
698.30 including:

698.31 (1) establishing a local fund of county money through which the agency may
698.32 reimburse foster parents for the cost of repairing damage done to the home and contents by
698.33 the foster child and the additional care insurance premium cost of a child who possesses a
698.34 permit or license to drive a car; and

699.1 (2) paying a fee for specific services provided by the foster parent, based on the
699.2 parent's skills, experience, or training. This fee must not be considered foster care
699.3 maintenance.

699.4 (h) The following events end the child's enrollment in the pre-Northstar Care for
699.5 Children foster care program:

699.6 (1) reunification with parent or other relative;

699.7 (2) adoption or transfer of permanent legal and physical custody;

699.8 (3) removal from the current foster home to a different foster home;

699.9 (4) another event that ends the current placement episode; or

699.10 (5) attaining the age of 21.

699.11 Subd. 2. **Consideration of other programs.** (a) When a child in foster care
699.12 is eligible to receive a grant of Retirement Survivors Disability Insurance (RSDI)
699.13 or Supplemental Security Income for the aged, blind, and disabled, or a foster care
699.14 maintenance payment under title IV-E of the Social Security Act, United States Code, title
699.15 42, sections 670 to 676, the child's needs must be met through these programs. Every
699.16 effort must be made to establish a child's eligibility for a title IV-E grant to reimburse the
699.17 county or tribe from the federal funds available for this purpose.

699.18 (b) When a child in foster care qualifies for home and community-based waived
699.19 services under section 256B.49 for community alternative care (CAC), community
699.20 alternatives for disabled individuals (CADI), or traumatic brain injury (TBI) waivers,
699.21 this service does not substitute for the child foster care program. When a foster child is
699.22 receiving waived services benefits, the county of financial responsibility under section
699.23 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, assesses and
699.24 provides foster care maintenance including difficulty of care using the established tool in
699.25 Minnesota Rules, part 9560.0654. If it is determined that additional services are needed to
699.26 meet the child's needs in the home that are not or cannot be met by the foster care program,
699.27 the needs must be referred to the waived service program.

699.28 Sec. 21. **[260C.4412] PAYMENT FOR RESIDENTIAL PLACEMENTS.**

699.29 When a child is placed in a foster care group residential setting under Minnesota
699.30 Rules, parts 2960.0020 to 2960.0710, foster care maintenance payments must be made on
699.31 behalf of the child to cover the cost of providing food, clothing, shelter, daily supervision,
699.32 school supplies, child's personal incidentals and supports, reasonable travel for visitation,
699.33 or other transportation needs associated with the items listed. Daily supervision in the
699.34 group residential setting includes routine day-to-day direction and arrangements to

700.1 ensure the well-being and safety of the child. It may also include reasonable costs of
700.2 administration and operation of the facility.

700.3 **EFFECTIVE DATE.** This section is effective January 1, 2015.

700.4 Sec. 22. **[260C.4413] INITIAL CLOTHING ALLOWANCE.**

700.5 (a) An initial clothing allowance must be available to a child eligible for:

700.6 (1) the pre-Northstar Care for Children foster care program under section 260C.4411,
700.7 subdivision 1; and

700.8 (2) the Northstar Care for Children benefits under section 256N.21.

700.9 (b) An initial clothing allowance must also be available for a foster child in a group
700.10 residential setting based on the child's individual needs during the first 60 days of the
700.11 child's initial placement. The agency must consider the parent's ability to provide for a
700.12 child's clothing needs and the residential facility contracts.

700.13 (c) The county of financial responsibility under section 256G.02 or tribal agency
700.14 authorized under section 256.01, subdivision 14b, shall approve an initial clothing
700.15 allowance consistent with the child's needs. The amount of the initial clothing allowance
700.16 must not exceed the monthly basic rate for the child's age group under section 256N.26,
700.17 subdivision 3.

700.18 **EFFECTIVE DATE.** This section is effective January 1, 2015.

700.19 Sec. 23. Minnesota Statutes 2012, section 260C.446, is amended to read:

700.20 **260C.446 DISTRIBUTION OF FUNDS RECOVERED FOR ASSISTANCE**
700.21 **FURNISHED.**

700.22 When any amount shall be recovered from any source for assistance furnished
700.23 under the provisions of sections 260C.001 to 260C.421 ~~and 260C.441~~, there shall be paid
700.24 into the treasury of the state or county in the proportion in which they have respectively
700.25 contributed toward the total assistance paid.

700.26 **EFFECTIVE DATE.** This section is effective January 1, 2015.

700.27 Sec. 24. **REPEALER.**

700.28 (a) Minnesota Statutes 2012, sections 256.82, subdivision 4; and 260C.441, are
700.29 repealed effective January 1, 2015.

700.30 (b) Minnesota Rules, parts 9560.0650, subparts 1, 3, and 6; 9560.0651; and
700.31 9560.0655, are repealed effective January 1, 2015.

APPENDIX
Article locations in H1233-4

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ARTICLE 17	NORTHSTAR CARE FOR CHILDREN	Page.Ln 647.24

62J.693 MEDICAL RESEARCH.

Subdivision 1. **Definitions.** For purposes of this section, health care research means approved clinical, outcomes, and health services investigations.

Subd. 2. **Grant application process.** (a) The commissioner of health shall make recommendations for a process for the submission, review, and approval of research grant applications. The process shall give priority for grants to applications that are intended to gather preliminary data for submission for a subsequent proposal for funding from a federal agency or foundation, which awards research money on a competitive, peer-reviewed basis. Grant recipients must be able to demonstrate the ability to comply with federal regulations on human subjects research in accordance with Code of Federal Regulations, title 45, section 46, and shall conduct the proposed research. Grants may be awarded to the University of Minnesota, the Mayo Clinic, or any other public or private organization in the state involved in medical research. The commissioner shall report to the legislature by January 15, 2000, with recommendations.

(b) The commissioner may appoint a research advisory committee to provide advice and oversight on the grant application process. If the commissioner appoints a research advisory committee, the committee shall be governed by section 15.059 for membership terms and removal of members.

103I.005 DEFINITIONS.

Subd. 20. **Vertical heat exchanger.** "Vertical heat exchanger" means an earth-coupled heating or cooling device consisting of a sealed closed-loop piping system installed vertically in the ground to transfer heat to or from the surrounding earth with no discharge.

144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES; EXCEPTIONS.

Subd. 2. **Fee amounts.** The commissioner of health shall charge a handling fee prescribed in subdivision 1. The fee shall approximate the costs to the department of handling specimens including reporting, postage, specimen kit preparation, and overhead costs. The fee prescribed in subdivision 1 shall be \$25 per specimen.

144A.46 LICENSURE.

Subdivision 1. **License required.** (a) A home care provider may not operate in the state without a current license issued by the commissioner of health. A home care provider may hold a separate license for each class of home care licensure.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122 and information sufficient to show that the applicant meets the requirements of licensure.

Subd. 2. **Exemptions.** The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) a person who is licensed as a registered nurse under sections 148.171 to 148.285 and who independently provides nursing services in the home without any contractual or employment relationship to a home care provider or other organization;

(2) a personal care assistant who provides services to only one individual under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16;

(3) a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, 256B.04, subdivision 16, and 256B.0659;

(4) a person who is licensed under sections 148.65 to 148.78 and who independently provides physical therapy services in the home without any contractual or employment relationship to a home care provider or other organization;

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(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

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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

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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

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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.

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Subd. 5a. **Initial licensure and inspection fees.** The licensure and inspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

149A.53 RENEWAL OF LICENSE TO OPERATE CREMATORY.

Subd. 9. **Renewal and reinspection fees.** The renewal and reinspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

151.19 REGISTRATION; FEES.

Subd. 2. **Nonresident pharmacies.** The board shall require and provide for an annual nonresident special pharmacy registration for all pharmacies located outside of this state that regularly dispense medications for Minnesota residents and mail, ship, or deliver prescription medications into this state. Nonresident special pharmacy registration shall be granted by the board upon payment of any applicable fee specified in section 151.065 and the disclosure and certification by a pharmacy:

(1) that it is licensed in the state in which the dispensing facility is located and from which the drugs are dispensed;

(2) the location, names, and titles of all principal corporate officers and all pharmacists who are dispensing drugs to residents of this state;

(3) that it complies with all lawful directions and requests for information from the Board of Pharmacy of all states in which it is licensed or registered, except that it shall respond directly to all communications from the board concerning emergency circumstances arising from the dispensing of drugs to residents of this state;

(4) that it maintains its records of drugs dispensed to residents of this state so that the records are readily retrievable from the records of other drugs dispensed;

(5) that it cooperates with the board in providing information to the Board of Pharmacy of the state in which it is licensed concerning matters related to the dispensing of drugs to residents of this state;

(6) that during its regular hours of operation, but not less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(7) that, upon request of a resident of a long-term care facility located within the state of Minnesota, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with the provisions of section 151.415, subdivision 5.

151.25 REGISTRATION OF MANUFACTURERS; FEE; PROHIBITIONS.

The board shall require and provide for the annual registration of every person engaged in manufacturing drugs, medicines, chemicals, or poisons for medicinal purposes, now or hereafter doing business with accounts in this state. Upon a payment of any applicable fee specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to such manufacturer. Such registration certificate shall be displayed in a conspicuous place in such manufacturer's or wholesaler's place of business for which it is issued and expire on the date set by the board. It shall be unlawful for any person to manufacture drugs, medicines, chemicals, or poisons for medicinal purposes unless such a certificate has been issued to the person by the board. It shall be unlawful for any person engaged in the manufacture of drugs, medicines, chemicals, or poisons for medicinal purposes, or the person's agent, to sell legend drugs to other than a pharmacy, except as provided in this chapter.

151.45 WHOLESALE DRUG DISTRIBUTOR ADVISORY TASK FORCE.

The board shall appoint a Wholesale Drug Distributor Advisory Task Force composed of five members, to be selected and to perform duties and responsibilities as follows:

(a) One member shall be a pharmacist who is neither a member of the board nor a board employee.

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(b) Two members shall be representatives of wholesale drug distributors as defined in section 151.44, paragraph (b).

(c) One member shall be a representative of drug manufacturers.

(d) One member shall be a public member as defined by section 214.02.

(e) The advisory task force shall review and make recommendations to the board on the merit of all rules dealing with wholesale drug distributors and drug manufacturers that are proposed by the board; and no rule affecting wholesale drug distributors proposed by the board shall be adopted without first being submitted to the task force for review and comment.

(f) In making advisory task force appointments, the board shall consider recommendations received from each of the wholesale drug distributor, pharmacist, and drug manufacturer classes cited in paragraphs (a) to (c), and shall adopt rules that provide for solicitation of the recommendations.

151.47 WHOLESALE DRUG DISTRIBUTOR LICENSING REQUIREMENTS.

Subd. 2. **Requirements must conform with federal law.** All requirements set forth in this section shall conform to wholesale drug distributor licensing guidelines formally adopted by the United States Food and Drug Administration; and in case of conflict between a wholesale drug distributor licensing requirement imposed by the board and a Food and Drug Administration wholesale drug distributor guideline, the latter shall control.

151.48 OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING.

(a) It is unlawful for an out-of-state wholesale drug distributor to conduct business in the state without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for an out-of-state wholesale drug distributor license under this section shall be made on a form furnished by the board.

(c) No person acting as principal or agent for any out-of-state wholesale drug distributor may sell or distribute drugs in the state unless the distributor has obtained a license.

(d) The board may adopt regulations that permit out-of-state wholesale drug distributors to obtain a license on the basis of reciprocity to the extent that an out-of-state wholesale drug distributor:

(1) possesses a valid license granted by another state under legal standards comparable to those that must be met by a wholesale drug distributor of this state as prerequisites for obtaining a license under the laws of this state; and

(2) can show that the other state would extend reciprocal treatment under its own laws to a wholesale drug distributor of this state.

245A.655 FEDERAL GRANTS TO ESTABLISH AND MAINTAIN A SINGLE COMMON ENTRY POINT FOR REPORTING MALTREATMENT OF A VULNERABLE ADULT.

(a) The commissioner of human services shall seek federal funding to design, implement, maintain, and evaluate the common entry point for reports of suspected maltreatment made under Minnesota Statutes, section 626.557. The purpose of the federal grant funds is to establish a common entry point with a statewide toll-free telephone number and Web site-based system to report known or suspected abuse, neglect, or exploitation of a vulnerable adult.

(b) A common entry point must be operated in a manner that enables the common entry point staff to:

(1) operate under Minnesota Statutes, section 626.557, subdivision 9, paragraph (b); and subdivision 9a;

(2) when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; and

(3) immediately identify and locate prior reports of abuse, neglect, or exploitation.

(c) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

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(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.

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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.

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Subd. 24. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to consumers served by the license holder.

245B.03 APPLICABILITY AND EFFECT.

Subdivision 1. **Applicability.** The standards in this chapter govern services to persons with developmental disabilities receiving services from license holders providing residential-based habilitation; day training and habilitation services for adults; supported employment; semi-independent living services; residential programs that serve more than four consumers, including intermediate care facilities for persons with developmental disabilities; and respite care provided outside the consumer's home for more than four consumers at the same time at a single site.

Subd. 2. **Relationship to other standards governing services at ICF's/MR.** (a) ICF's/MR are exempt from:

(1) section 245B.04;
(2) section 245B.06, subdivisions 4 and 6; and
(3) section 245B.07, subdivisions 4, paragraphs (b) and (c); 7; and 8, paragraph (a), clause (4), and paragraph (b).

(b) License holders also licensed under chapter 144 as a supervised living facility are exempt from section 245B.04.

(c) Residential service sites controlled by license holders licensed under this chapter for home and community-based waived services for four or fewer adults are exempt from compliance with Minnesota Rules, parts 9543.0040, subpart 2, item C; 9555.5505; 9555.5515, items B and G; 9555.5605; 9555.5705; 9555.6125, subparts 3, item C, subitem (2), and 4 to 6; 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265; and as provided under section 245B.06, subdivision 2, the license holder is exempt from the program abuse prevention plans and individual abuse prevention plans otherwise required under sections 245A.65, subdivision 2, and 626.557, subdivision 14. The commissioner may approve alternative methods of providing overnight supervision using the process and criteria for granting a variance in section 245A.04, subdivision 9. This chapter does not apply to foster care homes that do not provide residential habilitation services funded under the home and community-based waiver programs defined in section 256B.092.

(d) Residential service sites controlled by license holders licensed under this chapter for home and community-based waived services for four or fewer children are exempt from compliance with Minnesota Rules, parts 2960.3060, subpart 3, items B and C; 2960.3070; 2960.3100, subpart 1, items C, F, and I; and 2960.3210.

(e) The commissioner may exempt license holders from applicable standards of this chapter when the license holder meets the standards under section 245A.09, subdivision 7. License holders that are accredited by an independent accreditation body shall continue to be licensed under this chapter.

(f) License holders governed by sections 245B.02 to 245B.07 must also meet the licensure requirements in chapter 245A.

(g) Nothing in this chapter prohibits license holders from concurrently serving consumers with and without developmental disabilities provided this chapter's standards are met as well as other relevant standards.

(h) The documentation that sections 245B.02 to 245B.07 require of the license holder meets the individual program plan required in section 256B.092 or successor provisions.

Subd. 3. **Continuity of care.** (a) When a consumer changes service to the same type of service provided under a different license held by the same license holder and the policies and procedures under section 245B.07, subdivision 8, are substantially similar, the license holder is exempt from the requirements in sections 245B.06, subdivisions 2, paragraphs (e) and (f), and 4; and 245B.07, subdivision 9, clause (2).

(b) When a direct service staff person begins providing direct service under one or more licenses other than the license for which the staff person initially received the staff orientation requirements under section 245B.07, subdivision 5, the license holder is exempt from all staff orientation requirements under section 245B.07, subdivision 5, except that:

(1) if the service provision location changes, the staff person must receive orientation regarding any policies or procedures under section 245B.07, subdivision 8, that are specific to the service provision location; and

(2) if the staff person provides direct service to one or more consumers for whom the staff person has not previously provided direct service, the staff person must review each consumer's:
(i) service plans and risk management plan in accordance with section 245B.07, subdivision 5,

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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

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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;

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(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

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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

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(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.

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(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

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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;

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(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 licenser, 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

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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

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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

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(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

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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.

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Subd. 5. **Information.** The commissioner shall make information available to consumers and interested others regarding the licensing status of a license holder.

Subd. 6. **Implementation.** The commissioner shall seek advice from parties affected by the implementation of this chapter.

Subd. 7. **Deem status.** The commissioner may exempt a license holder from duplicative standards if the license holder is already licensed under chapter 245A.

245D.08 RECORD REQUIREMENTS.

Subdivision 1. **Record-keeping systems.** The license holder must ensure that the content and format of service recipient, personnel, and program records are uniform, legible, and in compliance with the requirements of this chapter.

Subd. 2. **Service recipient record.** (a) The license holder must:

(1) maintain a record of current services provided to each person on the premises where the services are provided or coordinated; and

(2) protect service recipient records against loss, tampering, or unauthorized disclosure in compliance with sections 13.01 to 13.10 and 13.46.

(b) The license holder must maintain the following information for each person:

(1) identifying information, including the person's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of the person's legal representative, if any, an emergency contact, the case manager, and family members or others as identified by the person or case manager;

(3) service information, including service initiation information, verification of the person's eligibility for services, and documentation verifying that services have been provided as identified in the service plan according to paragraph (a);

(4) health information, including medical history and allergies, and when the license holder is assigned responsibility for meeting the person's health needs according to section 245D.05:

(i) current orders for medication, treatments, or medical equipment;

(ii) medication administration procedures;

(iii) a medication administration record documenting the implementation of the medication administration procedures, including any agreements for administration of injectable medications by the license holder; and

(iv) a medical appointment schedule;

(5) the person's current service plan or that portion of the plan assigned to the license holder. When a person's case manager does not provide a current service plan, the license holder must make a written request to the case manager to provide a copy of the service plan and inform the person of the right to a current service plan and the right to appeal under section 256.045;

(6) a record of other service providers serving the person when the person's service plan identifies the need for coordination between the service providers that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to the service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3; and

(12) discharge summary, including service termination notice and related documentation, when applicable.

Subd. 3. **Access to service recipient records.** The license holder must ensure that the following people have access to the information in subdivision 1 in accordance with applicable state and federal law, regulation, or rule:

(1) the person, the person's legal representative, and anyone properly authorized by the person;

(2) the person's case manager;

(3) staff providing services to the person unless the information is not relevant to carrying out the service plan; and

(4) the county adult foster care licenser, when services are also licensed as adult foster care.

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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.

252.40 SERVICE PRINCIPLES AND RATE-SETTING PROCEDURES.

Sections 252.40 to 252.46 apply to day training and habilitation services for adults with developmental disabilities when the services are authorized to be funded by a county and provided under a contract between a county board and a vendor as defined in section 252.41. Nothing in sections 252.40 to 252.46 absolves intermediate care facilities for persons with developmental disabilities of the responsibility for providing active treatment and habilitation under federal regulations with which those facilities must comply to be certified by the Minnesota Department of Health.

252.46 PAYMENT RATES.

Subdivision 1. **Rates.** (a) Payment rates to vendors, except regional centers, for county-funded day training and habilitation services and transportation provided to persons receiving day training and habilitation services established by a county board are governed by subdivisions 2 to 19. The commissioner shall approve the following three payment rates for services provided by a vendor:

(1) a full-day service rate for persons who receive at least six service hours a day, including the time it takes to transport the person to and from the service site;

(2) a partial-day service rate that must not exceed 75 percent of the full-day service rate for persons who receive less than a full day of service; and

(3) a transportation rate for providing, or arranging and paying for, transportation of a person to and from the person's residence to the service site.

(b) Notwithstanding any law or rule to the contrary, the commissioner may authorize county participation in a voluntary individualized payment rate structure for day training and habilitation services to allow a county the flexibility to change, after consulting with providers, from a site-based payment rate structure to an individual payment rate structure for the providers of day training and habilitation services in the county. The commissioner shall seek input from providers and consumers in establishing procedures for determining the structure of voluntary individualized payment rates to ensure that there is no additional cost to the state or counties and that the rate structure is cost-neutral to providers of day training and habilitation services, on July 1, 2004, or on day one of the individual rate structure, whichever is later.

(c) Medical assistance rates for home and community-based service provided under section 256B.501, subdivision 4, by licensed vendors of day training and habilitation services must not be greater than the rates for the same services established by counties under sections 252.40 to 252.46. For very dependent persons with special needs the commissioner may approve an exception to the approved payment rate under section 256B.501, subdivision 4 or 8.

Subd. 2. **Rate minimum.** Unless a variance is granted under subdivision 6, the minimum payment rates set by a county board for each vendor must be equal to the payment rates approved by the commissioner for that vendor in effect January 1 of the previous calendar year.

Subd. 3. **Rate maximum.** Unless a variance is granted under subdivision 6, the maximum payment rates for each vendor for a calendar year must be equal to the payment rates approved by the commissioner for that vendor in effect December 1 of the previous calendar year. The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual inflation adjustments in reimbursement rates for each vendor, based upon the projected percentage

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change in the Urban Consumer Price Index, all items, published by the United States Department of Labor, for the upcoming calendar year over the current calendar year.

Subd. 4. **New vendors.** (a) Payment rates established by a county for a new vendor for which there were no previous rates must not exceed 95 percent of the greater of 125 percent of the statewide median rates or 125 percent of the average payment rates in the regional development commission district under sections 462.381 to 462.396 in which the new vendor is located unless the criteria in paragraph (b) are met.

(b) A payment rate equal to 200 percent of the statewide average rates shall be assigned to persons served by the new vendor when those persons are persons with very severe self-injurious or assaultive behaviors, persons with medical conditions requiring delivery of physician-prescribed medical interventions at one-to-one staffing for at least 15 minutes each time they are performed, or persons discharged from a regional treatment center after May 1, 1993, to the vendor's program. All other persons for whom the new service is needed must be assigned a rate equal to 95 percent of the greater of 125 percent of the statewide median rates or 125 percent of the regional average rates, whichever is higher, and the maximum payment rate that may be recommended is determined by multiplying the number of clients at each limit by the rate corresponding to that limit and dividing the sum by the total number of clients. When the recommended payment rates exceed 95 percent of 125 percent of the greater of the statewide median or regional average rates, whichever is higher, the county must include documentation verifying the medical or behavioral needs of clients. The approved payment rates must be based on 12 months budgeted expenses divided by at least 90 percent of authorized service units associated with the new vendor's licensed capacity. The county must include documentation verifying the person's discharge from a regional treatment center and that admission of new clients to existing services eligible for a rate variance under subdivision 6 was considered before recommending payment rates for a new vendor. Nothing in this subdivision permits development of a new program that primarily results in refinancing of services for individuals already receiving services in existing programs.

Subd. 5. **Submitting recommended rates.** The county board shall submit recommended payment rates to the commissioner on forms supplied by the commissioner at least 60 days before revised payment rates or payment rates for new vendors are to be effective. The forms must include the county board's written verification of the individual documentation required under section 252.44, clause (a). If a vendor provides services at more than one licensed site, the county board may recommend the same payment rates for each site based on the average rate for all sites. The county board may also recommend differing payment rates for each licensed site if it would result in a total annual payment to the vendor that is equal to or less than the total annual payment that would result if the average rates had been used for all sites. For purposes of this subdivision, the average payment rate for all service sites used by a vendor must be computed by adding the amounts that result when the payment rates for each licensed site are multiplied by the projected annual number of service units to be provided at that site and dividing the sum of those amounts by the total units of service to be provided by the vendor at all sites.

Subd. 6. **Variances.** (a) A variance from the minimum or maximum payment rates in subdivisions 2 and 3 may be granted by the commissioner when the vendor requests and the county board submits to the commissioner a written variance request on forms supplied by the commissioner with the recommended payment rates.

(b) A variance to the rate maximum may be utilized for costs associated with compliance with state administrative rules, compliance with court orders, capital costs required for continued licensure, increased insurance costs, start-up and conversion costs for supported employment, direct service staff salaries and benefits, transportation, and other program related costs when one of the criterion in clauses (1) to (4) is also met:

(1) a determination of need under section 252.28 is approved for a significant program change that is necessary for a vendor to provide authorized services to one or more clients who meet one or more of the following criteria:

(i) the client is a new client and:

(A) exhibits severe behavior as indicated on the screening document;

(B) periodically requires one-to-one staff time for at least 15 minutes at a time to deliver physician prescribed medical interventions; or

(C) has been discharged directly to the vendor's program from a regional treatment center or the Minnesota extended treatment option.

(ii) the client is an existing client who has developed one of the following changed circumstances which increases costs that are not covered by the vendor's current rate, and for whom a significant program change is necessary to ensure the continued provision of authorized services to that client:

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(A) severe behavior as indicated on the screening document;
(B) a medical condition periodically requiring one-to-one staff time for at least 15 minutes at a time to deliver physician prescribed medical interventions; or

(C) a permanent decrease in skill functioning, as verified by medical reports or assessments;

(2) a licensing determination requires a program change that the vendor cannot comply with due to funding restraints;

(3) a determination of need under section 252.28 is approved for a significant and permanent decrease in licensed capacity and the vendor demonstrates the need to retain certain staffing levels to serve the remaining clients; or

(4) in cases where conditions in clauses (1) to (3) do not apply, but a determination of need under section 252.28 is approved for an unusual circumstance which exists that significantly impacts the type or amount of services delivered, as evidenced by documentation presented by the vendor and with the concurrence of the commissioner.

(c) A variance to the rate minimum may be granted when:

(1) the county board contracts for increased services from a vendor and for some or all individuals receiving services from the vendor lower per unit fixed costs result; or

(2) the actual costs of delivering authorized service over a 12-month contract period have decreased.

(d) The written variance request under this subdivision must include documentation that all the following criteria have been met:

(1) the commissioner and the county board have both conducted a review and have identified a need for a change in the payment rates and recommended an effective date for the change in the rate;

(2) the vendor documents efforts to reallocate current staff and any additional staffing needs cannot be met by using temporary special needs rate exceptions under Minnesota Rules, parts 9510.1020 to 9510.1140;

(3) the vendor documents that financial resources have been reallocated before applying for a variance. No variance may be granted for equipment, supplies, or other capital expenditures when depreciation expense for repair and replacement of such items is part of the current rate;

(4) for variances related to loss of clientele, the vendor documents the other program and administrative expenses, if any, that have been reduced;

(5) the county board submits verification of the conditions for which the variance is requested, a description of the nature and cost of the proposed changes, and how the county will monitor the use of money by the vendor to make necessary changes in services;

(6) the county board's recommended payment rates do not exceed 95 percent of the greater of 125 percent of the current statewide median or 125 percent of the regional average payment rates, whichever is higher, for each of the regional commission districts under sections 462.381 to 462.396 in which the vendor is located except for the following: when a variance is recommended to allow authorized service delivery to new clients with severe behaviors or with medical conditions requiring delivery of physician prescribed medical interventions, or to persons being directly discharged from a regional treatment center or Minnesota extended treatment options to the vendor's program, those persons must be assigned a payment rate of 200 percent of the current statewide average rates. All other clients receiving services from the vendor must be assigned a payment rate equal to the vendor's current rate unless the vendor's current rate exceeds 95 percent of 125 percent of the statewide median or 125 percent of the regional average payment rates, whichever is higher. When the vendor's rates exceed 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates, the maximum rates assigned to all other clients must be equal to the greater of 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates. The maximum payment rate that may be recommended for the vendor under these conditions is determined by multiplying the number of clients at each limit by the rate corresponding to that limit and then dividing the sum by the total number of clients.

(e) The commissioner shall have 60 calendar days from the date of the receipt of the complete request to accept or reject it, or the request shall be deemed to have been granted. If the commissioner rejects the request, the commissioner shall state in writing the specific objections to the request and the reasons for its rejection.

Subd. 7. Rate reconsiderations. A host county that disagrees with a rate decision of the commissioner under subdivision 6 or 9 may request reconsideration by the commissioner within 45 days after the date the host county received notification of the commissioner's decision. The request must state the reasons why the host county is requesting reconsideration of the rate decision and present evidence explaining the host county's disagreement with the rate decision.

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The commissioner shall review the host county's evidence and provide the host county with written notification of the decision on the request within 60 days. The commissioner's decision on the request is final.

Until a reconsideration request is decided, payments must continue at a rate the commissioner determines complies with this section. If a higher rate is approved, the commissioner shall order a retroactive payment as determined in the commissioner's decision.

Subd. 8. **Commissioner's notice to boards, vendors.** The commissioner shall notify the county boards and vendors of the average regional payment rates, 95 percent of 125 percent of the average regional payments rates for each of the regional development commission districts designated in sections 462.381 to 462.396, 95 percent of 125 percent of the statewide median rates, and 200 percent of the statewide average rates.

Subd. 9. **Approval or denial of rates.** The commissioner shall approve the county board's recommended payment rates when the rates and verification justifying the projected service units comply with subdivisions 2 to 18. The commissioner shall notify the county board in writing of the approved payment rates within 60 days of receipt of the rate recommendations. If the rates are not approved, or if rates different from those originally recommended are approved, the commissioner shall within 60 days of receiving the rate recommendation notify the county board in writing of the reasons for denying or substituting a different rate for the recommended rates. Approved payment rates remain effective until the commissioner approves different rates in accordance with subdivisions 2 and 3.

Subd. 10. **Vendor's report; audit.** The vendor shall report to the commissioner and the county board on forms prescribed by the commissioner at times specified by the commissioner. The reports shall include programmatic and fiscal information. The audit must be done according to generally accepted auditing standards to result in statements that include a balance sheet, income statement, changes in financial position, and the certified public accountant's opinion. The county's annual audit shall satisfy the audit required under this subdivision for any county-operated day training and habilitation program. Except for day training and habilitation programs operated by a county, the audit must provide supplemental statements for each day training and habilitation program with an approved unique set of rates.

Subd. 11. **Improper transactions.** Transactions that have the effect of circumventing subdivisions 1 to 18 must not be considered by the commissioner for the purpose of payment rate approval under the principle that the substance of the transaction prevails over the form.

Subd. 16. **Payment rate criteria; allocation of expenditures.** Payment rates approved under subdivision 9 must reflect the payment rate criteria in paragraphs (a) and (b) and the allocation principles in paragraph (c).

(a) Payment rates must be based on reasonable costs that are ordinary, necessary, and related to delivery of authorized client services.

(b) The commissioner shall not pay for:

(1) unauthorized service delivery;

(2) services provided in accordance with receipt of a special grant;

(3) services provided under contract to a local school district;

(4) extended employment services under Minnesota Rules, parts 3300.1950 to 3300.3050, or vocational rehabilitation services provided under Title I, section 110 or Title VI-C, Rehabilitation Act Amendments of 1992, as amended, and not through use of medical assistance or county social service funds; or

(5) services provided to a client by a licensed medical, therapeutic, or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee for service basis.

(c) On an annual basis, actual and projected contract year expenses must be allocated to standard budget line items corresponding to direct and other program and administrative expenses as submitted to the commissioner with the host county's recommended payment rates. Central or corporate office costs must be allocated to licensed vendor sites within the group served by the central or corporate office according to the cost allocation principles under section 256B.432.

(d) The vendor must maintain records documenting that clients received the billed services.

Subd. 17. **Hourly rate structure.** Counties participating as host counties under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, may recommend continuation of the hourly rates for participating vendors. The recommendation must be made annually under subdivision 5 and according to the methods and standards provided by the commissioner. The commissioner shall approve the hourly rates when service authorization, billing, and payment for services is possible through the Medicaid management information system and the other criteria in this subdivision are met. Counties and vendors operating under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117,

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shall work with the commissioner to translate the hourly rates and actual expenditures into rates meeting the criteria in subdivisions 1 to 16 unless hourly rates are approved under this subdivision. If the rates meeting the criteria in subdivisions 1 to 16 are lower than the county's or vendor's current rate, the county or vendor must continue to receive the current rate.

Subd. 18. **Pilot study rates.** By January 1, 1994, counties and vendors operating under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, shall work with the commissioner to translate the hourly rates and actual expenditures into rates meeting the criteria in subdivisions 1 to 16 unless hourly rates are approved under subdivision 17.

Subd. 19. **Vendor appeals.** With the concurrence of the county board, a vendor may appeal the commissioner's rejection of a variance request which has been submitted by the county under subdivision 6 and may appeal the commissioner's denial under subdivision 9 of a rate which has been recommended by the county. To appeal, the vendor and county board must file a written notice of appeal with the commissioner. The notice of appeal must be filed or received by the commissioner within 45 days of the postmark date on the commissioner's notification to the vendor and county agency that a variance request or county recommended rate has been denied. The notice of appeal must specify the reasons for the appeal, the dollar amount in dispute, and the basis in statute or rule for challenging the commissioner's decision.

Within 45 days of receipt of the notice of appeal, the commissioner must convene a reconciliation conference to attempt to resolve the rate dispute. If the dispute is not resolved to the satisfaction of the parties, the parties may initiate a contested case proceeding under sections 14.57 to 14.69. In a contested case hearing held under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner incorrectly applied the governing law or regulations, or that the commissioner improperly exercised the commissioner's discretion, in refusing to grant a variance or in refusing to adopt a county recommended rate.

Until the appeal is fully resolved, payments must continue at the existing rate pending the appeal. Retroactive payments consistent with the final decision shall be made after the appeal is fully resolved.

Subd. 20. **Study of day training and habilitation vendors.** The commissioner shall study the feasibility of grouping vendors of similar size, location, direct service staffing needs or performance outcomes to establish payment rate limits that define cost-effective service. Based on the conclusions of the feasibility study the department shall consider developing a method to redistribute dollars from less cost-effective to more cost-effective services based on vendor achievement of performance outcomes. The department shall report to the legislature by January 15, 1996, with results of the study and recommendations for further action. The department shall consult with an advisory committee representing counties, service consumers, vendors, and the legislature.

Subd. 21. **Managed care pilot.** (a) The commissioner may initiate a capitated risk-based managed care option for persons with developmental disabilities, which includes capitated payments for day training and habilitation and alternative active treatment services. The commissioner may permit the health plan, care system, or other health plan network participating in this managed care option to negotiate day training and habilitation rates. The commissioner may grant a variance to any of the provisions in sections 252.40 to 252.46 and Minnesota Rules, parts 9525.1200 to 9525.1580, necessary to implement the pilot.

(b) The commissioner shall report to the legislature financial and program results along with a recommendation as to whether the pilot should be expanded.

256.82 PAYMENTS BY STATE.

Subd. 4. **Rules.** The commissioner shall adopt rules to implement subdivision 3. In developing rules, the commissioner shall take into consideration any existing difficulty of care payment rates so that, to the extent possible, no child for whom a difficulty of care rate is currently established will be adversely affected.

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

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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"

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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:

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- (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

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(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:

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(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

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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;

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(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.

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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.

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(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

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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

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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 waived services to meet federal requirements and assess the implications of changing resources on the provision of services and "research period" means the time period during which the research rate is being assessed by the commissioner.

(b) The commissioner shall determine and publish initial frameworks and values to generate research rates for individuals receiving home and community-based services.

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(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.

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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.501 RATES FOR COMMUNITY-BASED SERVICES FOR DISABLED.

Subd. 8. **Payment for persons with special needs.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivision 2, including rates established under section 252.46 when they apply to services provided to residents of intermediate care facilities for persons with developmental disabilities, and procedures to be followed for rate limitation exemptions for intermediate care facilities for persons with developmental disabilities. Rate payments under subdivision 8a are eligible for a rate exception under this subdivision. No excess payment approved by the commissioner after June 30, 1991, shall be authorized unless:

(1) the need for specific level of service is documented in the individual service plan of the person to be served;

(2) the level of service needed can be provided within the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, without a rate exception within 12 months;

(3) staff hours beyond those available under the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, necessary to deliver services do not exceed 1,440 hours within 12 months;

(4) there is a basis for the estimated cost of services;

(5) the provider requesting the exception documents that current per diem rates are insufficient to support needed services;

(6) estimated costs, when added to the costs of current medical assistance-funded residential and day training and habilitation services and calculated as a per diem, do not exceed the per diem established for the regional treatment centers for persons with developmental disabilities on July 1, 1990, indexed annually by the urban Consumer Price Index, All Items, as forecasted by Data Resources Inc., for the next fiscal year over the current fiscal year;

(7) any contingencies for an approval as outlined in writing by the commissioner are met; and

(8) any commissioner orders for use of preferred providers are met.

The commissioner shall evaluate the services provided pursuant to this subdivision through program and fiscal audits.

The commissioner may terminate the rate exception at any time under any of the conditions outlined in Minnesota Rules, part 9510.1120, subpart 3, for county termination, or by reason of information obtained through program and fiscal audits which indicate the criteria outlined in this subdivision have not been, or are no longer being, met.

The commissioner may approve no more than one rate exception, up to 12 months duration, for an eligible client.

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,

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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.

Subdivision 1. **MFIP assistance unit.** An MFIP assistance unit is either a group of individuals with at least one minor child who live together whose needs, assets, and income are considered together and who receive MFIP assistance, or a pregnant woman and her spouse who receive MFIP assistance.

Individuals identified in subdivision 2 must be included in the MFIP assistance unit. Individuals identified in subdivision 3 are ineligible to receive MFIP. Individuals identified in subdivision 4 may be included in the assistance unit at their option. Individuals not included in the assistance unit who are identified in section 256J.37, subdivisions 1 to 2, must have their income and assets considered when determining eligibility and benefits for an MFIP assistance unit. All assistance unit members, whether mandatory or elective, who live together and for whom one caregiver or two caregivers apply must be included in a single assistance unit.

Subd. 2. **Mandatory assistance unit composition.** Except for minor caregivers and their children who must be in a separate assistance unit from the other persons in the household, when the following individuals live together, they must be included in the assistance unit:

- (1) a minor child, including a pregnant minor;
- (2) the minor child's minor siblings, minor half siblings, and minor stepsiblings;
- (3) the minor child's birth parents, adoptive parents, and stepparents; and
- (4) the spouse of a pregnant woman.

A minor child must have a caregiver for the child to be included in the assistance unit.

Subd. 3. **Individuals who must be excluded from an assistance unit.** (a) The following individuals who are part of the assistance unit determined under subdivision 2 are ineligible to receive MFIP:

- (1) individuals who are recipients of Supplemental Security Income or Minnesota supplemental aid;
- (2) individuals disqualified from the food stamp or food support program or MFIP, until the disqualification ends;
- (3) children on whose behalf federal, state or local foster care payments are made, except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2;
- (4) children receiving ongoing monthly adoption assistance payments under section 259.67; and
- (5) individuals disqualified from the work participation cash benefit program until that disqualification ends.

(b) The exclusion of a person under this subdivision does not alter the mandatory assistance unit composition.

Subd. 4. **Individuals who may elect to be included in the assistance unit.** (a) The minor child's eligible caregiver may choose to be in the assistance unit, if the caregiver is not required to be in the assistance unit under subdivision 2. If the eligible caregiver chooses to be in the assistance unit, that person's spouse must also be in the unit.

(b) Any minor child not related as a sibling, stepsibling, or adopted sibling to the minor child in the unit, but for whom there is an eligible caregiver may elect to be in the unit.

(c) A foster care provider of a minor child who is receiving federal, state, or local foster care maintenance payments may elect to receive MFIP if the provider meets the definition of caregiver under section 256J.08, subdivision 11. If the provider chooses to receive MFIP, the spouse of the provider must also be included in the assistance unit with the provider. The provider and spouse are eligible for assistance even if the only minor child living in the provider's home is receiving foster care maintenance payments.

(d) The adult caregiver or caregivers of a minor parent are eligible to be a separate assistance unit from the minor parent and the minor parent's child when:

- (1) the adult caregiver or caregivers have no other minor children in the household;
- (2) the minor parent and the minor parent's child are living together with the adult caregiver or caregivers; and

(3) the minor parent and the minor parent's child receive MFIP, or would be eligible to receive MFIP, if they were not receiving SSI benefits.

Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based on the number of persons in the assistance unit eligible for both food and cash assistance unless the restrictions in subdivision 6 on the birth of a child apply. The amount of the transitional standard is published annually by the Department of Human Services.

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Subd. 5a. **Food portion of MFIP transitional standard.** The commissioner shall adjust the food portion of the MFIP transitional standard as needed to reflect adjustments to the Supplemental Nutrition Assistance Program. The commissioner shall publish the transitional standard including a breakdown of the cash and food portions for an assistance unit of sizes one to ten in the State Register whenever an adjustment is made.

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.

Subd. 7. **Family wage level.** The family wage level is 110 percent of the transitional standard under subdivision 5 or 6, when applicable, and is the standard used when there is earned income in the assistance unit. As specified in section 256J.21, earned income is subtracted from the family wage level to determine the amount of the assistance payment. The assistance payment may not exceed the transitional standard under subdivision 5 or 6, or the shared household standard under subdivision 9, whichever is applicable, for the assistance unit.

Subd. 9. **Shared household standard; MFIP.** (a) Except as prohibited in paragraph (b), the county agency must use the shared household standard when the household includes one or more unrelated members, as that term is defined in section 256J.08, subdivision 86a. The county agency must use the shared household standard, unless a member of the assistance unit is a victim of family violence and has an alternative employment plan, regardless of the number of unrelated members in the household.

(b) The county agency must not use the shared household standard when all unrelated members are one of the following:

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(1) a recipient of public assistance benefits, including food stamps or food support, Supplemental Security Income, adoption assistance, relative custody assistance, or foster care payments;

(2) a roomer or boarder, or a person to whom the assistance unit is paying room or board;

(3) a minor child under the age of 18;

(4) a minor caregiver living with the minor caregiver's parents or in an approved supervised living arrangement;

(5) a caregiver who is not the parent of the minor child in the assistance unit; or

(6) an individual who provides child care to a child in the MFIP assistance unit.

(c) The shared household standard must be discontinued if it is not approved by the United States Department of Agriculture under the MFIP waiver.

Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least 115 percent of the federal poverty guidelines at the time of the adjustment. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented whenever a Supplemental Nutrition Assistance Program adjustment is reflected in the food portion of the MFIP transitional standard as required under subdivision 5a.

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).

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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

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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.

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 200 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance.

Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period of eligibility.

Subd. 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

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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.

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the \$10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.

256L.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

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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.

260C.441 COST, PAYMENT.

[For text of this section, see M.S.2012]

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 waived services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waived services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waived services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60; and

(10) alternative care services under Minnesota Statutes, section 256B.0913.

(c) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers. To implement the rate reductions in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect up to a 1.67 percent reduction for the specified services for the period of July 1, 2013, through December 31, 2013.

The above payment rate reduction, allocation rates, and rate limits shall expire for services rendered on December 31, 2013.

4668.0002 APPLICABILITY, AUTHORITY, AND SCOPE.

This chapter implements the licensing of home care providers under Minnesota Statutes, sections 144A.43 to 144A.47, under the authority of Minnesota Statutes, sections 144A.45, subdivision 1, and 144A.4605. Unless otherwise provided, all licensed home care providers must meet the requirements of this chapter. Provisions that apply only to specified classes of licensees are identified by those provisions. The commissioner may delegate any authority or responsibility to an agent of the department. This chapter must be read together with Minnesota Statutes, sections 144A.43 to 144A.47.

4668.0003 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 4668.0002 to 4668.0870, the terms in subparts 2 to 45 have the meanings given them.

Subp. 2. **Ambulatory.** "Ambulatory" means the ability to move about and transfer between locations without the assistance of another person, either with or without the assistance of a walking device or wheel chair.

Subp. 2a. **Assistance with self-administration of medication.** "Assistance with self-administration of medication" means performing a task to enable a client to self-administer medication, including:

- A. bringing the medication to the client;
- B. opening a container containing medications set up by a nurse, physician, or pharmacist;
- C. emptying the contents from the container into the client's hand;
- D. providing liquids or nutrition to accompany medication that a client is self-administering; or
- E. reporting information to a nurse regarding concerns about a client's self-administration of medication.

Subp. 2b. **Class F home care provider.** "Class F home care provider" has the meaning given in Minnesota Statutes, section 144A.4605, subdivision 1.

Subp. 2c. **Assisted living home care service.** "Assisted living home care service" means a nursing service, delegated nursing service, other service performed by an unlicensed person, or central storage of medications provided solely for a resident of a housing with services establishment registered under Minnesota Statutes, chapter 144D.

Subp. 3. **Assisted living services.** "Assisted living services," as provided under a class E home care license, means individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. In this subpart, "individualized" means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illnesses, disabilities, or physical conditions.

Subp. 4. **Business.** "Business" means an individual or other legal entity that provides services to persons in their homes.

Subp. 5. **Client.** "Client" means a person to whom a home care provider provides home care services.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 7. **Contract.** "Contract" means a legally binding agreement, whether in writing or not.

Subp. 8. **Department.** "Department" means the Minnesota Department of Health.

Subp. 9. **Home care aide tasks.** "Home care aide tasks" means those services specified in part 4668.0110, subpart 1.

Subp. 10. **Home care provider or provider.** "Home care provider" or "provider" has the meaning given to home care provider by Minnesota Statutes, section 144A.43, subdivision 4.

Subp. 11. **Home care service.** "Home care service" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3.

Subp. 12. **Home health aide tasks.** "Home health aide tasks" means those tasks allowed in part 4668.0100, subpart 1.

Subp. 13. **Home management services.** "Home management services" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3, clause (8).

Subp. 14. **Home management tasks.** "Home management tasks" means all home management services that are not home health aide or home care aide tasks.

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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.

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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

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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.

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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.

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(5) Class F home care provider license. Under this license, a provider may provide assisted living home care services solely for residents of one or more registered housing with services establishments, as provided by Minnesota Statutes, section 144A.4605.

B. If a provider meets the requirements of more than one license class, the commissioner shall issue to the provider a separate license for each applicable class of home care licensure.

Subp. 4. Applicability of rules to classes.

A. A class A licensee must comply with parts 4668.0002 to 4668.0180, and 4668.0218 to 4668.0240, except that one certified for Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with the requirements listed in part 4668.0180, subpart 10.

B. A class B licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0190, and 4668.0218 to 4668.0240.

C. A class C licensee must comply with parts 4668.0002 to 4668.0035, 4668.0050 to 4668.0065, 4668.0075 to 4668.0170, 4668.0200, and 4668.0218 to 4668.0240.

D. A class E licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0215, and 4668.0218 to 4668.0240.

E. A class F home care provider licensee must comply with parts 4668.0002 to 4668.0050, 4668.0065, 4668.0070, 4668.0170, 4668.0218 to 4668.0240, and 4668.0800 to 4668.0870.

Subp. 5. New license. A license shall be issued to an applicant that is not currently licensed if the applicant completes the application, pays the fee in full, and complies with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. A license is effective for one year after the date the license is issued.

Subp. 6. License application. To apply for a license under this chapter, an applicant must follow the procedures in items A and B.

A. An applicant for a license under this chapter must provide the following information on forms provided by the commissioner:

(1) the applicant's name and address, including the name of the county in which the applicant resides or has its principal place of business;

(2) address and telephone number of the principal administrative office;

(3) address and telephone number of each branch office, if any;

(4) names and addresses of all owners and managerial officials;

(5) documentation of compliance with the background study requirements of Minnesota Statutes, section 144A.46, subdivision 5, for all persons involved in the management, operation, or control of a provider;

(6) evidence of workers' compensation coverage, as required by Minnesota Statutes, sections 176.181 and 176.182;

(7) in the case of class C applicants, proof that the applicant is not contagious with tuberculosis, as required by part 4668.0065, subparts 1 and 2;

(8) in the case of class C applicants, proof that the applicant has met any applicable training and supervision requirements for paraprofessionals, as provided by parts 4668.0100 and 4668.0110; and

(9) a list of those home care services listed in Minnesota Statutes, section 144A.43, subdivision 3, or 144A.4605, that will be made available to clients.

B. An application on behalf of a corporation, association, or unit of government must be signed by an officer or managing agent.

Subp. 7. Agent. Each application for a home care provider license or for renewal of a home care provider license shall designate one or more owners, managerial officials, or employees, as an agent:

A. who is authorized to transact business with the commissioner of health on all matters provided for in this chapter and Minnesota Statutes, sections 144A.43 to 144A.47; and

B. upon whom all notices and orders shall be served, and who is authorized to accept service of notices and orders on behalf of the licensee, in proceedings under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

The designation of one or more persons under this subpart shall not affect the legal responsibility of any other owner or managerial official under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

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Subp. 8. **Notification of changes in information.** The licensee shall notify the commissioner in writing within ten working days after any change in the information required to be provided by subparts 6 and 7, except for the information required by subpart 6, item A, subitem (4), which will be required at the time of license renewal, and except for services reported under subpart 6, item A, subitem (9), that are discontinued for less than 90 days.

Subp. 9. **Application processing.** The commissioner shall process an application in the manner provided by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (b). No application shall be processed without payment of the license fee in full, in the amount provided by subpart 18.

Subp. 10. **Prelicensing survey.** Before granting a license, the commissioner may investigate the applicant for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 11. **Denial of license.** A license shall be denied if:

A. the applicant; an owner of the applicant, individually or as an owner of another home care provider; or another home care provider of which an owner of the applicant also was or is an owner; has ever been issued a correction order for failing to assist its clients, in violation of part 4668.0050, subpart 2, upon the licensee's decision to cease doing business as a home care provider;

B. the applicant is not in compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

C. the applicant is disqualified under Minnesota Statutes, sections 144.057 and 245A.04;

D. the applicant or an owner or managerial official has been unsuccessful in having a disqualification under Minnesota Statutes, section 144.057 or 245A.04, set aside; or

E. the commissioner determines that an owner or managerial official, as an owner or managerial official of another licensee, was substantially responsible for the other licensee's failure to substantially comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 12. **Change of classification.** A licensee may change to a different class of license under subpart 3, by submitting a new application under subpart 6 and meeting all applicable requirements of this chapter. An application under this subpart shall be accompanied by the fee provided by subpart 18.

Subp. 13. **License renewals.** Except as provided in subpart 14 or 15, a license will be renewed for a period of one year if the licensee satisfies items A to C. The licensee must:

A. submit an application for renewal on forms provided by the commissioner at least 30 days before expiration of the license;

B. submit the renewal fee, in the amount provided by subpart 18; and

C. comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 14. **Conditional license.** If a licensee is not in full compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, at the time of expiration of its license, and the violations do not warrant denial of renewal of the license, the commissioner shall issue a license for a limited period conditioned on the licensee achieving full compliance within the term of the license or the term of any correction orders.

Subp. 15. **Suspension, revocation, or denial of renewal of license.** The commissioner may deny renewal of a license, or may suspend, revoke, or make conditional a license, if the licensee, or an owner or managerial official of the licensee:

A. is in violation, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47;

B. permits, aids, or abets the commission of any illegal act in the provision of home care;

C. performs any act detrimental to the welfare of a client;

D. obtained the license by fraud or misrepresentation;

E. knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

F. denies representatives of the commissioner access to any part of the provider, its books, records, or files, or employees;

G. interferes with or impedes a representative of the commissioner in contacting the provider's clients;

H. interferes with or impedes a representative of the commissioner in the enforcement of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

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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.

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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

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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

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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.

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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:

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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

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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

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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.

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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.

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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.

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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;

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- 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

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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;

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- 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;

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- 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.

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Subp. 3. **Fulfillment of services.** A class F home care provider licensee must provide all services required by a client's service plan under part 4668.0815.

Subp. 4. **Referrals.** If a class F home care provider licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee must:

- A. inform the client of the possible need;
- B. determine the client's preferences with respect to obtaining the service; and
- C. if the client desires the service, inform the client about available providers or referral services.

Subp. 5. **Availability of contact person.** A class F home care provider licensee must have a contact person available for consultation whenever an unlicensed person employed by the licensee is performing assisted living home care services for a client. The contact person must be available to unlicensed personnel in person, by telephone, or by other means of direct communication.

Subp. 6. **Violations of rules.** For each violation of parts 4668.0800 to 4668.0870 subject to a fine under Minnesota Statutes, section 144.653, subdivisions 5 to 8, a fine shall be assessed according to the schedules established in parts 4668.0800 to 4668.0870.

Subp. 7. **Failure to correct deficiency.** If, upon subsequent reinspection after a fine has been imposed under subpart 6, the deficiency has still not been corrected, another fine must be assessed. This fine must be double the amount of the previous fine.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 3, \$350;
- B. subpart 4, \$200; and
- C. subpart 5, \$300.

4668.0805 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.

Subp. 2. **Content.** The orientation required under subpart 1 must contain the following topics:

- A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- B. handling emergencies and using emergency services;
- C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- D. the home care bill of rights, Minnesota Statutes, section 144A.44;
- E. handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and
- F. the services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by a class F home care provider licensee or may be obtained from other sources. The commissioner must provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** A class F home care provider licensee must retain evidence that each person has completed the orientation training required under this part.

Subp. 5. **Transferability.** A class F home care provider licensee may accept written verification from another provider that a person has completed the orientation required under this part.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 1, \$300;
- B. subpart 2, \$100; and
- C. subpart 4, \$50.

4668.0810 CLIENT RECORDS.

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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;

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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;

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(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;

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- G. providing skin care, including full or partial bathing and foot soaks;
- H. during episodes of serious disease or acute illness, providing the following services or assisting a client to:
 - (1) maintain the hygiene of the client's body and immediate environment;
 - (2) satisfy nutritional needs;
 - (3) assist with the client's mobility, including movement, change of location, and positioning;
 - (4) bathe;
 - (5) maintain oral hygiene;
 - (6) dress;
 - (7) care for hair;
 - (8) use the toilet;
 - (9) change bedding;
 - (10) perform basic housekeeping; and
 - (11) prepare meals; and
- I. providing central storage of medications, according to part 4668.0865.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

- A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
- B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;
- C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
- D. the procedures for each client are documented in the client's record; and
- E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 5. **Information to determine delegation.** The licensee must establish and implement policies to communicate up-to-date information to the registered nurse regarding the current available unlicensed personnel and their training and qualifications, so the registered nurse has sufficient information to determine the appropriateness of delegating tasks in individual situations.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$250;
- B. subpart 3, \$350;
- C. subpart 4, \$350; and
- D. subpart 5, \$350.

4668.0830 OTHER SERVICES PERFORMED BY UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides other services performed by unlicensed personnel.

Subp. 2. **Other services.** A person who satisfies the requirements of part 4668.0835 may perform services in the registered housing with services establishment including:

- A. preparing modified diets, including diabetic or low sodium diets;
- B. providing medication reminders;
- C. performing household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;
- D. performing household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease;
- E. assisting with dressing, oral hygiene, hair care, grooming, and bathing; and
- F. performing home management tasks.

Subp. 3. **Schedule of fines.** A fine of \$350 shall be assessed for a violation of subpart 2.

4668.0835 QUALIFICATIONS FOR UNLICENSED PERSONNEL WHO PERFORM ASSISTED LIVING HOME CARE SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Qualifications.** An unlicensed person may offer to perform, or be employed to perform nursing services delegated to unlicensed personnel as provided under part 4668.0825, other services performed by unlicensed personnel as provided under part 4668.0830, or central storage of medications as provided under part 4668.0865, only if the person has:

A. successfully completed the training and passed the competency evaluation according to part 4668.0840, subpart 2;

B. successfully completed the training under part 4668.0840, subpart 3, and passed a competency evaluation according to part 4668.0840, subpart 4; or

C. satisfied the requirements of part 4668.0100, subpart 5.

Subp. 3. **In-service training and demonstration of competency.** For each unlicensed person who performs assisted living home care services, a class F home care provider licensee must comply with items A to C.

A. For each 12 months of employment, a person who performs assisted living home care services must complete at least eight hours of in-service training in topics relevant to the provision of home care services, including training in infection control required under part 4668.0065, subpart 3, obtained from the licensee or another source.

B. If a person has not performed assisted living home care services for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence according to part 4668.0840, subpart 4, item C.

C. A licensee must retain documentation of satisfying this part and must provide documentation to a person who completes the in-service training.

Subp. 4. **Documentation.**

A. An unlicensed person who performs assisted living home care services must provide documentation to the employing licensee of satisfying this part.

B. A class F home care provider licensee must verify that unlicensed persons employed by the licensee to perform assisted living home care services have satisfied the requirements of this part, and must retain documentation in the personnel records.

Subp. 5. **Initiation of services by unlicensed personnel.** Before initiating delegated nursing services by unlicensed personnel, a registered nurse must orient each person who is to perform assisted living home care services to each client and to the assisted living home care services to be performed. Based on the professional judgment of the registered nurse and on the individual needs of the client, the orientation may occur onsite, verbally, or in writing.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, \$300;

B. subpart 3, \$300;

C. subpart 4, \$50; and

D. subpart 5, \$350.

4668.0840 TRAINING AND COMPETENCY EVALUATION FOR UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Scope of training course and instructor.** The training required under part 4668.0835, subpart 2, must:

A. include each assisted living home care service offered to clients that the unlicensed person will perform, taught by a registered nurse with experience or training in the subject being taught;

B. include the core training requirements specified in subpart 3;

C. include the competency evaluation required under subpart 4; and

D. use a curriculum that meets the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

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Subp. 3. Core training of unlicensed personnel.

A. An unlicensed person performing assisted living home care services must successfully complete training or demonstrate competency in the topics described in subitems (1) to (12). The required topics are:

- (1) an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- (2) recognizing and handling emergencies and using emergency services;
- (3) reporting maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- (4) the home care bill of rights, Minnesota Statutes, section 144A.44;
- (5) handling clients' complaints and reporting complaints to the Office of Health Facility Complaints;
- (6) the services of the ombudsman for older Minnesotans;
- (7) communication skills;
- (8) observing, reporting, and documenting client status and the care or services provided;
- (9) basic infection control;
- (10) maintaining a clean, safe, and healthy environment;
- (11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and
- (12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

B. The core training of unlicensed personnel must be taught by a registered nurse with experience or training in home care, except that item A, subitems (1) to (7), may be taught by another instructor under the direction of the registered nurse.

C. The core training curriculum must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. Competency evaluation.

A. The competency evaluation tests required under part 4668.0835, subpart 2, items A and B, must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

B. A registered nurse must complete and document each competency evaluation.

C. To qualify to perform assisted living home care services, a person must demonstrate competency by successfully completing:

- (1) a written, oral, or practical test of the topics in subpart 3; and
- (2) a written, oral, or practical test of all assisted living home care provider services that the person will perform.

Subp. 5. Evidence of qualifications. A class F home care provider licensee that provides the training and the competency evaluation required by this part must provide each person who successfully completes the training or passes the competency evaluation with written verification of satisfying this part.

Subp. 6. Schedule of fines. For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$300;
- B. subpart 3, \$300;
- C. subpart 4, \$300; and
- D. subpart 5, \$50.

4668.0845 PERIODIC SUPERVISION OF UNLICENSED PERSONNEL.

Subpart 1. Scope. This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. Services that require supervision by a registered nurse.

A. After the orientation required under part 4668.0835, subpart 5, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who perform assisted living home care services that require supervision by

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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.

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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.

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Subp. 4. **Authorizations.** An order for medication or treatment must be dated and signed by the prescriber, except as provided by subparts 6 and 7, and must be current and consistent with the nursing assessment required under part 4668.0855, subpart 2.

Subp. 5. **Content of medication orders.** An order for medication must contain the name of the drug, dosage indication, and directions for use.

Subp. 6. **Verbal orders.** Upon receiving an order verbally from a prescriber, a nurse must:

- A. record and sign the order; and
- B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 7. **Electronically transmitted orders.**

A. An order received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.291 to 144.298 and 144A.44.

B. An order received by telephone, facsimile machine, or other electronic means must be communicated to the supervising registered nurse within one hour of receipt.

C. An order received by electronic means, not including facsimile machine, must be immediately recorded or placed in the client's record by a nurse and must be countersigned by the prescriber within 62 days.

D. An order received by facsimile machine must have been signed by the prescriber and must be immediately recorded or a durable copy placed in the client's record by a person authorized by the class F home care provider licensee.

Subp. 8. **Implementation of order.** When an order is received, the class F home care provider licensee or an employee of the licensee must take action to implement the order within 24 hours of receipt of the order.

Subp. 9. **Renewal of orders.** A medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$350;
- B. subpart 3, \$350;
- C. subpart 4, \$350;
- D. subpart 5, \$350;
- E. subpart 6, \$350;
- F. subpart 7, item A, \$250;
- G. subpart 7, item B, \$300;
- H. subpart 7, item C, \$300;
- I. subpart 7, item D, \$300;
- J. subpart 8, \$500 per day; and
- K. subpart 9, \$100.

4668.0865 CENTRAL STORAGE OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Nursing assessment and service plan.** For a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of a client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Control of medications.**

A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

- B. The system must contain at least the following provisions:

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- (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.

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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.

9525.1860 REIMBURSABLE SERVICES. Subp. 3. Billing for services.

B. In verbal or written contact with professionals or others regarding the person's progress in attaining the goals and objectives specified in the person's individual service plan.

9525.1860 REIMBURSABLE SERVICES. Subp. 3. Billing for services.

C. In planning activities including attending the person's interdisciplinary team meetings, developing goals and objectives for the person's individual service plan, assessing and reviewing the person's specified goals and objectives, documenting the person's progress toward attaining the goals and objectives in the person's individual service plan and assessing the adequacy of the services related to the goals and objectives in the person's individual service plan.

9525.1860 REIMBURSABLE SERVICES. Subp. 4. Service limitations.

D. Leave days are reimbursable for supported living services for children or supported living services for adults. If the person is not receiving respite care or other supported living services, billings may be made for leave days when the person is:

- (1) hospitalized;
- (2) on an overnight trip or vacation; or
- (3) home for a visit.

Leave days that are not included in the individual service plan may not be billed for without the county board's written authorization. The county board and the provider must document all leave days for which billings are made and specify the reasons the county board authorized the leave days.

9560.0650 MAINTENANCE STANDARDS.

Subpart 1. **Payments.** The local agency shall make payments based on the following maintenance standards:

Age	Monthly Maintenance Standard	Initial Clothing
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0-11	\$212 (\$244 effective January 1984)	up to \$146 (up to \$168 effective January 1984)
12-14	\$293	up to \$288
15-18	\$320	up to \$348

The initial clothing allowance shall be available based on the child's needs during the first 60 days of the initial placement. The state agency shall annually review and revise the maintenance standard based on "USDA Estimates of the Cost of Raising a Child," issued by the United States Department of Agriculture, Agricultural Resources Service, Publication 1411 (October, 1982).

9560.0650 MAINTENANCE STANDARDS.

Subp. 3. **Agency contract care.** When foster care is provided for a child by a provider licensed under parts 9545.0010 to 9545.0260 through contract with a public or private agency, foster care maintenance payments and difficulty of care payments shall be determined according to the rate schedules in subpart 1 and parts 9560.0653 to 9560.0655. If the local agency is contracting for administrative or social services costs, the payments to the contracting agency shall be in addition to the rates established in subpart 1 and parts 9560.0653 to 9560.0655.

9560.0650 MAINTENANCE STANDARDS.

Subp. 6. **Reassessment.** The agency shall reassess a child:

- A. at the end of 12 months;
- B. at the request of a foster parent;
- C. when a child is placed in a different facility; or
- D. if a child's level of need changes.

9560.0651 DIFFICULTY OF CARE ASSESSMENTS AND PAYMENTS.

Parts 9560.0652 to 9560.0656 provide criteria for assessing the difficulty of care and the payment rate for a child in foster care.

9560.0655 DIFFICULTY OF CARE PAYMENT RATE.

Subpart 1. **Payment rate.** Except as provided by subpart 2, the local agency shall make payments to the foster care provider at the rate of \$3.70 per month for each point assessed under part 9560.0654.

Subp. 2. **Existing placements.** In a placement for which a difficulty of care payment was established and was being made prior to January 1, 1989, and the payment is greater than the payment which would be made under subpart 1, the local agency shall continue to pay the greater amount until the child's difficulty of care changes or the placement terminates.

Subp. 3. **Annual revision of payment rate.** By November 1 of each year following January 1, 1989, the commissioner shall review and revise the difficulty of care payment rate in subpart 1 based on USDA Estimates of the Cost of Raising a Child, published by the United States Department of Agriculture, Agricultural Resources Service, Publication 1411. The revision shall be the average percentage by which costs increase for the age ranges represented in the USDA Estimates of the Cost of Raising a Child. The USDA Estimates of the Cost of Raising a Child is subject to annual revision.