

1.1 A bill for an act

1.2 relating to health and human services; relieving counties of certain mandates;
1.3 allowing counties to place children for treatment in bordering states; modifying
1.4 county payment of funeral expenses; modifying provisions related to children's
1.5 therapeutic services and supports; modifying certain nursing facility rules;
1.6 providing an alternative licensing method for day training and habilitation
1.7 services; accepting certain independent audits; modifying renewal notice
1.8 requirements; modifying health care program information that school district
1.9 or charter school must provide; amending Minnesota Statutes 2008, sections
1.10 62Q.37, subdivision 3; 144A.04, subdivision 11, by adding a subdivision;
1.11 144A.45, subdivision 1; 157.22; 245.4871, subdivision 10; 245.4882, subdivision
1.12 1; 245.4885, subdivision 1a; 245A.09, subdivision 7; 256.935; 256.962,
1.13 subdivisions 6, 7; 256B.0915, subdivision 3h; 256B.0943, subdivisions 4, 6, 9;
1.14 256B.0945, subdivision 1; 256F.13, subdivision 1; 260C.212, subdivisions 4a,
1.15 11; 261.035; 471.61, subdivision 1.

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

1.17 **ARTICLE 1**

1.18 **HUMAN SERVICES**

1.19 Section 1. Minnesota Statutes 2008, section 157.22, is amended to read:

1.20 **157.22 EXEMPTIONS.**

1.21 This chapter shall not be construed to apply to:

1.22 (1) interstate carriers under the supervision of the United States Department of
1.23 Health and Human Services;

1.24 (2) any building constructed and primarily used for religious worship;

1.25 (3) any building owned, operated, and used by a college or university in accordance
1.26 with health regulations promulgated by the college or university under chapter 14;

1.27 (4) any person, firm, or corporation whose principal mode of business is licensed
1.28 under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food

S.F. No. 986, 1st Engrossment - 86th Legislative Session (2009-2010) [s0986-1]

2.1 or beverage establishment; provided that the holding of any license pursuant to sections
2.2 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable
2.3 provisions of this chapter or the rules of the state commissioner of health relating to
2.4 food and beverage service establishments;

2.5 (5) family day care homes and group family day care homes governed by sections
2.6 245A.01 to 245A.16;

2.7 (6) nonprofit senior citizen centers for the sale of home-baked goods;

2.8 (7) fraternal or patriotic organizations that are tax exempt under section 501(c)(3),
2.9 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of
2.10 1986, or organizations related to or affiliated with such fraternal or patriotic organizations.
2.11 Such organizations may organize events at which home-prepared food is donated by
2.12 organization members for sale at the events, provided:

2.13 (i) the event is not a circus, carnival, or fair;

2.14 (ii) the organization controls the admission of persons to the event, the event agenda,
2.15 or both; and

2.16 (iii) the organization's licensed kitchen is not used in any manner for the event;

2.17 (8) food not prepared at an establishment and brought in by individuals attending a
2.18 potluck event for consumption at the potluck event. An organization sponsoring a potluck
2.19 event under this clause may advertise the potluck event to the public through any means.
2.20 Individuals who are not members of an organization sponsoring a potluck event under this
2.21 clause may attend the potluck event and consume the food at the event. Licensed food
2.22 establishments other than schools cannot be sponsors of potluck events. A school may
2.23 sponsor and hold potluck events in areas of the school other than the school's kitchen,
2.24 provided that the school's kitchen is not used in any manner for the potluck event. For
2.25 purposes of this clause, "school" means a public school as defined in section 120A.05,
2.26 subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization
2.27 at which a child is provided with instruction in compliance with sections 120A.22 and
2.28 120A.24. Potluck event food shall not be brought into a licensed food establishment
2.29 kitchen; ~~and~~

2.30 (9) a home school in which a child is provided instruction at home; and

2.31 (10) group residential facilities of ten or fewer beds licensed by the commissioner of
2.32 human services under Minnesota Rules, chapter 2960, provided the facility employs or
2.33 contracts with a certified food manager under Minnesota Rules, part 4626.2015.

2.34 Sec. 2. Minnesota Statutes 2008, section 245.4871, subdivision 10, is amended to read:

3.1 Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or
3.2 "day treatment program" means a structured program of treatment and care provided to a
3.3 child in:

3.4 (1) an outpatient hospital accredited by the Joint Commission on Accreditation of
3.5 Health Organizations and licensed under sections 144.50 to 144.55;

3.6 (2) a community mental health center under section 245.62;

3.7 (3) an entity that is under contract with the county board to operate a program that
3.8 meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts
3.9 9505.0170 to 9505.0475; or

3.10 (4) an entity that operates a program that meets the requirements of section
3.11 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is
3.12 under contract with an entity that is under contract with a county board.

3.13 Day treatment consists of group psychotherapy and other intensive therapeutic
3.14 services that are provided for a minimum ~~three-hour~~ two-hour time block by a
3.15 multidisciplinary staff under the clinical supervision of a mental health professional.

3.16 Day treatment may include education and consultation provided to families and
3.17 other individuals as an extension of the treatment process. The services are aimed at
3.18 stabilizing the child's mental health status, and developing and improving the child's daily
3.19 independent living and socialization skills. Day treatment services are distinguished from
3.20 day care by their structured therapeutic program of psychotherapy services. Day treatment
3.21 services are not a part of inpatient hospital or residential treatment services. ~~Day treatment~~
3.22 ~~services for a child are an integrated set of education, therapy, and family interventions.~~

3.23 A day treatment service must be available to a child ~~at least five days a week~~
3.24 throughout the year and must be coordinated with, integrated with, or part of an education
3.25 program offered by the child's school.

3.26 Sec. 3. Minnesota Statutes 2008, section 245.4882, subdivision 1, is amended to read:

3.27 Subdivision 1. **Availability of residential treatment services.** County boards must
3.28 provide or contract for enough residential treatment services to meet the needs of each
3.29 child with severe emotional disturbance residing in the county and needing this level of
3.30 care. Length of stay is based on the child's residential treatment need and shall be subject
3.31 to the six-month review process established in section 260C.212, subdivisions 7 and 9.
3.32 Services must be appropriate to the child's age and treatment needs and must be made
3.33 available as close to the county as possible that may include residential treatment services
3.34 provided in bordering states. Residential treatment must be designed to:

4.1 (1) prevent placement in settings that are more intensive, costly, or restrictive than
4.2 necessary and appropriate to meet the child's needs;

4.3 (2) help the child improve family living and social interaction skills;

4.4 (3) help the child gain the necessary skills to return to the community;

4.5 (4) stabilize crisis admissions; and

4.6 (5) work with families throughout the placement to improve the ability of the
4.7 families to care for children with severe emotional disturbance in the home.

4.8 Sec. 4. Minnesota Statutes 2008, section 245.4885, subdivision 1a, is amended to read:

4.9 Subd. 1a. **Emergency admission.** Effective July 1, 2006, if a child is admitted to
4.10 a treatment foster care setting, residential treatment facility, or acute care hospital for
4.11 emergency treatment or held for emergency care by a regional treatment center under
4.12 section 253B.05, subdivision 1, the level of care determination must occur within ~~three~~
4.13 five working days of admission.

4.14 Sec. 5. Minnesota Statutes 2008, section 256.935, is amended to read:

4.15 **256.935 CREMATION AND FUNERAL EXPENSES, PAYMENT BY**
4.16 **COUNTY AGENCY.**

4.17 Subdivision 1. **Funeral expenses.** On the death of any person receiving public
4.18 assistance through MFIP, the county agency shall pay for cremation of the person's
4.19 remains. If it is determined that cremation is not in accordance with the religious and
4.20 moral beliefs of the decedent or the decedent's spouse or the decedent's next of kin, the
4.21 county agency shall pay an amount for funeral expenses not exceeding the amount paid for
4.22 comparable services under section 261.035 plus actual cemetery charges. No cremation or
4.23 funeral expenses shall be paid if the estate of the deceased is sufficient to pay such expenses
4.24 or if the spouse, who was legally responsible for the support of the deceased while living,
4.25 is able to pay such expenses; ~~provided, that the additional payment or donation of the cost~~
4.26 ~~of cemetery lot, interment, religious service, or for the transportation of the body into or~~
4.27 ~~out of the community in which the deceased resided, shall not limit payment by the county~~
4.28 ~~agency as herein authorized. Freedom of choice in the selection of a funeral director shall~~
4.29 ~~be granted to persons lawfully authorized to make arrangements for the burial of any such~~
4.30 ~~deceased recipient.~~ In determining the sufficiency of such estate, due regard shall be had
4.31 for the nature and marketability of the assets of the estate. The county agency may grant
4.32 cremation or funeral expenses where the sale would cause undue loss to the estate. Any
4.33 amount paid for cremation or funeral expenses shall be a prior claim against the estate,
4.34 as provided in section 524.3-805, and any amount recovered shall be reimbursed to the

5.1 agency which paid the expenses. The commissioner shall specify requirements for reports,
5.2 including fiscal reports, according to section 256.01, subdivision 2, paragraph ~~(17)~~ (q).
5.3 The state share shall pay the entire amount of county agency expenditures. Benefits shall
5.4 be issued to recipients by the state or county subject to provisions of section 256.017.

5.5 Sec. 6. Minnesota Statutes 2008, section 256B.0943, subdivision 4, is amended to read:

5.6 Subd. 4. **Provider entity certification.** (a) Effective July 1, 2003, the commissioner
5.7 shall establish an initial provider entity application and certification process and
5.8 recertification process to determine whether a provider entity has an administrative
5.9 and clinical infrastructure that meets the requirements in subdivisions 5 and 6. The
5.10 commissioner shall recertify a provider entity at least every three years. The commissioner
5.11 shall establish a process for decertification of a provider entity that no longer meets the
5.12 requirements in this section. The county, tribe, and the commissioner shall be mutually
5.13 responsible and accountable for the county's, tribe's, and state's part of the certification,
5.14 recertification, and decertification processes.

5.15 (b) For purposes of this section, a provider entity must be:

5.16 (1) an Indian health services facility or a facility owned and operated by a tribe or
5.17 tribal organization operating as a 638 facility under Public Law 93-638 certified by the
5.18 state;

5.19 (2) a county-operated entity certified by the state; or

5.20 (3) a noncounty entity ~~recommended for certification by the provider's host county~~
5.21 ~~and~~ certified by the state.

5.22 Sec. 7. Minnesota Statutes 2008, section 256B.0943, subdivision 6, is amended to read:

5.23 Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be
5.24 an eligible provider entity under this section, a provider entity must have a clinical
5.25 infrastructure that utilizes diagnostic assessment, an individualized treatment plan,
5.26 service delivery, and individual treatment plan review that are culturally competent,
5.27 child-centered, and family-driven to achieve maximum benefit for the client. The provider
5.28 entity must review₂ and update as necessary, the clinical policies and procedures every
5.29 three years and must distribute the policies and procedures to staff initially and upon
5.30 each subsequent update.

5.31 (b) The clinical infrastructure written policies and procedures must include policies
5.32 and procedures for:

5.33 (1) providing or obtaining a client's diagnostic assessment that identifies acute and
5.34 chronic clinical disorders, co-occurring medical conditions, sources of psychological

6.1 and environmental problems, ~~and~~ including a functional assessment. The functional
6.2 assessment component must clearly summarize the client's individual strengths and needs;

6.3 (2) developing an individual treatment plan that is:

6.4 (i) based on the information in the client's diagnostic assessment;

6.5 (ii) developed no later than the end of the first psychotherapy session after the
6.6 completion of the client's diagnostic assessment by the mental health professional who
6.7 provides the client's psychotherapy;

6.8 (iii) developed through a child-centered, family-driven planning process that
6.9 identifies service needs and individualized, planned, and culturally appropriate
6.10 interventions that contain specific treatment goals and objectives for the client and the
6.11 client's family or foster family;

6.12 (iv) reviewed at least once every 90 days and revised, if necessary; and

6.13 (v) signed by the client or, if appropriate, by the client's parent or other person
6.14 authorized by statute to consent to mental health services for the client;

6.15 (3) developing an individual behavior plan that documents services to be provided
6.16 by the mental health behavioral aide. The individual behavior plan must include:

6.17 (i) detailed instructions on the service to be provided;

6.18 (ii) time allocated to each service;

6.19 (iii) methods of documenting the child's behavior;

6.20 (iv) methods of monitoring the child's progress in reaching objectives; and

6.21 (v) goals to increase or decrease targeted behavior as identified in the individual
6.22 treatment plan;

6.23 (4) clinical supervision of the mental health practitioner and mental health behavioral
6.24 aide. A mental health professional must document the clinical supervision the professional
6.25 provides by cosigning individual treatment plans and making entries in the client's record
6.26 on supervisory activities. Clinical supervision does not include the authority to make or
6.27 terminate court-ordered placements of the child. A clinical supervisor must be available
6.28 for urgent consultation as required by the individual client's needs or the situation. Clinical
6.29 supervision may occur individually or in a small group to discuss treatment and review
6.30 progress toward goals. The focus of clinical supervision must be the client's treatment
6.31 needs and progress and the mental health practitioner's or behavioral aide's ability to
6.32 provide services;

6.33 (4a) CTSS certified provider entities providing day treatment programs must meet
6.34 the conditions in items (i) to (iii):

7.1 (i) the supervisor must be present and available on the premises more than 50
7.2 percent of the time in a five-working-day period during which the supervisee is providing
7.3 a mental health service;

7.4 (ii) the diagnosis and the client's individual treatment plan or a change in the
7.5 diagnosis or individual treatment plan must be made by or reviewed, approved, and signed
7.6 by the supervisor; and

7.7 (iii) every 30 days, the supervisor must review and sign the record ~~of~~ indicating the
7.8 supervisor has reviewed the client's care for all activities in the preceding 30-day period;

7.9 (4b) for all other services provided under CTSS, clinical supervision standards
7.10 provided in items (i) to (iii) must be used:

7.11 (i) medical assistance shall reimburse a mental health practitioner who maintains a
7.12 consulting relationship with a mental health professional who accepts full professional
7.13 responsibility ~~and is present on site for at least one observation during the first 12 hours~~
7.14 ~~in which the mental health practitioner provides the individual, family, or group skills~~
7.15 ~~training to the child or the child's family;~~

7.16 (ii) ~~thereafter~~, the mental health professional is required to be present on site for
7.17 observation as clinically appropriate when the mental health practitioner is providing
7.18 individual, family, or group skills training to the child or the child's family; and

7.19 (iii) when conducted, the observation must be a minimum of one clinical unit. The
7.20 on-site presence of the mental health professional must be documented in the child's record
7.21 and signed by the mental health professional who accepts full professional responsibility;

7.22 (5) providing direction to a mental health behavioral aide. For entities that employ
7.23 mental health behavioral aides, the clinical supervisor must be employed by the provider
7.24 entity or other certified children's therapeutic supports and services provider entity to
7.25 ensure necessary and appropriate oversight for the client's treatment and continuity
7.26 of care. The mental health professional or mental health practitioner giving direction
7.27 must begin with the goals on the individualized treatment plan, and instruct the mental
7.28 health behavioral aide on how to construct therapeutic activities and interventions that
7.29 will lead to goal attainment. The professional or practitioner giving direction must also
7.30 instruct the mental health behavioral aide about the client's diagnosis, functional status,
7.31 and other characteristics that are likely to affect service delivery. Direction must also
7.32 include determining that the mental health behavioral aide has the skills to interact with
7.33 the client and the client's family in ways that convey personal and cultural respect and
7.34 that the aide actively solicits information relevant to treatment from the family. The aide
7.35 must be able to clearly explain the activities the aide is doing with the client and the
7.36 activities' relationship to treatment goals. Direction is more didactic than is supervision

8.1 and requires the professional or practitioner providing it to continuously evaluate the
8.2 mental health behavioral aide's ability to carry out the activities of the individualized
8.3 treatment plan and the individualized behavior plan. When providing direction, the
8.4 professional or practitioner must:

8.5 (i) review progress notes prepared by the mental health behavioral aide for accuracy
8.6 and consistency with diagnostic assessment, treatment plan, and behavior goals and the
8.7 professional or practitioner must approve and sign the progress notes;

8.8 (ii) identify changes in treatment strategies, revise the individual behavior plan,
8.9 and communicate treatment instructions and methodologies as appropriate to ensure
8.10 that treatment is implemented correctly;

8.11 (iii) demonstrate family-friendly behaviors that support healthy collaboration among
8.12 the child, the child's family, and providers as treatment is planned and implemented;

8.13 (iv) ensure that the mental health behavioral aide is able to effectively communicate
8.14 with the child, the child's family, and the provider; and

8.15 (v) record the results of any evaluation and corrective actions taken to modify the
8.16 work of the mental health behavioral aide;

8.17 (6) providing service delivery that implements the individual treatment plan and
8.18 meets the requirements under subdivision 9; and

8.19 (7) individual treatment plan review. The review must determine the extent to which
8.20 the services have met the goals and objectives in the previous treatment plan. The review
8.21 must assess the client's progress and ensure that services and treatment goals continue to
8.22 be necessary and appropriate to the client and the client's family or foster family. Revision
8.23 of the individual treatment plan does not require a new diagnostic assessment unless the
8.24 client's mental health status has changed markedly. The updated treatment plan must be
8.25 signed by the client, if appropriate, and by the client's parent or other person authorized by
8.26 statute to give consent to the mental health services for the child.

8.27 Sec. 8. Minnesota Statutes 2008, section 256B.0943, subdivision 9, is amended to read:

8.28 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a
8.29 certified provider entity must ensure that:

8.30 (1) each individual provider's caseload size permits the provider to deliver services
8.31 to both clients with severe, complex needs and clients with less intensive needs. The
8.32 provider's caseload size should reasonably enable the provider to play an active role in
8.33 service planning, monitoring, and delivering services to meet the client's and client's
8.34 family's needs, as specified in each client's individual treatment plan;

9.1 (2) site-based programs, including day treatment and preschool programs, provide
9.2 staffing and facilities to ensure the client's health, safety, and protection of rights, and that
9.3 the programs are able to implement each client's individual treatment plan;

9.4 (3) a day treatment program is provided to a group of clients by a multidisciplinary
9.5 team under the clinical supervision of a mental health professional. The day treatment
9.6 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
9.7 Commission on Accreditation of Health Organizations and licensed under sections
9.8 144.50 to 144.55; (ii) a community mental health center under section 245.62; and (iii)
9.9 an entity that is under contract with the county board to operate a program that meets
9.10 the requirements of sections 245.4712, subdivision 2, and 245.4884, subdivision 2,
9.11 and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must
9.12 stabilize the client's mental health status while developing and improving the client's
9.13 independent living and socialization skills. The goal of the day treatment program must
9.14 be to reduce or relieve the effects of mental illness and provide training to enable the
9.15 client to live in the community. The program must be available at least one day a week
9.16 for a ~~three-hour~~ two-hour time block. The ~~three-hour~~ two-hour time block must include
9.17 at least one hour, ~~but no more than two hours,~~ of individual or group psychotherapy.
9.18 ~~The remainder of the three-hour time block may include recreation therapy, socialization~~
9.19 ~~therapy, or independent living skills therapy, but only if the therapies are included in the~~
9.20 ~~client's individual treatment plan.~~ The structured treatment program may include individual
9.21 or group psychotherapy and recreation therapy, socialization therapy, or independent
9.22 living skills therapy, if included in the client's individual treatment plan. Day treatment
9.23 programs are not part of inpatient or residential treatment services; and

9.24 (4) a preschool program is a structured treatment program offered to a child who
9.25 is at least 33 months old, but who has not yet reached the first day of kindergarten, by a
9.26 preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts
9.27 9503.0005 to 9503.0175. The program must be available at least one day a week for a
9.28 minimum two-hour time block. The structured treatment program may include individual
9.29 or group psychotherapy and recreation therapy, socialization therapy, or independent
9.30 living skills therapy, if included in the client's individual treatment plan.

9.31 (b) A provider entity must deliver the service components of children's therapeutic
9.32 services and supports in compliance with the following requirements:

9.33 (1) individual, family, and group psychotherapy must be delivered as specified in
9.34 Minnesota Rules, part 9505.0323;

10.1 (2) individual, family, or group skills training must be provided by a mental health
10.2 professional or a mental health practitioner who has a consulting relationship with a
10.3 mental health professional who accepts full professional responsibility for the training;

10.4 (3) crisis assistance must be time-limited and designed to resolve or stabilize crisis
10.5 through arrangements for direct intervention and support services to the child and the
10.6 child's family. Crisis assistance must utilize resources designed to address abrupt or
10.7 substantial changes in the functioning of the child or the child's family as evidenced by
10.8 a sudden change in behavior with negative consequences for well being, a loss of usual
10.9 coping mechanisms, or the presentation of danger to self or others;

10.10 (4) medically necessary services that are provided by a mental health behavioral
10.11 aide must be designed to improve the functioning of the child and support the family in
10.12 activities of daily and community living. A mental health behavioral aide must document
10.13 the delivery of services in written progress notes. The mental health behavioral aide
10.14 must implement goals in the treatment plan for the child's emotional disturbance that
10.15 allow the child to acquire developmentally and therapeutically appropriate daily living
10.16 skills, social skills, and leisure and recreational skills through targeted activities. These
10.17 activities may include:

10.18 (i) assisting a child as needed with skills development in dressing, eating, and
10.19 toileting;

10.20 (ii) assisting, monitoring, and guiding the child to complete tasks, including
10.21 facilitating the child's participation in medical appointments;

10.22 (iii) observing the child and intervening to redirect the child's inappropriate behavior;

10.23 (iv) assisting the child in using age-appropriate self-management skills as related
10.24 to the child's emotional disorder or mental illness, including problem solving, decision
10.25 making, communication, conflict resolution, anger management, social skills, and
10.26 recreational skills;

10.27 (v) implementing deescalation techniques as recommended by the mental health
10.28 professional;

10.29 (vi) implementing any other mental health service that the mental health professional
10.30 has approved as being within the scope of the behavioral aide's duties; or

10.31 (vii) assisting the parents to develop and use parenting skills that help the child
10.32 achieve the goals outlined in the child's individual treatment plan or individual behavioral
10.33 plan. Parenting skills must be directed exclusively to the child's treatment; and

10.34 (5) direction of a mental health behavioral aide must include the following:

10.35 (i) a total of one hour of on-site observation by a mental health professional during
10.36 the first 12 hours of service provided to a child;

11.1 (ii) ongoing on-site observation by a mental health professional or mental health
11.2 practitioner for at least a total of one hour during every 40 hours of service provided
11.3 to a child; and

11.4 (iii) immediate accessibility of the mental health professional or mental health
11.5 practitioner to the mental health behavioral aide during service provision.

11.6 Sec. 9. Minnesota Statutes 2008, section 256B.0945, subdivision 1, is amended to read:

11.7 Subdivision 1. **Residential services; provider qualifications.** Counties must
11.8 arrange to provide residential services for children with severe emotional disturbance
11.9 according to sections 245.4882, 245.4885, and this section. Services must be provided
11.10 by a facility that is licensed according to section 245.4882 and administrative rules
11.11 promulgated thereunder, and under contract with the county. Eligible services may be
11.12 provided in a facility that is located in a state that borders Minnesota if:

11.13 (1) the facility is the closest facility to the child's home that provides the appropriate
11.14 level of care; and

11.15 (2) the county has inspected and certified that the facility meets the applicable
11.16 Minnesota licensing and provider standards.

11.17 Sec. 10. Minnesota Statutes 2008, section 256F.13, subdivision 1, is amended to read:

11.18 Subdivision 1. **Federal revenue enhancement.** (a) The commissioner of human
11.19 services may enter into an agreement with one or more family services collaboratives
11.20 to enhance federal reimbursement under title IV-E of the Social Security Act and
11.21 federal administrative reimbursement under title XIX of the Social Security Act. The
11.22 commissioner may contract with the Department of Education for purposes of transferring
11.23 the federal reimbursement to the commissioner of education to be distributed to the
11.24 collaboratives according to clause (2). The commissioner shall have the following
11.25 authority and responsibilities regarding family services collaboratives:

11.26 (1) the commissioner shall submit amendments to state plans and seek waivers as
11.27 necessary to implement the provisions of this section;

11.28 (2) the commissioner shall pay the federal reimbursement earned under this
11.29 subdivision to each collaborative based on their earnings. Payments to collaboratives for
11.30 expenditures under this subdivision will only be made of federal earnings from services
11.31 provided by the collaborative;

11.32 (3) the commissioner shall review expenditures of family services collaboratives
11.33 using reports specified in the agreement with the collaborative to ensure that the base level

12.1 of expenditures is continued and new federal reimbursement is used to expand education,
12.2 social, health, or health-related services to young children and their families;

12.3 (4) the commissioner may reduce, suspend, or eliminate a family services
12.4 collaborative's obligations to continue the base level of expenditures or expansion of
12.5 services if the commissioner determines that one or more of the following conditions
12.6 apply:

12.7 (i) imposition of levy limits that significantly reduce available funds for social,
12.8 health, or health-related services to families and children;

12.9 (ii) reduction in the net tax capacity of the taxable property eligible to be taxed by
12.10 the lead county or subcontractor that significantly reduces available funds for education,
12.11 social, health, or health-related services to families and children;

12.12 (iii) reduction in the number of children under age 19 in the county, collaborative
12.13 service delivery area, subcontractor's district, or catchment area when compared to the
12.14 number in the base year using the most recent data provided by the State Demographer's
12.15 Office; or

12.16 (iv) termination of the federal revenue earned under the family services collaborative
12.17 agreement;

12.18 (5) the commissioner shall not use the federal reimbursement earned under this
12.19 subdivision in determining the allocation or distribution of other funds to counties or
12.20 collaboratives;

12.21 (6) the commissioner may suspend, reduce, or terminate the federal reimbursement
12.22 to a provider that does not meet the reporting or other requirements of this subdivision;

12.23 (7) the commissioner shall recover from the family services collaborative any federal
12.24 fiscal disallowances or sanctions for audit exceptions directly attributable to the family
12.25 services collaborative's actions in the integrated fund, or the proportional share if federal
12.26 fiscal disallowances or sanctions are based on a statewide random sample; and

12.27 (8) the commissioner shall establish criteria for the family services collaborative
12.28 for the accounting and financial management system that will support claims for federal
12.29 reimbursement.

12.30 (b) The family services collaborative shall have the following authority and
12.31 responsibilities regarding federal revenue enhancement:

12.32 (1) the family services collaborative shall be the party with which the commissioner
12.33 contracts. A lead county shall be designated as the fiscal agency for reporting, claiming,
12.34 and receiving payments;

12.35 (2) the family services collaboratives may enter into subcontracts with other
12.36 counties, school districts, special education cooperatives, municipalities, and other public

13.1 and nonprofit entities for purposes of identifying and claiming eligible expenditures to
13.2 enhance federal reimbursement, or to expand education, social, health, or health-related
13.3 services to families and children;

13.4 ~~(3) the family services collaborative must continue the base level of expenditures for~~
13.5 ~~education, social, health, or health-related services to families and children from any state,~~
13.6 ~~county, federal, or other public or private funding source which, in the absence of the new~~
13.7 ~~federal reimbursement earned under this subdivision, would have been available for those~~
13.8 ~~services, except as provided in paragraph (a), clause (4). The base year for purposes of this~~
13.9 ~~subdivision shall be the four-quarter calendar year ending at least two calendar quarters~~
13.10 ~~before the first calendar quarter in which the new federal reimbursement is earned;~~

13.11 ~~(4)~~ the family services collaborative must use all new federal reimbursement
13.12 resulting from federal revenue enhancement to expand expenditures for education, social,
13.13 health, or health-related services to families and children beyond the base level, except
13.14 as provided in paragraph (a), clause (4);

13.15 ~~(5)~~ (4) the family services collaborative must ensure that expenditures submitted
13.16 for federal reimbursement are not made from federal funds or funds used to match other
13.17 federal funds. Notwithstanding section 256B.19, subdivision 1, for the purposes of family
13.18 services collaborative expenditures under agreement with the department, the nonfederal
13.19 share of costs shall be provided by the family services collaborative from sources other
13.20 than federal funds or funds used to match other federal funds;

13.21 ~~(6)~~ (5) the family services collaborative must develop and maintain an accounting
13.22 and financial management system adequate to support all claims for federal reimbursement,
13.23 including a clear audit trail and any provisions specified in the agreement; and

13.24 ~~(7)~~ (6) the family services collaborative shall submit an annual report to the
13.25 commissioner as specified in the agreement.

13.26 Sec. 11. Minnesota Statutes 2008, section 260C.212, subdivision 4a, is amended to
13.27 read:

13.28 Subd. 4a. **Monthly caseworker visits.** (a) Every child in foster care or on a trial
13.29 home visit shall be visited by the child's caseworker on a monthly basis, with the majority
13.30 of visits occurring in the child's residence. For the purposes of this section, the following
13.31 definitions apply:

13.32 (1) "visit" is defined as a face-to-face contact between a child and the child's
13.33 caseworker;

13.34 (2) "visited on a monthly basis" is defined as at least one visit per calendar month;

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14.1 (3) "the child's caseworker" is defined as the person who has responsibility for
14.2 managing the child's foster care placement case or another person who has responsibility
14.3 for visitation of the child, as assigned by the responsible social service agency; and

14.4 (4) "the child's residence" is defined as the home where the child is residing, and
14.5 can include the foster home, child care institution, or the home from which the child was
14.6 removed if the child is on a trial home visit.

14.7 (b) Caseworker visits shall be of sufficient substance and duration to address issues
14.8 pertinent to case planning and service delivery to ensure the safety, permanency, and
14.9 well-being of the child.

14.10 Sec. 12. Minnesota Statutes 2008, section 260C.212, subdivision 11, is amended to
14.11 read:

14.12 Subd. 11. **Rules; family and group foster care.** ~~The commissioner shall revise~~
14.13 ~~Minnesota Rules, parts 9545.0010 to 9545.0260, the rules setting standards for family and~~
14.14 ~~group family foster care.~~ The commissioner shall:

14.15 (1) require that, as a condition of licensure, foster care providers attend training on
14.16 understanding and validating the cultural heritage of all children in their care, and on the
14.17 importance of the Indian Child Welfare Act, United States Code, title 25, sections 1901 to
14.18 1923, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835; ~~and~~

14.19 (2) review and, where necessary, revise foster care rules to reflect sensitivity to
14.20 cultural diversity and differing lifestyles. Specifically, the commissioner shall examine
14.21 whether space and other requirements discriminate against single-parent, minority, or
14.22 low-income families who may be able to provide quality foster care reflecting the values
14.23 of their own respective cultures; and

14.24 (3) relieve relative foster care providers of the requirements promulgated as a result
14.25 of clauses (1) and (2) when the safety of the child is not jeopardized and as allowed
14.26 under federal law.

14.27 Sec. 13. Minnesota Statutes 2008, section 261.035, is amended to read:

14.28 **261.035 CREMATION AND FUNERALS AT EXPENSE OF COUNTY.**

14.29 When a person dies in any county without apparent means to provide for that
14.30 person's funeral or final disposition, the county board shall first investigate to determine
14.31 whether that person had contracted for any prepaid funeral arrangements. If prepaid
14.32 arrangements have been made, the county shall authorize arrangements to be implemented
14.33 in accord with the instructions of the deceased. If it is determined that the person did not
14.34 leave sufficient means to defray the necessary expenses of a funeral and final disposition,

15.1 nor any spouse of sufficient ability to procure the burial, the county board shall provide for
15.2 ~~a funeral and final disposition~~ cremation of the person's remains ~~to be made~~ at the expense
15.3 of the county. If it is determined that cremation is not in accordance with the religious
15.4 and moral beliefs of the decedent or the decedent's spouse or the decedent's next of kin,
15.5 the county board shall provide for a funeral. Any funeral and final disposition provided
15.6 at the expense of the county shall be in accordance with religious and moral beliefs of
15.7 the decedent or the decedent's spouse or the decedent's next of kin. If the wishes of the
15.8 decedent are not known and the county has no information about the existence of or
15.9 location of any next of kin, the county ~~may determine the method of final disposition~~ shall
15.10 provide for cremation of the person's remains.

15.11 **ARTICLE 2**

15.12 **HEALTH CARE**

15.13 Section 1. Minnesota Statutes 2008, section 62Q.37, subdivision 3, is amended to read:

15.14 Subd. 3. **Audits.** (a) The commissioner may conduct routine audits and
15.15 investigations as prescribed under the commissioner's respective state authorizing statutes.
15.16 If a nationally recognized independent organization has conducted an audit of the health
15.17 plan company using audit procedures that are comparable to or more stringent than the
15.18 commissioner's audit procedures:

15.19 (1) the commissioner ~~may~~ shall accept the independent audit and require no further
15.20 audit if the results of the independent audit show that the performance standard being
15.21 audited meets or exceeds state standards;

15.22 (2) the commissioner may accept the independent audit and limit further auditing
15.23 if the results of the independent audit show that the performance standard being audited
15.24 partially meets state standards;

15.25 (3) the health plan company must demonstrate to the commissioner that the
15.26 nationally recognized independent organization that conducted the audit is qualified and
15.27 that the results of the audit demonstrate that the particular performance standard partially
15.28 or fully meets state standards; and

15.29 (4) if the commissioner has partially or fully accepted an independent audit of the
15.30 performance standard, the commissioner may use the finding of a deficiency with regard
15.31 to statutes or rules by an independent audit as the basis for a targeted audit or enforcement
15.32 action.

15.33 (b) If a health plan company has formally delegated activities that are required
15.34 under either state law or contract to another organization that has undergone an audit by
15.35 a nationally recognized independent organization, that health plan company may use

16.1 the nationally recognized accrediting body's determination on its own behalf under this
16.2 section.

16.3 Sec. 2. Minnesota Statutes 2008, section 144A.04, subdivision 11, is amended to read:

16.4 Subd. 11. **Incontinent residents.** Notwithstanding Minnesota Rules, part
16.5 4658.0520, an incontinent resident must be ~~checked according to a specific time interval~~
16.6 ~~written in the resident's~~ treated according to the comprehensive assessment and care plan.
16.7 ~~The resident's attending physician must authorize in writing any interval longer than~~
16.8 ~~two hours unless the resident, if competent, or a family member or legally appointed~~
16.9 ~~conservator, guardian, or health care agent of a resident who is not competent, agrees in~~
16.10 ~~writing to waive physician involvement in determining this interval, and this waiver~~
16.11 ~~is documented in the resident's care plan.~~

16.12 Sec. 3. Minnesota Statutes 2008, section 144A.04, is amended by adding a subdivision
16.13 to read:

16.14 Subd. 12. **Resident positioning.** Notwithstanding Minnesota Rules, part 4658.0525,
16.15 subpart 4, the position of residents unable to change their own position must be changed
16.16 based on the comprehensive assessment and care plan.

16.17 Sec. 4. Minnesota Statutes 2008, section 144A.45, subdivision 1, is amended to read:

16.18 Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of
16.19 home care providers pursuant to sections 144A.43 to 144A.47. The rules shall include
16.20 the following:

16.21 (1) provisions to assure, to the extent possible, the health, safety and well-being, and
16.22 appropriate treatment of persons who receive home care services;

16.23 (2) requirements that home care providers furnish the commissioner with specified
16.24 information necessary to implement sections 144A.43 to 144A.47;

16.25 (3) standards of training of home care provider personnel, which may vary according
16.26 to the nature of the services provided or the health status of the consumer;

16.27 (4) standards for medication management which may vary according to the nature of
16.28 the services provided, the setting in which the services are provided, or the status of the
16.29 consumer. Medication management includes the central storage, handling, distribution,
16.30 and administration of medications;

16.31 (5) standards for supervision of home care services requiring supervision by a
16.32 registered nurse or other appropriate health care professional which must occur on site
16.33 at least every 62 days, or more frequently if indicated by a clinical assessment, and in

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17.1 accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that;
17.2 ~~notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 5, item B,~~
17.3 ~~supervision of a person performing home care aide tasks for a class B licensee providing~~
17.4 ~~paraprofessional services must occur only every 180 days, or more frequently if indicated~~
17.5 ~~by a clinical assessment~~ does not require nursing supervision;

17.6 (6) standards for client evaluation or assessment which may vary according to the
17.7 nature of the services provided or the status of the consumer;

17.8 (7) requirements for the involvement of a consumer's physician, the documentation
17.9 of physicians' orders, if required, and the consumer's treatment plan, and the maintenance
17.10 of accurate, current clinical records;

17.11 (8) the establishment of different classes of licenses for different types of providers
17.12 and different standards and requirements for different kinds of home care services; and

17.13 (9) operating procedures required to implement the home care bill of rights.

17.14 Sec. 5. Minnesota Statutes 2008, section 245A.09, subdivision 7, is amended to read:

17.15 Subd. 7. **Regulatory methods.** (a) Where appropriate and feasible the commissioner
17.16 shall identify and implement alternative methods of regulation and enforcement to the
17.17 extent authorized in this subdivision. These methods shall include:

17.18 (1) expansion of the types and categories of licenses that may be granted;

17.19 (2) when the standards of another state or federal governmental agency or an
17.20 independent accreditation body have been shown to require the same standards, methods,
17.21 or alternative methods to achieve substantially the same intended outcomes as the
17.22 licensing standards, the commissioner shall consider compliance with the governmental
17.23 or accreditation standards to be equivalent to partial compliance with the licensing
17.24 standards; ~~and~~

17.25 (3) use of an abbreviated inspection that employs key standards that have been
17.26 shown to predict full compliance with the rules; and

17.27 (4) for day training and habilitation service providers, the commissioner shall deem
17.28 three-year accreditation by the Commission on Rehabilitation Facilities as equivalent to
17.29 compliance with the licensing standards.

17.30 (b) If the commissioner accepts accreditation as documentation of compliance with a
17.31 licensing standard under paragraph (a), the commissioner shall continue to investigate
17.32 complaints related to noncompliance with all licensing standards. The commissioner
17.33 may take a licensing action for noncompliance under this chapter and shall recognize all
17.34 existing appeal rights regarding any licensing actions taken under this chapter.

18.1 (c) The commissioner shall work with the commissioners of health, public
18.2 safety, administration, and education in consolidating duplicative licensing and
18.3 certification rules and standards if the commissioner determines that consolidation is
18.4 administratively feasible, would significantly reduce the cost of licensing, and would
18.5 not reduce the protection given to persons receiving services in licensed programs.
18.6 Where administratively feasible and appropriate, the commissioner shall work with the
18.7 commissioners of health, public safety, administration, and education in conducting joint
18.8 agency inspections of programs.

18.9 (d) The commissioner shall work with the commissioners of health, public safety,
18.10 administration, and education in establishing a single point of application for applicants
18.11 who are required to obtain concurrent licensure from more than one of the commissioners
18.12 listed in this clause.

18.13 (e) Unless otherwise specified in statute, the commissioner may conduct routine
18.14 inspections biennially.

18.15 Sec. 6. Minnesota Statutes 2008, section 256.962, subdivision 6, is amended to read:

18.16 Subd. 6. **School districts and charter schools.** (a) At the beginning of each school
18.17 year, a school district or charter school shall provide information to each student on the
18.18 availability of health care coverage through the Minnesota health care programs.

18.19 ~~(b) For each child who is determined to be eligible for the free and reduced-price
18.20 school lunch program, the district shall provide the child's family with information on how
18.21 to obtain an application for the Minnesota health care programs and application assistance.~~

18.22 ~~(c)~~ A school district or charter school shall also ensure that applications and
18.23 information on application assistance are available at early childhood education sites and
18.24 public schools located within the district's jurisdiction.

18.25 ~~(d) Each district shall designate an enrollment specialist to provide application
18.26 assistance and follow-up services with families who have indicated an interest in receiving
18.27 information or an application for the Minnesota health care program. A district is eligible
18.28 for the application assistance bonus described in subdivision 5.~~

18.29 ~~(e) Each~~ (c) If a school district or charter school maintains a district Web site, the
18.30 school district or charter school shall provide on ~~their~~ its Web site a link to information on
18.31 how to obtain an application and application assistance.

18.32 Sec. 7. Minnesota Statutes 2008, section 256.962, subdivision 7, is amended to read:

18.33 Subd. 7. **Renewal notice.** (a) ~~Beginning December 1, 2007,~~ The commissioner shall
18.34 mail a renewal notice to enrollees notifying the enrollees that the enrollees eligibility must

19.1 be renewed. A notice shall be sent at least ~~90 days prior to the renewal date and at least~~
19.2 60 days prior to the renewal date.

19.3 ~~(b) For enrollees who are receiving services through managed care plans, the~~
19.4 ~~managed care plan must provide a follow-up renewal call at least 60 days prior to the~~
19.5 ~~enrollees' renewal dates.~~

19.6 ~~(c)~~ The commissioner shall include the end of coverage dates on the monthly rosters
19.7 of enrollees provided to managed care organizations.

19.8 Sec. 8. Minnesota Statutes 2008, section 256B.0915, subdivision 3h, is amended to
19.9 read:

19.10 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
19.11 payment rates for 24-hour customized living services is a monthly rate negotiated and
19.12 authorized by the lead agency within the parameters established by the commissioner
19.13 of human services. The payment agreement must delineate the services that have been
19.14 customized for each recipient and specify the amount of each service to be provided. The
19.15 lead agency shall ensure that there is a documented need for all services authorized.
19.16 The lead agency shall not authorize 24-hour customized living services unless there is
19.17 a documented need for 24-hour supervision. For purposes of this section, "24-hour
19.18 supervision" means that the recipient requires assistance due to needs related to one or
19.19 more of the following:

- 19.20 (1) intermittent assistance with toileting or transferring;
19.21 (2) cognitive or behavioral issues;
19.22 (3) a medical condition that requires clinical monitoring; or
19.23 (4) other conditions or needs as defined by the commissioner of human services.

19.24 The lead agency shall ensure that the frequency and mode of supervision of the recipient
19.25 and the qualifications of staff providing supervision are described and meet the needs
19.26 of the recipient. Customized living services must not include rent or raw food costs.
19.27 The negotiated payment rate for 24-hour customized living services must be based on
19.28 services to be provided. Negotiated rates must not exceed payment rates for comparable
19.29 elderly waiver or medical assistance services and must reflect economies of scale. The
19.30 individually negotiated 24-hour customized living payments, in combination with the
19.31 payment for other elderly waiver services, including case management, must not exceed
19.32 the recipient's community budget cap specified in subdivision 3a.

19.33 (b) Twenty-four hour customized living services are delivered by a provider licensed
19.34 by the commissioner of health as a class A or class F home care provider and provided in a
19.35 building that is registered as a housing with services establishment under chapter 144D.

20.1 Those home care providers with a capacity to serve 12 or fewer clients may provide
20.2 nighttime supervision to clients using personnel who have other duties and are located in
20.3 an adjoining building if:

20.4 (1) the personnel providing supervision have been trained and determined to be
20.5 competent in accordance with all applicable home care licensing requirements;

20.6 (2) the provider has assessed the clients needing 24-hour supervision and determined
20.7 that their needs can be safely met;

20.8 (3) the provider has a communication system that permits staff providing supervision
20.9 to be summoned by the clients; and

20.10 (4) staff providing supervision to clients are able to respond within a time frame that
20.11 meets the clients' needs and in no event exceeds ten minutes.

20.12 Sec. 9. Minnesota Statutes 2008, section 471.61, subdivision 1, is amended to read:

20.13 Subdivision 1. **Officers, employees.** A county, municipal corporation, town, school
20.14 district, county extension committee, other political subdivision or other body corporate
20.15 and politic of this state, other than the state or any department of the state, through its
20.16 governing body, and any two or more subdivisions acting jointly through their governing
20.17 bodies, may insure or protect its or their officers and employees, and their dependents, or
20.18 any class or classes of officers, employees, or dependents, under a policy or policies or
20.19 contract or contracts of group insurance or benefits covering life, health, and accident, in
20.20 the case of employees, and medical and surgical benefits and hospitalization insurance
20.21 or benefits for both employees and dependents or dependents of an employee whose
20.22 death was due to causes arising out of and in the course of employment, or any one or
20.23 more of those forms of insurance or protection. A governmental unit, including county
20.24 extension committees and those paying their employees, may pay all or any part of
20.25 the premiums or charges on the insurance or protection. A payment is deemed to be
20.26 additional compensation paid to the officers or employees, but for purposes of determining
20.27 contributions or benefits under a public pension or retirement system it is not deemed
20.28 to be additional compensation. One or more governmental units may determine that
20.29 a person is an officer or employee if the person receives income from the governmental
20.30 subdivisions without regard to the manner of election or appointment, including but not
20.31 limited to employees of county historical societies that receive funding from the county
20.32 and employees of the Minnesota Inter-county Association. The appropriate officer of
20.33 the governmental unit, or those disbursing county extension funds, shall deduct from
20.34 the salary or wages of each officer and employee who elects to become insured or so
20.35 protected, on the officer's or employee's written order, all or part of the officer's or

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21.1 employee's share of premiums or charges and remit the share or portion to the insurer or
21.2 company issuing the policy or contract.

21.3 A governmental unit, other than a school district, that pays all or part of the premiums
21.4 or charges is authorized to levy and collect a tax, if necessary, in the next annual tax levy
21.5 for the purpose of providing the necessary money for the payment of the premiums or
21.6 charges, and the sums levied and appropriated are not, in the event the sum exceeds the
21.7 maximum sum allowed by the charter of a municipal corporation, considered part of
21.8 the cost of government of the governmental unit as defined in any levy or expenditure
21.9 limitation; provided at least 50 percent of the cost of benefits on dependents must be
21.10 contributed by the employee or be paid by levies within existing charter tax limitations.

21.11 The word "dependents" as used in this subdivision means spouse and minor
21.12 unmarried children under the age of 18 years actually dependent upon the employee.

21.13 Notwithstanding any other law to the contrary, a political subdivision described in
21.14 this subdivision may provide health benefits to its employees, dependents, and other
21.15 eligible persons through negotiated contributions to self-funded multiemployer health
21.16 and welfare funds.

21.17 **EFFECTIVE DATE.** This section is effective the day following final enactment;
21.18 applies to contributions made before, on, or after that date; and is intended as a clarification
21.19 of existing law.

APPENDIX
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