

CHAPTER 108—H.F.No. 1233

An act relating to state government; establishing the health and human services budget; modifying provisions related to health care, continuing care, human services licensing, children and family services, program integrity, health-related licensing boards, chemical and mental health services, managed care organizations, waiver provider standards, home care, and the Department of Health; redesigning home and community-based services; establishing payment methodologies for home and community-based services; adjusting provider rates; setting and modifying fees; modifying autism coverage; modifying assistance programs; establishing Northstar care for children; making technical changes; requiring studies; requiring reports; appropriating money; amending Minnesota Statutes 2012, sections 13.381, subdivisions 2, 10; 13.461, by adding subdivisions; 16A.724, subdivisions 2, 3; 16C.10, subdivision 5; 16C.155, subdivision 1; 43A.23, by adding a subdivision; 62J.692, subdivisions 1, 3, 4, 5, 9, by adding a subdivision; 62Q.19, subdivision 1; 103I.005, by adding a subdivision; 103I.521; 119B.011, by adding a subdivision; 119B.02, by adding a subdivision; 119B.025, subdivision 1; 119B.03, subdivision 4; 119B.05, subdivision 1; 119B.13, subdivisions 1, 1a, 3a, 6, 7, by adding subdivisions; 144.051, by adding subdivisions; 144.0724, subdivisions 4, 6; 144.123, subdivision 1; 144.125, subdivision 1; 144.212; 144.213; 144.215, subdivisions 3, 4; 144.216, subdivision 1; 144.217, subdivision 2; 144.218, subdivision 5; 144.225, subdivisions 1, 4, 7, 8; 144.226; 144.966, subdivisions 2, 3a; 144.98, subdivisions 3, 5, by adding subdivisions; 144.99, subdivision 4; 144A.071, subdivision 4b; 144A.351; 144A.43; 144A.44; 144A.45; 144D.01, subdivision 4; 145.906; 145.986; 145A.17, subdivision 1; 145C.01, subdivision 7; 148B.17, subdivision 2; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5, 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4; 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions 1, 2, 4; 149A.74; 149A.91, subdivision 9; 149A.93, subdivisions 3, 6; 149A.94; 149A.96, subdivision 9; 151.19, subdivisions 1, 3; 151.37, subdivision 4; 151.47, subdivision 1, by adding a subdivision; 151.49; 174.30, subdivision 1; 214.12, by adding a subdivision; 214.40, subdivision 1; 243.166, subdivisions 4b, 7; 245.03, subdivision 1; 245.462, subdivision 20; 245.4661, subdivisions 5, 6; 245.4682, subdivision 2; 245.4871, subdivision 26; 245.4875, subdivision 8; 245.4881, subdivision 1; 245.91, by adding a subdivision; 245.94, subdivisions 2, 2a; 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04, subdivision 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08, subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435; 245A.144; 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5; 245A.50; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245D.02; 245D.03; 245D.04; 245D.05; 245D.06; 245D.07; 245D.09; 245D.10; 246.18, subdivision 8, by adding a subdivision; 246.54; 252.27, subdivision 2a; 252.291, by adding a subdivision; 252.41, subdivision 3; 252.42; 252.43; 252.44; 252.45; 252.46, subdivision 1a; 253B.10, subdivision 1; 254B.04, subdivision 1; 254B.13; 256.01, subdivisions 2, 24, 34, by adding subdivisions; 256.0112, by adding a subdivision; 256.015, subdivision 1; 256.82, subdivisions 2, 3; 256.9657, subdivisions 3, 3a, 4; 256.969, subdivision 29; 256.975, subdivision 7, by adding subdivisions; 256.9754, subdivision 5, by adding subdivisions; 256.98, subdivision 8; 256B.02, subdivision 17, as added, by adding subdivisions; 256B.021, by adding subdivisions; 256B.04, subdivisions 18, 21, by adding a subdivision; 256B.055,

subdivisions 3a, 6, 10, 14, 15, by adding a subdivision; 256B.056, subdivisions 1, 1c, 3, 4, as amended, 5c, 10, by adding a subdivision; 256B.057, subdivisions 1, 8, 10, by adding a subdivision; 256B.06, subdivision 4; 256B.0623, subdivision 2; 256B.0625, subdivisions 9, 13, 13e, 19c, 31, 39, 48, 56, 58, by adding subdivisions; 256B.0631, subdivision 1; 256B.064, subdivisions 1a, 1b, 2; 256B.0659, subdivision 21; 256B.0755, subdivision 3; 256B.0756; 256B.0911, subdivisions 1, 1a, 3a, 4d, 6, 7, by adding a subdivision; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 5, by adding a subdivision; 256B.0916, by adding a subdivision; 256B.0917, subdivisions 6, 13, by adding subdivisions; 256B.092, subdivisions 1a, 7, 11, 12, by adding subdivisions; 256B.0943, subdivisions 1, 2, 7, by adding a subdivision; 256B.0946; 256B.095; 256B.0951, subdivisions 1, 4; 256B.0952, subdivisions 1, 5; 256B.0955; 256B.097, subdivisions 1, 3; 256B.196, subdivision 2; 256B.431, subdivision 44; 256B.434, subdivision 4, by adding subdivisions; 256B.437, subdivision 6; 256B.439, subdivisions 1, 2, 3, 4, by adding subdivisions; 256B.441, subdivisions 13, 44, 53, by adding subdivisions; 256B.49, subdivisions 11a, 12, 13, 14, 15, by adding subdivisions; 256B.4912, subdivisions 1, 2, 3, 7, by adding subdivisions; 256B.4913, subdivisions 5, 6, by adding a subdivision; 256B.492; 256B.493, subdivision 2; 256B.501, by adding a subdivision; 256B.5011, subdivision 2; 256B.5012, by adding subdivisions; 256B.69, subdivisions 5c, 5i, 8, 9c, 31, by adding subdivisions; 256B.694; 256B.76, subdivisions 1, 2, 4, by adding a subdivision; 256B.761; 256B.764; 256B.766; 256B.767; 256D.44, subdivision 5; 256I.05, by adding a subdivision; 256J.08, subdivision 24; 256J.21, subdivisions 2, 3; 256J.24, subdivisions 5, 7; 256J.35; 256J.621; 256J.626, subdivision 7; 256K.45; 256L.01, subdivisions 3a, 5, by adding subdivisions; 256L.02, subdivision 2, by adding subdivisions; 256L.03, subdivisions 1, 1a, 3, 5, 6, by adding a subdivision; 256L.04, subdivisions 1, 7, 8, 10, 12, by adding subdivisions; 256L.05, subdivisions 1, 2, 3, 3c; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3; 256L.09, subdivision 2; 256L.11, subdivisions 1, 3; 256L.12, subdivision 1; 256L.15, subdivisions 1, 2; 256M.40, subdivision 1; 257.0755, subdivision 1; 257.75, subdivision 7; 257.85, subdivisions 2, 5, 6; 259A.20, subdivision 4; 260B.007, subdivisions 6, 16; 260C.007, subdivisions 6, 31; 260C.446; 260C.635, subdivision 1; 299C.093; 402A.10; 402A.18; 471.59, subdivision 1; 517.001; 518A.60; 626.556, subdivisions 2, 3, 10d; 626.557, subdivisions 4, 9, 9a, 9e; 626.5572, subdivision 13; Laws 1998, chapter 407, article 6, section 116; Laws 2011, First Special Session chapter 9, article 1, section 3; article 2, section 27; article 10, section 3, subdivision 3, as amended; Laws 2012, chapter 247, article 6, section 4; Laws 2013, chapter 1, section 6; proposing coding for new law in Minnesota Statutes, chapters 62A; 144; 144A; 145; 149A; 151; 214; 245; 245A; 245D; 254B; 256; 256B; 256J; 256L; 259A; 260C; 402A; proposing coding for new law as Minnesota Statutes, chapters 245E; 256N; repealing Minnesota Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 144.123, subdivision 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9; 151.19, subdivision 2; 151.25; 151.45; 151.47, subdivision 2; 151.48; 245A.655; 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, 7; 245B.055; 245B.06; 245B.07; 245B.08; 245D.08; 252.40; 252.46, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, 21; 256.82, subdivision 4; 256B.055, subdivisions 3, 5, 10b; 256B.056, subdivision 5b; 256B.057, subdivisions 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917, subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.096, subdivisions 1, 2, 3, 4; 256B.14, subdivision 3a; 256B.49, subdivision 16a; 256B.4913, subdivisions 1, 2, 3, 4; 256B.501, subdivision 8; 256B.5012, subdivision 13; 256J.24; 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, 10a; 256L.05, subdivision 3b; 256L.07, subdivisions 1, 5, 8, 9; 256L.11, subdivisions 5, 6; 256L.17, subdivisions 1, 2, 3, 4, 5; 260C.441; 485.14; 609.093; Laws 2011, First Special Session chapter 9, article 7, section 54, as amended; Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030;

4668.0035; 4668.0040; 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080;
 4668.0100; 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170;
 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240; 4668.0800;
 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840;
 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010; 4669.0020;
 4669.0030; 4669.0040; 4669.0050; 9525.1860, subparts 3, items B, C, 4, item D; 9560.0650,
 subparts 1, 3, 6; 9560.0651; 9560.0655.

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

ARTICLE 1

AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH CARE FOR MORE MINNESOTANS

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

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

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

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

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

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

(b) A person not entitled to services under paragraph (a), but with family income that is less than 215 percent of the federal poverty guidelines for the applicable family size, shall be eligible to receive chemical dependency fund services within the limit of funds appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556,

subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

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

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

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

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

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

(2) Medicaid funding; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) medical assistance under this chapter;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) not pregnant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up~~

~~to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.~~

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

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

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

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

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

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

- (1) household goods and personal effects are not considered;
- (2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;
- (3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;
- (4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;
- (5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);
- (6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section

256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013 is required to have qualified for medical assistance under section 256B.057, subdivision 9, prior to age 65 for at least 20 months in the 24 months prior to reaching age 65; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) is under age 65;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) services for routine prenatal care;

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

(v) elective surgery;

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

(vii) preventative health care and family planning services;

(viii) dialysis;

(ix) chemotherapy or therapeutic radiation services;

(x) rehabilitation services;

(xi) physical, occupational, or speech therapy;

(xii) transportation services;

(xiii) case management;

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

(xv) dental services;

(xvi) hospice care;

(xvii) audiology services and hearing aids;

(xviii) podiatry services;

(xix) chiropractic services;

(xx) immunizations;

(xxi) vision services and eyeglasses;

(xxii) waiver services;

(xxiii) individualized education programs; or

(xxiv) chemical dependency treatment.

(i) ~~Beginning July 1, 2009, Pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the~~

period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall consider, and may approve, contracting on a single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons ~~with a disability who voluntarily enroll~~ enrolled in state public health care programs, in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in ~~section 256B.69, subdivision 23~~ sections 256B.69 and 256B.692, are satisfied. ~~Nothing in this paragraph supersedes or modifies the requirements in paragraph (a):~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 2. **Commissioner's duties.** (a) The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all ~~eligible providers~~ participating entities under contract

with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services.

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

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

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

Subd. 5. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments, payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of management and budget, when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

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

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

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

Subd. 6. **Coordination with Minnesota Insurance Marketplace.** MinnesotaCare shall be considered a public health care program for purposes of chapter 62V.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 7. **Single adults and households with no children.** ~~(a) The definition of eligible persons includes all individuals and households families with no children who have gross family incomes that are~~

above 133 percent and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size.

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

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

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

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

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

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

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

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

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

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

documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who

are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. General assistance medical care recipients may qualify for retroactive coverage under this subdivision at six-month renewal. This subdivision does not apply, and shall not be implemented by the commissioner, once eligibility determination for MinnesotaCare is conducted by the Minnesota Insurance Marketplace eligibility determination system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3. **Other health coverage.** ~~(a) Families and individuals enrolled in the MinnesotaCare program must have no~~ To be eligible, a family or individual must not have minimum essential health

coverage while enrolled, as defined by section 5000A of the Internal Revenue Code. Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health coverage for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 200 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

- (1) lacks two or more of the following:
 - (i) basic hospital insurance;
 - (ii) medical-surgical insurance;
 - (iii) prescription drug coverage;
 - (iv) dental coverage; or
 - (v) vision coverage;
- (2) requires a deductible of \$100 or more per person per year; or
- (3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, subdivisions 1 to 32, under which selection of

entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d) (c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery~~

and Reinvestment Act of 2009, Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

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

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

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

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

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

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

137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-275%	7.2%

Federal Poverty Guideline

<u>Greater than or Equal to</u>	<u>Less than</u>	<u>Individual Premium Amount</u>
<u>0%</u>	<u>55%</u>	<u>\$4</u>
<u>55%</u>	<u>80%</u>	<u>\$6</u>
<u>80%</u>	<u>90%</u>	<u>\$8</u>
<u>90%</u>	<u>100%</u>	<u>\$10</u>
<u>100%</u>	<u>110%</u>	<u>\$12</u>
<u>110%</u>	<u>120%</u>	<u>\$15</u>
<u>120%</u>	<u>130%</u>	<u>\$18</u>
<u>130%</u>	<u>140%</u>	<u>\$21</u>
<u>140%</u>	<u>150%</u>	<u>\$25</u>
<u>150%</u>	<u>160%</u>	<u>\$29</u>
<u>160%</u>	<u>170%</u>	<u>\$33</u>
<u>170%</u>	<u>180%</u>	<u>\$38</u>
<u>180%</u>	<u>190%</u>	<u>\$43</u>
<u>190%</u>		<u>\$50</u>

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

Sec. 64. **DETERMINATION OF FUNDING ADEQUACY FOR MINNESOTACARE.**

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

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

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

- (1) an indicator identifying the health plan product under which an enrollee is covered;
- (2) an indicator identifying whether an enrollee's policy is an individual or small group market policy;
- (3) an indicator identifying, if applicable, the metal level of an enrollee's health plan product, and whether the policy is a catastrophic policy; and
- (4) additional identified demographic data necessary to link individuals' data across health carriers and insurance affordability programs with 95 percent accuracy. The commissioner shall not collect more than the last four digits of an individual's Social Security number.

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

- (1) if the data submitted are adequately complete, accurate, and timely;
- (2) if the data should be further enriched by nontraditional risk adjusters that help in better explaining variation in health care costs of a given population and account for risk selection across metal levels;
- (3) whether additional data or identifiers have the potential to strengthen a Minnesota-based risk adjustment approach; and
- (4) what, if any, changes to the technical infrastructure will be necessary to effectively perform state-based risk adjustment.

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

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

- (1) explaining the variation in health care costs of a given population;
- (2) linking risk factors to daily clinical practices and that which is clinically meaningful to providers;
- (3) encouraging favorable behavior among health care market participants and discouraging unfavorable behavior;
- (4) whether risk adjustment factors are relatively easy for stakeholders to understand and participate in;

- (5) providing stable risk scores over time and across health plan products;
- (6) minimizing administrative costs;
- (7) accounting for risk selection across metal levels;
- (8) aligning each of the elements of the methodology; and
- (9) can be conducted at per-member cost equal to or lower than the projected cost of the federal risk adjustment model.

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

(f) The commissioner of health shall submit an interim report to the legislature by March 15, 2014, with preliminary findings from the assessment conducted in paragraph (b). The interim report shall include legislative recommendations for any necessary changes to Minnesota Statutes, section 62Q.03. The commissioners of health and human services shall submit a final report to the legislature by October 1, 2015. The final report must include findings from the overall assessment conducted under paragraph (e), and a recommendation on whether to conduct state-based risk adjustment.

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

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

Sec. 66. REQUEST FOR FEDERAL AUTHORITY.

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

Sec. 67. REVISOR'S INSTRUCTION.

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

Sec. 68. REPEALER.

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

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

ARTICLE 2

CONTINGENT REFORM 2020; REDESIGNING HOME AND COMMUNITY-BASED SERVICES

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

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

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

- (1) a new admission assessment must be completed by day 14 following admission;
- (2) an annual assessment which must have an assessment reference date (ARD) within 366 days of the ARD of the last comprehensive assessment;
- (3) a significant change assessment must be completed within 14 days of the identification of a significant change; and
- (4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment.

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

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

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

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

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

Subdivision 1. Report requirements. The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using

long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. The report shall address:

- (1) demographics and need for long-term care services and supports in Minnesota;
- (2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;
- (3) status of long-term care services and related mental health services, housing options, and supports by county and region including:
 - (i) changes in availability of the range of long-term care services and housing options;
 - (ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and
 - (iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and changes over time; and
- (4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding

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

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

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

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

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

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

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

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

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

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are

to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) deliver information and assistance based on national and state standards;
- (2) provide information about state and federal eligibility requirements, benefits, and service options;
- (3) provide benefits and options counseling;
- (4) make referrals to appropriate support entities;
- (5) educate people on their options so they can make well-informed choices and link them to quality profiles;
- (6) help support the timely resolution of service access and benefit issues;
- (7) inform people of their long-term community services and supports;
- (8) provide necessary resources and supports that can lead to employment and increased economic stability of people with disabilities; and
- (9) serve as the technical assistance and help center for the Web-based tool, Minnesota's Disability Benefits 101.org.

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

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care

benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, shall serve older adults as the designated Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006 in partnership with the Disability Linkage Line under section 256.01, subdivision 24, and must be available during business hours through a statewide toll-free number and ~~must also be available through~~ the Internet. The Minnesota Board on Aging shall consult with, and when appropriate work through, the area agencies on aging counties, and other entities that serve aging and disabled populations of all ages, to provide and maintain the telephone infrastructure and related support for the Aging and Disability Resource Center partners which agree by memorandum to access the infrastructure, including the designated providers of the Senior LinkAge Line and the Disability Linkage Line.

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

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

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

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

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

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

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

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

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

(9) develop an outreach plan to seniors and their caregivers with a particular focus on establishing a clear presence in places that seniors recognize and:

(i) place a significant emphasis on improved outreach and service to seniors and their caregivers by establishing annual plans by neighborhood, city, and county, as necessary, to address the unique needs of geographic areas in the state where there are dense populations of seniors;

(ii) establish an efficient workforce management approach and assign community living specialist staff and volunteers to geographic areas as well as aging and disability resource center sites so that seniors and their caregivers and professionals recognize the Senior LinkAge Line as the place to call for aging services and information;

(iii) recognize the size and complexity of the metropolitan area service system by working with metropolitan counties to establish a clear partnership with them, including seeking county advice on the establishment of local aging and disabilities resource center sites; and

(iv) maintain dashboards with metrics that demonstrate how the service is expanding and extending or enhancing its outreach efforts in dispersed or hard to reach locations in varied population centers;

~~(9)~~ (10) incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

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

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

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

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

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

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

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

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

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

~~(12)~~ (13) develop referral protocols and processes that will assist certified health care homes and hospitals to identify at-risk older adults and determine when to refer these individuals to the Senior LinkAge Line for long-term care options counseling under this section. The commissioner is directed to work with the commissioner of health to develop protocols that would comply with the health care home designation

criteria and protocols available at the time of hospital discharge. The commissioner shall keep a record of the number of people who choose long-term care options counseling as a result of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) persons described in paragraph (a);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

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

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

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

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

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

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

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

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

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

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

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

is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment.

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

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

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

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

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

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

- (1) written recommendations for community-based services and consumer-directed options;
- (2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;
- (3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;
- (4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (7), and (b);
- (5) information about Minnesota health care programs;

- (6) the person's freedom to accept or reject the recommendations of the team;
- (7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;
- (8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in section 256B.0911, subdivision 4a, ~~paragraph (d)~~ 4e, and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and
- (9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the person is age 65 or older;

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

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

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

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

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

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

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

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

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

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

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

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

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

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

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

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

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

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

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

These projects are intended to create incentives for new and expanded home and community-based services in Minnesota in order to:

- (1) reach older adults early in the progression of their need for long-term services and supports, providing them with low-cost, high-impact services that will prevent or delay the use of more costly services;
- (2) support older adults to live in the most integrated, least restrictive community setting;
- (3) support the informal caregivers of older adults;
- (4) develop and implement strategies to integrate long-term services and supports with health care services, in order to improve the quality of care and enhance the quality of life of older adults and their informal caregivers;
- (5) ensure cost-effective use of financial and human resources;
- (6) build community-based approaches and community commitment to delivering long-term services and supports for older adults in their own homes;
- (7) achieve a broad awareness and use of lower-cost in-home services as an alternative to nursing homes and other residential services;
- (8) strengthen and develop additional home and community-based services and alternatives to nursing homes and other residential services; and
- (9) strengthen programs that use volunteers.

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

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

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

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

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

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

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

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

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

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

- (1) develop a local long-term services and supports strategy consistent with state goals and objectives;
- (2) identify and use existing local skills, knowledge, and relationships, and build on these assets;
- (3) coordinate planning for funds to provide services to older adults, including funds received under Title III of the Older Americans Act, Title XX of the Social Security Act, and the Local Public Health Act;
- (4) target service development and technical assistance where nursing facility closures have occurred or are occurring or in areas where service needs have been identified through activities under section 144A.351;
- (5) provide sufficient staff for development and technical support in its designated area; and
- (6) designate a single public or nonprofit member of the eldercare development partnerships to apply grant funding and manage the project.

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

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

- (1) establish a local coordinated network of volunteer and paid respite workers;
- (2) coordinate assignment of respite workers care services to clients and care receivers and assure the health and safety of the client; and caregivers of older adults;
- (3) provide training for caregivers and ensure that support groups are available in the community.

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

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

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

- (1) the ability of the proposal to demonstrate need in the area served, as evidenced by a community needs assessment or other demographic data;
- (2) the ability of the proposal to clearly describe how the project
- (3) assure the health and safety of the older adults;
- (4) identify at-risk caregivers;
- (5) provide information, education, and training for caregivers in the designated community; and

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

(b) Projects must clearly describe:

- (1) how they will achieve the their purpose defined in paragraph (b);
- (3) the ability of the proposal to reach underserved populations;
- (4) the ability of the proposal to demonstrate community commitment to the project, as evidenced by letters of support and cooperation as well as formation of a community task force;
- (5) the ability of the proposal to clearly describe (2) the process for recruiting, training, and retraining volunteers; and
- (6) the inclusion in the proposal of the (3) a plan to promote the project in the designated community, including outreach to persons needing the services.

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

- (1) hire a coordinator to develop a coordinated network of volunteer and paid respite care services and assign workers to clients;
 - (2) recruit and train volunteer providers;
 - (3) train provide information, training, and education to caregivers;
 - (4) ensure the development of support groups for caregivers;
 - (5) (4) advertise the availability of the caregiver support and respite care project; and
 - (6) (5) purchase equipment to maintain a system of assigning workers to clients.
- (d) Project funds may not be used to supplant existing funding sources.

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

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

- (1) have a credible, public, or private nonprofit sponsor providing ongoing financial support;
- (2) have a specific, clearly defined geographic service area;
- (3) use a practice framework designed to identify high-risk older adults and help them take action to better manage their chronic conditions and maintain their community living;
- (4) have a team approach to coordination and care, ensuring that the older adult participants, their families, and the formal and informal providers are all part of planning and providing services;
- (5) provide information, support services, homemaking services, counseling, and training for the older adults and family caregivers;
- (6) encourage service area or neighborhood residents and local organizations to collaborate in meeting the needs of older adults in their geographic service areas;
- (7) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to older adults and their caregivers; and

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

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

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

- ~~(1) caregiver support and respite care projects under subdivision 6;~~
- ~~(2) the living-at-home/block nurse grant under subdivisions 7 to 10; and~~
- ~~(3) services identified as needed for community transition.~~

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

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

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

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

- (1) defining the goals of the report card, including measuring outcomes, providing consumer information, and defining vehicle-for-pay performance;
 - (2) developing separate measures for programs for the elderly population and for persons with disabilities;
 - (3) the sources of information needed that are standardized and contain sufficient data;
 - (4) the financial support needed for creating and publicizing the housing information guide, and ongoing funding for data collection and staffing to monitor, report, and analyze;
 - (5) a recognition that home and community-based services settings exist with significant variations in size, settings, and services available;
 - (6) ensuring that consumer choice and consumer information is retained and valued;
 - (7) the applicability of these measures to providers based on payor source, size, and population served;
- and

(8) dissemination of quality profiles.

The advisory groups shall discuss whether there are additional funding, resources, and research needed. The commissioner shall report recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services issues by August 1, 2014. The report card shall be available on July 1, 2015.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 39. Minnesota Statutes 2012, section 256B.69, subdivision 8, is amended to read:

Subd. 8. **Preadmission screening waiver.** Except as applicable to the project's operation, the provisions of ~~section~~ sections 256.975 and 256B.0911 are waived for the purposes of this section for recipients enrolled with demonstration providers or in the prepaid medical assistance program for seniors.

Sec. 40. Minnesota Statutes 2012, section 256I.05, is amended by adding a subdivision to read:

Subd. 10. **Supplementary service rate; exemptions.** A county agency shall not negotiate a supplementary service rate under this section for any individual that has been determined to be eligible for Housing Stability Services as approved by the Centers for Medicare and Medicaid Services, and who resides in an establishment voluntarily registered under section 144D.025, as a supportive housing establishment or participates in the Minnesota supportive housing demonstration program under section 256I.04, subdivision 3, paragraph (a), clause (4).

Sec. 41. Minnesota Statutes 2012, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a Web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

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

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

Sec. 42. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:

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

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

- (1) the time and date of the report;
- (2) the name, address, and telephone number of the person reporting;
- (3) the time, date, and location of the incident;

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

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

(6) a description of the suspected maltreatment;

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

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

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

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

(11) whether law enforcement has been notified;

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

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

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

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

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

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

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

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

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

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

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

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

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

Sec. 43. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:

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

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

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

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

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

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

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

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

Sec. 44. **FEDERAL APPROVAL.**

This article is contingent on federal approval.

Sec. 45. **REPEALER.**

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

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

ARTICLE 3

SAFE AND HEALTHY DEVELOPMENT OF CHILDREN, YOUTH, AND FAMILIES

Section 1. Minnesota Statutes 2012, section 119B.011, is amended by adding a subdivision to read:

Subd. 19b. **Student parent.** "Student parent" means a person who is:

- (1) under 21 years of age and has a child;
- (2) pursuing a high school or general equivalency diploma;
- (3) residing within a county that has a basic sliding fee waiting list under section 119B.03, subdivision 4; and
- (4) not an MFIP participant.

EFFECTIVE DATE. This section is effective November 11, 2013.

Sec. 2. Minnesota Statutes 2012, section 119B.02, is amended by adding a subdivision to read:

Subd. 7. **Child care market rate survey.** Biennially, the commissioner shall survey prices charged by child care providers in Minnesota to determine the 75th percentile for like-care arrangements in county price clusters.

EFFECTIVE DATE. This section is effective February 3, 2014.

Sec. 3. Minnesota Statutes 2012, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. **Factors which must be verified.** (a) The county shall verify the following at all initial child care applications using the universal application:

- (1) identity of adults;
- (2) presence of the minor child in the home, if questionable;
- (3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;
- (4) age;
- (5) immigration status, if related to eligibility;
- (6) Social Security number, if given;
- (7) income;
- (8) spousal support and child support payments made to persons outside the household;
- (9) residence; and
- (10) inconsistent information, if related to eligibility.

(b) If a family did not use the universal application or child care addendum to apply for child care assistance, the family must complete the universal application or child care addendum at its next eligibility redetermination and the county must verify the factors listed in paragraph (a) as part of that redetermination. Once a family has completed a universal application or child care addendum, the county shall use the redetermination form described in paragraph (c) for that family's subsequent redeterminations. Eligibility must be redetermined at least every six months. A family is considered to have met the eligibility redetermination requirement if a complete redetermination form and all required verifications are received within 30 days after the date the form was due. Assistance shall be payable retroactively from the redetermination due date. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year. If a family reports a change in an eligibility factor before the family's next regularly scheduled redetermination, the county must recalculate eligibility without requiring verification of any eligibility factor that did not change.

(c) The commissioner shall develop a redetermination form to redetermine eligibility and a change report form to report changes that minimize paperwork for the county and the participant.

EFFECTIVE DATE. This section is effective August 4, 2014.

Sec. 4. Minnesota Statutes 2012, section 119B.03, subdivision 4, is amended to read:

Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school or general equivalency diploma or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

- (1) child care needs of minor parents;
- (2) child care needs of parents under 21 years of age; and
- (3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(d) Fourth priority must be given to families in which at least one parent is a veteran as defined under section 197.447.

(e) Families under paragraph (b) must be added to the basic sliding fee waiting list on the date they begin the transition year under section 119B.011, subdivision 20, and must be moved into the basic sliding fee program as soon as possible after they complete their transition year.

EFFECTIVE DATE. This section is effective November 11, 2013.

Sec. 5. Minnesota Statutes 2012, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

- (1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;
- (2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;
- (3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;
- (4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;
- (5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;
- (6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;
- (7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; ~~and~~
- (8) families who are participating in the transition year extension under section 119B.011, subdivision 20a; ~~and~~
- (9) student parents as defined under section 119B.011, subdivision 19b.

EFFECTIVE DATE. This section is effective November 11, 2013.

Sec. 6. Minnesota Statutes 2012, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) ~~Beginning October 31, 2011~~ February 3, 2014, the maximum rate paid for child care assistance in any county or ~~multicounty region~~ county price cluster under the child care fund shall be the ~~rate for like-care arrangements in the county effective July 1, 2006, decreased by 2.5 percent~~ greater of the 25th percentile of the 2011 child care provider rate survey or the maximum rate effective November 28, 2011. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

~~(b) Biennially, beginning in 2012, the commissioner shall survey rates charged by child care providers in Minnesota to determine the 75th percentile for like-care arrangements in counties. When the commissioner determines that, using the commissioner's established protocol, the number of providers responding to the survey is too small to determine the 75th percentile rate for like-care arrangements in a county or multicounty region, the commissioner may establish the 75th percentile maximum rate based on like-care arrangements in a county, region, or category that the commissioner deems to be similar.~~

~~(c)~~ (b) A rate which includes a special needs rate paid under subdivision 3 or under a school readiness service agreement paid under section 119B.231, may be in excess of the maximum rate allowed under this subdivision.

~~(d)~~ (c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care. The maximum payment to a provider for one day of care must not exceed the daily rate. The maximum payment to a provider for one week of care must not exceed the weekly rate.

~~(e)~~ (d) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

~~(f)~~ (e) When the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

~~(g)~~ (f) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

(g) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration fees in effect on January 1, 2013, shall remain in effect.

Sec. 7. Minnesota Statutes 2012, section 119B.13, subdivision 1a, is amended to read:

Subd. 1a. **Legal nonlicensed family child care provider rates.** (a) Legal nonlicensed family child care providers receiving reimbursement under this chapter must be paid on an hourly basis for care provided to families receiving assistance.

(b) The maximum rate paid to legal nonlicensed family child care providers must be 68 percent of the county maximum hourly rate for licensed family child care providers. In counties or county price clusters where the maximum hourly rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by 0.68. The maximum payment to a provider for one day of care must not exceed the maximum hourly rate times ten. The maximum payment to a provider for one week of care must not exceed the maximum hourly rate times 50.

(c) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(d) Legal nonlicensed family child care providers receiving reimbursement under this chapter may not be paid registration fees for families receiving assistance.

EFFECTIVE DATE. This section is effective February 3, 2014.

Sec. 8. Minnesota Statutes 2012, section 119B.13, subdivision 3a, is amended to read:

Subd. 3a. **Provider rate differential for accreditation.** A family child care provider or child care center shall be paid a 15 percent differential above the maximum rate established in subdivision 1, up to the actual provider rate, if the provider or center holds a current early childhood development credential or is accredited. For a family child care provider, early childhood development credential and accreditation includes an individual who has earned a child development associate degree, a child development associate credential, a diploma in child development from a Minnesota state technical college, or a bachelor's or post baccalaureate degree in early childhood education from an accredited college or university, or who is accredited by the National Association for Family Child Care or the Competency Based Training and Assessment Program. For a child care center, accreditation includes accreditation that meets the following criteria: the accrediting organization must demonstrate the use of standards that promote the physical, social, emotional, and cognitive development of children. The accreditation standards shall include, but are not limited to, positive interactions between adults and children, age-appropriate learning activities, a system of tracking children's learning, use of assessment to meet children's needs, specific qualifications for staff, a learning environment that supports developmentally appropriate experiences for children, health and safety requirements, and family engagement strategies. ~~The commissioner of human services, in conjunction with the commissioners of education and health, will develop an application and approval process based~~

~~on the criteria in this section and any additional criteria. The process developed by the commissioner of human services must address periodic reassessment of approved accreditations. The commissioner of human services must report the criteria developed, the application, approval, and reassessment processes, and any additional recommendations by February 15, 2013, to the chairs and ranking minority members of the legislative committees having jurisdiction over early childhood issues. Based on an application process developed by the commissioner in conjunction with the commissioners of education and health, the Department of Human Services must accept applications from accrediting organizations beginning on July 1, 2013, and on an annual basis thereafter. The provider rate differential shall be paid to centers holding an accreditation from an approved accrediting organization beginning on a billing cycle to be determined by the commissioner, no later than the last Monday in February of a calendar year. The commissioner shall annually publish a list of approved accrediting organizations. An approved accreditation must be reassessed by the commissioner every two years. If an approved accrediting organization is determined to no longer meet the approval criteria, the organization and centers being paid the differential under that accreditation must be given a 90-day notice by the commissioner and the differential payment must end after a 15-day notice to affected families and centers as directed in Minnesota Rules, part 3400.0185, subparts 3 and 4. The following accreditations shall be recognized for the provider rate differential until an approval process is implemented: the National Association for the Education of Young Children, the Council on Accreditation, the National Early Childhood Program Accreditation, the National School-Age Care Association, or the National Head Start Association Program of Excellence. For Montessori programs, accreditation includes the American Montessori Society, Association of Montessori International-USA, or the National Center for Montessori Education.~~

Sec. 9. Minnesota Statutes 2012, section 119B.13, is amended by adding a subdivision to read:

Subd. 3b. **Provider rate differential for Parent Aware.** A family child care provider or child care center shall be paid a 15 percent differential if they hold a three-star Parent Aware rating or a 20 percent differential if they hold a four-star Parent Aware rating. A 15 percent or 20 percent rate differential must be paid above the maximum rate established in subdivision 1, up to the actual provider rate.

EFFECTIVE DATE. This section is effective March 3, 2014.

Sec. 10. Minnesota Statutes 2012, section 119B.13, is amended by adding a subdivision to read:

Subd. 3c. **Weekly rate paid for children attending high-quality care.** A licensed child care provider or license-exempt center may be paid up to the applicable weekly maximum rate, not to exceed the provider's actual charge, when the following conditions are met:

- (1) the child is age birth to five years, but not yet in kindergarten;
- (2) the child attends a child care provider that qualifies for the rate differential identified in subdivision 3a or 3b; and
- (3) the applicant's activities qualify for at least 30 hours of care per week under sections 119B.03, 119B.05, 119B.10, and Minnesota Rules, chapter 3400.

EFFECTIVE DATE. This section is effective August 4, 2014.

Sec. 11. Minnesota Statutes 2012, section 119B.13, subdivision 6, is amended to read:

Subd. 6. Provider payments. (a) The provider shall bill for services provided within ten days of the end of the service period. If bills are submitted within ten days of the end of the service period, payments under the child care fund shall be made within 30 days of receiving a bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of six months from the date the provider is issued an authorization of care and billing form.

(d) A county may refuse to issue a child care authorization to a licensed or legal nonlicensed provider, revoke an existing child care authorization to a licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) a county finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after receipt of an order of suspension or an order of revocation of the provider's license, or the provider has been issued an order citing violations of licensing standards that affect the health and safety of children in care due to the nature, chronicity, or severity of the licensing violations, until the licensing agency determines those violations have been corrected;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request; or

(6) the provider gives false child care price information.

The county may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(e) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

EFFECTIVE DATE. This section is effective February 3, 2014.

Sec. 12. Minnesota Statutes 2012, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding holidays, in a fiscal year, or for more than ten consecutive full-day absent days. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the ~~ten~~ absent day days limit. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Notwithstanding paragraph (a), children with documented medical conditions that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive full-day absent days limit. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the absent days limit in a fiscal year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner.

~~(b)~~ (c) Notwithstanding paragraph (a), children in families may exceed the ~~ten~~ absent days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school or general equivalency diploma; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

~~(c)~~ (d) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the ~~ten~~ absent ~~day~~ days limit.

~~(d)~~ (e) A family or child care provider must not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family or provider did not timely report a change as required under law.

~~(e)~~ (f) The provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days per child, excluding holidays, in a fiscal year; and ten consecutive full-day absent days.

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

Sec. 13. Minnesota Statutes 2012, section 245A.07, subdivision 2a, is amended to read:

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. The burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses, or if the actions of other individuals or conditions in the program poses an imminent risk of harm to the health, safety, or rights of persons served by the program. "Reasonable cause" means there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that

there is an imminent risk of harm to the health, safety, or rights of persons served by the program. When the commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in section 245A.1435, the commissioner is not required to demonstrate that an infant died or was injured as a result of the safe sleep violations.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten working days from the close of the record. Within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall make a determination regarding whether a final licensing sanction shall be issued under subdivision 3. The license holder shall continue to be prohibited from operation of the program during this 90-day period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivision 3 and the license holder appeals that sanction, the license holder continues to be prohibited from operation of the program pending a final commissioner's order under section 245A.08, subdivision 5, regarding the final licensing sanction.

Sec. 14. Minnesota Statutes 2012, section 245A.1435, is amended to read:

245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT DEATH SYNDROME IN LICENSED PROGRAMS.

(a) When a license holder is placing an infant to sleep, the license holder must place the infant on the infant's back, unless the license holder has documentation from the infant's parent physician directing an alternative sleeping position for the infant. The parent physician directive must be on a form approved by the commissioner and must include a statement that the parent or legal guardian has read the information provided by the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance of placing an infant or child on its back to sleep to reduce the risk of SIDS. remain on file at the licensed location. An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant regularly rolls over at home.

(b) ~~The license holder must place the infant in a crib directly on a firm mattress with a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be dislodged by pulling on the corner of the sheet. The license holder must not place pillows, quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib with the infant~~ The license holder must place the infant in a crib directly on a firm mattress with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. The license holder must not place anything in the crib with the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title 16, part 1511. The requirements of this section apply to license holders serving infants up to and including 12 months younger than one year of age. Licensed child care providers must meet the crib requirements under section 245A.146.

(c) If an infant falls asleep before being placed in a crib, the license holder must move the infant to a crib as soon as practicable, and must keep the infant within sight of the license holder until the infant is placed in a crib. When an infant falls asleep while being held, the license holder must consider the supervision needs of other children in care when determining how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant must not be in a position where the airway may be blocked or with anything covering the infant's face.

(d) Placing a swaddled infant down to sleep in a licensed setting is not recommended for an infant of any age and is prohibited for any infant who has begun to roll over independently. However, with the written consent of a parent or guardian according to this paragraph, a license holder may place the infant who has not yet begun to roll over on its own down to sleep in a one-piece sleeper equipped with an attached system that fastens securely only across the upper torso, with no constriction of the hips or legs, to create a swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant on a form provided by the commissioner and prepared in partnership with the Minnesota Sudden Infant Death Center.

Sec. 15. Minnesota Statutes 2012, section 245A.144, is amended to read:

245A.144 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT DEATH AND SHAKEN-BABY SYNDROME ABUSIVE HEAD TRAUMA FOR CHILD FOSTER CARE PROVIDERS.

(a) Licensed child foster care providers that care for infants or children through five years of age must document that before staff persons and caregivers assist in the care of infants or children through five years of age, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death syndrome and shaken-baby syndrome for abusive head trauma from shaking infants and young children. This section does not apply to emergency relative placement under section 245A.035. The training on reducing the risk of sudden unexpected infant death syndrome and shaken-baby syndrome abusive head trauma may be provided as:

(1) orientation training to child foster care providers, who care for infants or children through five years of age, under Minnesota Rules, part 2960.3070, subpart 1; or

(2) in-service training to child foster care providers, who care for infants or children through five years of age, under Minnesota Rules, part 2960.3070, subpart 2.

(b) Training required under this section must be at least one hour in length and must be completed at least once every five years. At a minimum, the training must address the risk factors related to sudden unexpected infant death syndrome and shaken-baby syndrome abusive head trauma, means of reducing the risk of sudden unexpected infant death syndrome and shaken-baby syndrome abusive head trauma, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death syndrome and shaken-baby syndrome abusive head trauma.

(c) Training for child foster care providers must be approved by the county or private licensing agency that is responsible for monitoring the child foster care provider under section 245A.16. The approved training fulfills, in part, training required under Minnesota Rules, part 2960.3070.

Sec. 16. Minnesota Statutes 2012, section 245A.1444, is amended to read:

245A.1444 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT DEATH SYNDROME AND SHAKEN-BABY SYNDROME ABUSIVE HEAD TRAUMA BY OTHER PROGRAMS.

A licensed chemical dependency treatment program that serves clients with infants or children through five years of age, who sleep at the program and a licensed children's residential facility that serves infants or children through five years of age, must document that before program staff persons or volunteers assist in the care of infants or children through five years of age, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death syndrome and shaken-baby syndrome abusive head trauma from shaking infants and young children. The training conducted under this section may be used to fulfill training requirements under Minnesota Rules, parts 2960.0100, subpart 3; and 9530.6490, subpart 4, item B.

This section does not apply to child care centers or family child care programs governed by sections 245A.40 and 245A.50.

Sec. 17. **[245A.148] FAMILY CHILD CARE DIAPERING AREA DISINFECTION.**

Notwithstanding Minnesota Rules, part 9502.0435, a family child care provider may disinfect the diaper changing surface with chlorine bleach in a manner consistent with label directions for disinfection or with a surface disinfectant that meets the following criteria:

(1) the manufacturer's label or instructions state that the product is registered with the United States Environmental Protection Agency;

(2) the manufacturer's label or instructions state that the disinfectant is effective against Staphylococcus aureus, Salmonella choleraesuis, and Pseudomonas aeruginosa;

(3) the manufacturer's label or instructions state that the disinfectant is effective with a ten minute or less contact time;

(4) the disinfectant is clearly labeled by the manufacturer with directions for mixing and use;

(5) the disinfectant is used only in accordance with the manufacturer's directions; and

(6) the product does not include triclosan or derivatives of triclosan.

Sec. 18. **[245A.147] FAMILY CHILD CARE INFANT SLEEP SUPERVISION REQUIREMENTS.**

Subdivision 1. **In-person checks on infants.** (a) License holders that serve infants are encouraged to monitor sleeping infants by conducting in-person checks on each infant in their care every 30 minutes.

(b) Upon enrollment of an infant in a family child care program, the license holder is encouraged to conduct in-person checks on the sleeping infant every 15 minutes, during the first four months of care.

(c) When an infant has an upper respiratory infection, the license holder is encouraged to conduct in-person checks on the sleeping infant every 15 minutes throughout the hours of sleep.

Subd. 2. **Use of audio or visual monitoring devices.** In addition to conducting the in-person checks encouraged under subdivision 1, license holders serving infants are encouraged to use and maintain an audio or visual monitoring device to monitor each sleeping infant in care during all hours of sleep.

Sec. 19. **[245A.152] CHILD CARE LICENSE HOLDER INSURANCE.**

(a) A license holder must provide a written notice to all parents or guardians of all children to be accepted for care prior to admission stating whether the license holder has liability insurance. This notice may be incorporated into and provided on the admission form used by the license holder.

(b) If the license holder has liability insurance:

(1) the license holder shall inform parents in writing that a current certificate of coverage for insurance is available for inspection to all parents or guardians of children receiving services and to all parents seeking services from the family child care program;

(2) the notice must provide the parent or guardian with the date of expiration or next renewal of the policy; and

(3) upon the expiration date of the policy, the license holder must provide a new written notice indicating whether the insurance policy has lapsed or whether the license holder has renewed the policy.

If the policy was renewed, the license holder must provide the new expiration date of the policy in writing to the parents or guardians.

(c) If the license holder does not have liability insurance, the license holder must provide an annual notice, on a form developed and made available by the commissioner, to the parents or guardians of children in care indicating that the license holder does not carry liability insurance.

(d) The license holder must notify all parents and guardians in writing immediately of any change in insurance status.

(e) The license holder must make available upon request the certificate of liability insurance to the parents of children in care, to the commissioner, and to county licensing agents.

(f) The license holder must document, with the signature of the parent or guardian, that the parent or guardian received the notices required by this section.

Sec. 20. Minnesota Statutes 2012, section 245A.40, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~ abusive head trauma training.** (a) License holders must document that before staff persons and volunteers care for infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death syndrome. In addition, license holders must document that before staff persons care for infants or children under school age, they receive training on the risk of ~~shaken baby syndrome~~ abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as orientation training under subdivision 1 and in-service training under subdivision 7.

(b) Sudden unexpected infant death syndrome reduction training required under this subdivision must be at least one-half hour in length and must be completed at least once every ~~five years~~ year. At a minimum, the training must address the risk factors related to sudden unexpected infant death syndrome, means of reducing the risk of sudden unexpected infant death syndrome in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death syndrome.

(c) ~~Shaken baby syndrome~~ Abusive head trauma training under this subdivision must be at least one-half hour in length and must be completed at least once every ~~five years~~ year. At a minimum, the training must address the risk factors related to ~~shaken baby syndrome~~ for shaking infants and young children, means to reduce the risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive head trauma.

(d) The commissioner shall make available for viewing a video presentation on the dangers associated with shaking infants and young children. The video presentation must be part of the orientation and annual in-service training of licensed child care center staff persons caring for children under school age. The commissioner shall provide to child care providers and interested individuals, at cost, copies of a video approved by the commissioner of health under section 144.574 on the dangers associated with shaking infants and young children.

Sec. 21. Minnesota Statutes 2012, section 245A.50, is amended to read:

245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.

Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes must comply with the training requirements in this section.

(b) Helpers who assist with care on a regular basis must complete six hours of training within one year after the date of initial employment.

Subd. 2. **Child growth and development and behavior guidance training.** (a) For purposes of family and group family child care, the license holder and each adult caregiver who provides care in the licensed setting for more than 30 days in any 12-month period shall complete and document at least ~~two~~ four hours of child growth and development and behavior guidance training ~~within the first year of~~ prior to initial licensure, and before caring for children. For purposes of this subdivision, "child growth and development training" means training in understanding how children acquire language and develop physically, cognitively, emotionally, and socially. "Behavior guidance training" means training in the understanding of the functions of child behavior and strategies for managing challenging situations. Child growth and development and behavior guidance training must be repeated annually. Training curriculum shall be developed or approved by the commissioner of human services by January 1, 2014.

(b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

- (1) have taken a three-credit course on early childhood development within the past five years;
- (2) have received a baccalaureate or master's degree in early childhood education or school-age child care within the past five years;
- (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or
- (4) have received a baccalaureate degree with a Montessori certificate within the past five years.

Subd. 3. **First aid.** (a) When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present in the home who has been trained in first aid. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training include individuals approved as first aid instructors. First aid training must be repeated every two years.

(b) A family child care provider is exempt from the first aid training requirements under this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.

(c) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.

Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present in the home who has been trained in cardiopulmonary resuscitation (CPR) and in the treatment of obstructed airways that includes CPR techniques for infants and children. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every ~~three~~ two years, and must be documented in the staff person's records.

(b) A family child care provider is exempt from the CPR training requirement in this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.

~~(c) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.~~ Persons providing CPR training must use CPR training that has been developed:

- (1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or
- (2) using nationally recognized, evidence-based guidelines for CPR training and incorporates psychomotor skills to support the instruction.

Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~ abusive head trauma training.** (a) License holders must document that before staff persons, caregivers, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death syndrome. In addition, license holders must document that before staff persons, caregivers, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of ~~shaken baby syndrome~~ abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

(b) Sudden unexpected infant death syndrome reduction training required under this subdivision must be at least one-half hour in length and must be completed in person at least once every ~~five years~~ two years. On the years when the license holder is not receiving the in-person training on sudden unexpected infant death reduction, the license holder must receive sudden unexpected infant death reduction training through a video of no more than one hour in length developed or approved by the commissioner. At a minimum, the training must address the risk factors related to sudden unexpected infant death syndrome, means of reducing the risk of sudden unexpected infant death syndrome in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death syndrome.

(c) ~~Shaken baby syndrome~~ Abusive head trauma training required under this subdivision must be at least one-half hour in length and must be completed at least once every ~~five years~~ year. At a minimum, the training must address the risk factors related to ~~shaken baby syndrome~~ shaking infants and young children, means of reducing the risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive head trauma.

(d) Training for family and group family child care providers must be developed by the commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved by the county licensing agency by the Minnesota Center for Professional Development.

(e) ~~The commissioner shall make available for viewing by all licensed child care providers a video presentation on the dangers associated with shaking infants and young children. The video presentation shall be part of the initial and ongoing annual training of licensed child care providers, caregivers, and helpers caring for children under school age. The commissioner shall provide to child care providers and interested individuals, at cost, copies of a video approved by the commissioner of health under section 144.574 on the dangers associated with shaking infants and young children.~~

Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

(b) Family and group family child care programs licensed by the Department of Human Services that serve a child or children under nine years of age must document training that fulfills the requirements in this subdivision.

(1) Before a license holder, staff person, caregiver, or helper transports a child or children under age nine in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this subdivision may be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

(2) Training required under this subdivision must be at least one hour in length, completed at initial training, and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(3) Training under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety Web site or by contacting the agency.

(c) Child care providers that only transport school-age children as defined in section 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

Subd. 7. **Training requirements for family and group family child care.** For purposes of family and group family child care, the license holder and each primary caregiver must complete ~~eight~~ 16 hours of ongoing training each year. For purposes of this subdivision, a primary caregiver is an adult caregiver who provides services in the licensed setting for more than 30 days in any 12-month period. Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

(1) "child growth and development training" ~~has the meaning given in~~ under subdivision 2, paragraph (a);

(2) "learning environment and curriculum" ~~includes, including~~ training in establishing an environment and providing activities that provide learning experiences to meet each child's needs, capabilities, and interests;

(3) "assessment and planning for individual needs" ~~includes, including~~ training in observing and assessing what children know and can do in order to provide curriculum and instruction that addresses their developmental and learning needs, including children with special needs and bilingual children or children for whom English is not their primary language;

(4) "interactions with children" ~~includes, including~~ training in establishing supportive relationships with children, guiding them as individuals and as part of a group;

(5) "families and communities" ~~includes, including~~ training in working collaboratively with families and agencies or organizations to meet children's needs and to encourage the community's involvement;

(6) "health, safety, and nutrition" ~~includes, including~~ training in establishing and maintaining an environment that ensures children's health, safety, and nourishment, including child abuse, maltreatment, prevention, and reporting; home and fire safety; child injury prevention; communicable disease prevention and control; first aid; and CPR; ~~and~~

(7) "program planning and evaluation" ~~includes, including~~ training in establishing, implementing, evaluating, and enhancing program operations; ~~and~~

(8) behavior guidance, including training in the understanding of the functions of child behavior and strategies for managing behavior.

Subd. 8. **Other required training requirements.** (a) The training required of family and group family child care providers and staff must include training in the cultural dynamics of early childhood development and child care. The cultural dynamics and disabilities training and skills development of child care providers must be designed to achieve outcomes for providers of child care that include, but are not limited to:

(1) an understanding and support of the importance of culture and differences in ability in children's identity development;

(2) understanding the importance of awareness of cultural differences and similarities in working with children and their families;

- (3) understanding and support of the needs of families and children with differences in ability;
- (4) developing skills to help children develop unbiased attitudes about cultural differences and differences in ability;
- (5) developing skills in culturally appropriate caregiving; and
- (6) developing skills in appropriate caregiving for children of different abilities.

The commissioner shall approve the curriculum for cultural dynamics and disability training.

(b) The provider must meet the training requirement in section 245A.14, subdivision 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child care or group family child care home to use the swimming pool located at the home.

Subd. 9. Supervising for safety; training requirement. Effective July 1, 2014, all family child care license holders and each adult caregiver who provides care in the licensed family child care home for more than 30 days in any 12-month period shall complete and document at least six hours of approved training on supervising for safety prior to initial licensure, and before caring for children. At least two hours of training on supervising for safety must be repeated annually. For purposes of this subdivision, "supervising for safety" includes supervision basics, supervision outdoors, equipment and materials, illness, injuries, and disaster preparedness. The commissioner shall develop the supervising for safety curriculum by January 1, 2014.

Subd. 10. Approved training. County licensing staff must accept training approved by the Minnesota Center for Professional Development, including:

- (1) face-to-face or classroom training;
- (2) online training; and
- (3) relationship-based professional development, such as mentoring, coaching, and consulting.

Subd. 11. Provider training. New and increased training requirements under this section must not be imposed on providers until the commissioner establishes statewide accessibility to the required provider training.

Sec. 22. Minnesota Statutes 2012, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. Contribution amount. (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than ~~100~~ 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

~~(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is \$4 per month;~~

~~(2)~~ (1) if the adjusted gross income is equal to or greater than ~~175~~ 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at

~~one 2.76~~ percent of adjusted gross income at ~~175~~ 275 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

~~(3)~~ (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 7.5 percent of adjusted gross income;

~~(4)~~ (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 7.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ten percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

~~(5)~~ (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in the 12 months prior to July 1:

- (1) the parent applied for insurance for the child;
- (2) the insurer denied insurance;
- (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and
- (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30, 2015, the parental contribution shall be computed by applying the following contribution schedule to the adjusted gross income of the natural or adoptive parents:~~

~~(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is \$4 per month;~~

~~(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 525 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to eight percent of adjusted gross income for those with adjusted gross income up to 525 percent of federal poverty guidelines;~~

~~(3) if the adjusted gross income is greater than 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 9.5 percent of adjusted gross income;~~

~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 900 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross income. If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.~~

EFFECTIVE DATE. Paragraph (b) is effective January 1, 2014. Paragraph (j) is effective July 1, 2013.

Sec. 23. Minnesota Statutes 2012, section 256.98, subdivision 8, is amended to read:

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp or food support program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

- (1) for one year after the first offense;
- (2) for two years after the second offense; and
- (3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of ~~three months, six months, and one year~~ and two years for the first, ~~and second, and third~~ offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance

program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of one year for the first offense and two years for the second offense. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

EFFECTIVE DATE. This section is effective February 3, 2014.

Sec. 24. Minnesota Statutes 2012, section 256J.08, subdivision 24, is amended to read:

Subd. 24. **Disregard.** "Disregard" means earned income that is not counted ~~when determining initial eligibility in the initial income test in section 256J.21, subdivision 3, or income that is not counted when determining~~ ongoing eligibility and calculating the amount of the assistance payment for participants. ~~The commissioner shall determine the amount of the disregard according to section 256J.24, subdivision 10 for~~ ongoing eligibility shall be 50 percent of gross earned income.

EFFECTIVE DATE. This section is effective October 1, 2014, or upon approval from the United States Department of Agriculture, whichever is later.

Sec. 25. Minnesota Statutes 2012, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions

for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) state adoption assistance payments under section 259.67, and up to an equal amount of county adoption assistance payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476,

and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

(46) the principal portion of a contract for deed payment; ~~and~~

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC; and

(48) housing assistance grants under section 256J.35, paragraph (a).

Sec. 26. Minnesota Statutes 2012, section 256J.21, subdivision 3, is amended to read:

Subd. 3. **Initial income test.** The county agency shall determine initial eligibility by considering all earned and unearned income that is not excluded under subdivision 2. To be eligible for MFIP, the assistance unit's countable income minus the disregards in paragraphs (a) and (b) must be below the ~~transitional standard of assistance~~ family wage level according to section 256J.24 for that size assistance unit.

(a) The initial eligibility determination must disregard the following items:

(1) the employment disregard is 18 percent of the gross earned income whether or not the member is working full time or part time;

(2) dependent care costs must be deducted from gross earned income for the actual amount paid for dependent care up to a maximum of \$200 per month for each child less than two years of age, and \$175 per month for each child two years of age and older under this chapter and chapter 119B;

(3) all payments made according to a court order for spousal support or the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support, provided that, if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for a modification of the support order; and

(4) an allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver according to section 256J.36.

(b) Notwithstanding paragraph (a), when determining initial eligibility for applicant units when at least one member has received MFIP in this state within four months of the most recent application for MFIP, apply the disregard as defined in section 256J.08, subdivision 24, for all unit members.

After initial eligibility is established, the assistance payment calculation is based on the monthly income test.

EFFECTIVE DATE. This section is effective October 1, 2014, or upon approval from the United States Department of Agriculture, whichever is later.

Sec. 27. Minnesota Statutes 2012, section 256J.24, subdivision 5, is amended to read:

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.

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

Sec. 28. Minnesota Statutes 2012, section 256J.24, subdivision 7, is amended to read:

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.~~ If there is earned income in the assistance unit, earned income is subtracted from the family wage level to determine the amount of the assistance payment, as specified in section 256J.21. 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.

EFFECTIVE DATE. This section is effective October 1, 2014, or upon approval from the United States Department of Agriculture, whichever is later.

Sec. 29. Minnesota Statutes 2012, section 256J.35, is amended to read:

256J.35 AMOUNT OF ASSISTANCE PAYMENT.

Except as provided in paragraphs (a) to ~~(e)~~ (d), the amount of an assistance payment is equal to the difference between the MFIP standard of need or the Minnesota family wage level in section 256J.24 and countable income.

(a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing assistance grant of \$110 per month, unless:

(1) the housing assistance unit is currently receiving public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) and is subject to section 256J.37, subdivision 3a; or

(2) the assistance unit is a child-only case under section 256J.88.

~~(a)~~ (b) When MFIP eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision applies when an applicant loses at least one day of MFIP eligibility.

~~(b)~~ (c) MFIP overpayments to an assistance unit must be recouped according to section 256J.38, subdivision 4.

~~(e)~~ (d) An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

Sec. 30. Minnesota Statutes 2012, section 256J.621, is amended to read:

256J.621 WORK PARTICIPATION CASH BENEFITS.

Subdivision 1. **Program characteristics.** (a) Effective October 1, 2009, upon exiting the diversionary work program (DWP) or upon terminating the Minnesota family investment program with earnings, a participant who is employed may be eligible for work participation cash benefits of \$25 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

(b) To be eligible for work participation cash benefits, the participant shall not receive MFIP or diversionary work program assistance during the month and the participant or participants must meet the following work requirements:

(1) if the participant is a single caregiver and has a child under six years of age, the participant must be employed at least 87 hours per month;

(2) if the participant is a single caregiver and does not have a child under six years of age, the participant must be employed at least 130 hours per month; or

(3) if the household is a two-parent family, at least one of the parents must be employed 130 hours per month.

Whenever a participant exits the diversionary work program or is terminated from MFIP and meets the other criteria in this section, work participation cash benefits are available for up to 24 consecutive months.

(c) Expenditures on the program are maintenance of effort state funds under a separate state program for participants under paragraph (b), clauses (1) and (2). Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort funds. Months in which a participant receives work participation cash benefits under this section do not count toward the participant's MFIP 60-month time limit.

Subd. 2. **Program suspension.** (a) Effective December 1, 2014, the work participation cash benefits program shall be suspended.

(b) The commissioner of human services may reinstate the work participation cash benefits program if the United States Department of Human Services determines that the state of Minnesota did not meet the federal TANF work participation rate and sends a notice of penalty to reduce Minnesota's federal TANF block grant authorized under title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.

(c) The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance of the potential penalty and the commissioner's plans to reinstate the work participation cash benefit program within 30 days of the date the commissioner receives notification that the state failed to meet the federal work participation rate.

Sec. 31. Minnesota Statutes 2012, section 256J.626, subdivision 7, is amended to read:

~~Subd. 7. **Performance base funds.** (a) For the purpose of this section, the following terms have the meanings given.~~

~~(1) "Caseload Reduction Credit" (CRC) means the measure of how much Minnesota TANF and separate state program caseload has fallen relative to federal fiscal year 2005 based on caseload data from October 1 to September 30.~~

~~(2) "TANF participation rate target" means a 50 percent participation rate reduced by the CRC for the previous year.~~

~~(b) (a) For calendar year 2010 2016 and yearly thereafter, each county and tribe will must be allocated 95 100 percent of their initial calendar year allocation. Allocations for counties and tribes will must be allocated additional funds adjusted based on performance as follows:~~

~~(1) a county or tribe that achieves the TANF participation rate target or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation;~~

~~(2) (1)~~ a county or tribe that performs ~~within or above~~ its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will~~ must receive an additional allocation equal to 2.5 percent of its initial allocation; and

~~(3)~~ a county or tribe that does not achieve the TANF participation rate target or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent year for which the measurements are available, will not receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear improvement plan with the commissioner; or

~~(4) (2)~~ a county or tribe that does not perform ~~within or above~~ performs below its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to 2.5 percent of its initial allocation until after negotiating for two consecutive years must negotiate~~ a multiyear improvement plan with the commissioner. If no improvement is shown by the end of the multiyear plan, the county's or tribe's allocation must be decreased by 2.5 percent. The decrease must remain in effect until the county or tribe performs within or above its range of expected performance.

~~(e) (b)~~ For calendar year ~~2009~~ 2016 and yearly thereafter, performance-based funds for a federally approved tribal TANF program in which the state and tribe have in place a contract under section 256.01, addressing consolidated funding, ~~will~~ must be allocated as follows:

~~(1)~~ a tribe that achieves the participation rate approved in its federal TANF plan using the average of 12 consecutive months for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

~~(2) (1)~~ a tribe that performs ~~within or above~~ its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will~~ must receive an additional allocation equal to 2.5 percent of its initial allocation; or

~~(3)~~ a tribe that does not achieve the participation rate approved in its federal TANF plan using the average of 12 consecutive months for the most recent year for which the measurements are available, will not receive an additional allocation equal to 2.5 percent of its initial allocation until after negotiating a multiyear improvement plan with the commissioner; or

~~(4) (2)~~ a tribe that does not perform ~~within or above~~ performs below its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to 2.5 percent until after negotiating for two consecutive years must negotiate~~ a multiyear improvement plan with the commissioner. If no improvement is shown by the end of the multiyear plan, the tribe's allocation must be decreased by 2.5 percent. The decrease must remain in effect until the tribe performs within or above its range of expected performance.

~~(d) (c)~~ Funds remaining unallocated after the performance-based allocations in paragraph ~~(b) (a)~~ are available to the commissioner for innovation projects under subdivision 5.

~~(+)~~ ~~(d)~~ If available funds are insufficient to meet county and tribal allocations under ~~paragraph paragraphs (a) and (b)~~, the commissioner ~~may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium shall proportionally prorate~~ funds to counties and tribes that qualify for a bonus under paragraphs (a), clause (1), and (b), clause (2).

~~(2)~~ If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (b), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (b).

Sec. 32. [256J.78] TANF DEMONSTRATION PROJECTS OR WAIVER FROM FEDERAL RULES AND REGULATIONS.

Subdivision 1. **Duties of the commissioner.** The commissioner of human services may pursue TANF demonstration projects or waivers of TANF requirements from the United States Department of Health and Human Services as needed to allow the state to build a more results-oriented Minnesota Family Investment Program to better meet the needs of Minnesota families.

Subd. 2. **Purpose.** The purpose of the TANF demonstration projects or waivers is to:

(1) replace the federal TANF process measure and its complex administrative requirements with state-developed outcomes measures that track adult employment and exits from MFIP cash assistance;

(2) simplify programmatic and administrative requirements; and

(3) make other policy or programmatic changes that improve the performance of the program and the outcomes for participants.

Subd. 3. **Report to legislature.** The commissioner shall report to the members of the legislative committees having jurisdiction over human services issues by March 1, 2014, regarding the progress of this waiver or demonstration project.

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

Sec. 33. Minnesota Statutes 2012, section 256K.45, is amended to read:

256K.45 ~~RUNAWAY AND HOMELESS YOUTH ACT.~~

Subdivision 1. **Grant program established.** The commissioner of human services shall establish a Homeless Youth Act fund and award grants to providers who are committed to serving homeless youth and youth at risk of homelessness, to provide street and community outreach and drop-in programs, emergency shelter programs, and integrated supportive housing and transitional living programs, consistent with the program descriptions in this act to reduce the incidence of homelessness among youth.

~~Subdivision 1.~~ Subd. 1a. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services.

(c) "Homeless youth" means a person 21 years of age or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available, whose parent or legal guardian is unable or unwilling to provide shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution or a publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Homeless youth does not include persons incarcerated or otherwise detained under federal or state law.

(d) "Youth at risk of homelessness" means a person 21 years of age or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. Status or circumstances that indicate a significant danger may include: (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3) youth whose parents or primary caregivers are or were previously homeless; (4) youth who are exposed to abuse and neglect in their homes; (5) youth who experience conflict with parents due to chemical or alcohol dependency, mental health disabilities, or other disabilities; and (6) runaways.

(e) "Runaway" means an unmarried child under the age of 18 years who is absent from the home of a parent or guardian or other lawful placement without the consent of the parent, guardian, or lawful custodian.

Subd. 2. **Homeless and runaway youth report.** ~~The commissioner shall develop a report for homeless youth, youth at risk of homelessness, and runaways. The report shall include coordination of services as defined under subdivisions 3 to 5~~ prepare a biennial report, beginning in February 2015, which provides meaningful information to the legislative committees having jurisdiction over the issue of homeless youth, that includes, but is not limited to: (1) a list of the areas of the state with the greatest need for services and housing for homeless youth, and the level and nature of the needs identified; (2) details about grants made; (3) the distribution of funds throughout the state based on population need; (4) follow-up information, if available, on the status of homeless youth and whether they have stable housing two years after services are provided; and (5) any other outcomes for populations served to determine the effectiveness of the programs and use of funding.

Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and ongoing supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

- (1) family reunification services;
- (2) conflict resolution or mediation counseling;
- (3) assistance in obtaining temporary emergency shelter;
- (4) assistance in obtaining food, clothing, medical care, or mental health counseling;
- (5) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse, sexually transmitted diseases, and pregnancy;
- (6) referrals to other agencies that provide support services to homeless youth, youth at risk of homelessness, and runaways;
- (7) assistance with education, employment, and independent living skills;
- (8) aftercare services;
- (9) specialized services for highly vulnerable runaways and homeless youth, including teen parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and
- (10) homelessness prevention.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide homeless youth and runaways with referral and walk-in access to emergency, short-term residential care. The program shall provide homeless youth and runaways with safe, dignified shelter, including private shower facilities, beds, and at least one meal each day; and shall assist a runaway and homeless youth with reunification with the family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include, but are not limited to:

- (1) family reunification services;
- (2) individual, family, and group counseling;
- (3) assistance obtaining clothing;
- (4) access to medical and dental care and mental health counseling;
- (5) education and employment services;
- (6) recreational activities;
- (7) advocacy and referral services;
- (8) independent living skills training;
- (9) aftercare and follow-up services;
- (10) transportation; and
- (11) homelessness prevention.

Subd. 5. **Supportive housing and transitional living programs.** Transitional living programs must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program may also provide rental assistance and related supportive services, or refer youth to other organizations or agencies that provide such services. Services provided may include, but are not limited to:

- (1) educational assessment and referrals to educational programs;
- (2) career planning, employment, work skill training, and independent living skills training;
- (3) job placement;
- (4) budgeting and money management;
- (5) assistance in securing housing appropriate to needs and income;
- (6) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse, sexually transmitted diseases, and pregnancy;
- (7) referral for medical services or chemical dependency treatment;
- (8) parenting skills;
- (9) self-sufficiency support services or life skill training;
- (10) aftercare and follow-up services; and
- (11) homelessness prevention.

Subd. 6. **Funding.** ~~Any Funds appropriated for this section may be expended on programs described under subdivisions 3 to 5, technical assistance, and capacity building. Up to four percent of funds appropriated may be used for the purpose of monitoring and evaluating runaway and homeless youth programs receiving funding under this section. Funding shall be directed to meet the greatest need, with a significant share of the funding focused on homeless youth providers in greater Minnesota to meet the greatest need on a statewide basis.~~

Sec. 34. Minnesota Statutes 2012, section 256M.40, subdivision 1, is amended to read:

Subdivision 1. **Formula.** The commissioner shall allocate state funds appropriated under this chapter to each county board on a calendar year basis in an amount determined according to the formula in paragraphs (a) to (e).

(a) For calendar years 2011 and 2012, the commissioner shall allocate available funds to each county in proportion to that county's share in calendar year 2010.

(b) For calendar year 2013 and each calendar year thereafter, the commissioner shall allocate available funds to each county as follows:

(1) 75 percent must be distributed on the basis of the county share in calendar year 2012;

(2) five percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

(3) ten percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, and in the county as determined by the most recent data of the commissioner; and

(4) ten percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner.

(c) For calendar year 2014, the commissioner shall allocate available funds to each county as follows:

(1) 50 percent must be distributed on the basis of the county share in calendar year 2012;

(2) Ten percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

(3) 20 percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the county as determined by the most recent data of the commissioner; and

(4) 20 percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner. The commissioner is precluded from changing the formula under this subdivision or recommending a change to the legislature without public review and input.

(d) For calendar year 2015, the commissioner shall allocate available funds to each county as follows:

(1) 25 percent must be distributed on the basis of the county share in calendar year 2012;

(2) 15 percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

(3) 30 percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the county as determined by the most recent data of the commissioner; and

(4) 30 percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner.

(e) For calendar year 2016 and each calendar year thereafter, the commissioner shall allocate available funds to each county as follows:

(1) 20 percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

~~(2) 40 percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the county as determined by the most recent data of the commissioner, and~~

~~(3) 40 percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner.~~

Sec. 35. Minnesota Statutes 2012, section 257.0755, subdivision 1, is amended to read:

Subdivision 1. **Creation.** ~~One~~ Each ombudsperson shall operate independently from but in collaboration with ~~each of the following groups~~ the community-specific board that appointed the ombudsperson under section 257.0768: the Indian Affairs Council, the Council on Affairs of Chicano/Latino people, the Council on Black Minnesotans, and the Council on Asian-Pacific Minnesotans.

Sec. 36. Minnesota Statutes 2012, section 259A.20, subdivision 4, is amended to read:

Subd. 4. **Reimbursement for special nonmedical expenses.** (a) Reimbursement for special nonmedical expenses is available to children, except those eligible for adoption assistance based on being an at-risk child.

(b) Reimbursements under this paragraph shall be made only after the adoptive parent documents that the requested service was denied by the local social service agency, community agencies, the local school district, the local public health department, the parent's insurance provider, or the child's program. The denial must be for an eligible service or qualified item under the program requirements of the applicable agency or organization.

(c) Reimbursements must be previously authorized, adhere to the requirements and procedures prescribed by the commissioner, and be limited to:

(1) child care for a child age 12 and younger, or for a child age 13 or 14 who has a documented disability that requires special instruction for and services by the child care provider. Child care reimbursements may be made if all available adult caregivers are employed, unemployed due to a disability as defined in section 259A.01, subdivision 14, or attending educational or vocational training programs. Documentation from a qualified expert that is dated within the last 12 months must be provided to verify the disability. If a parent is attending an educational or vocational training program, child care reimbursement is limited to no more than the time necessary to complete the credit requirements for an associate or baccalaureate degree as determined by the educational institution. Child care reimbursement is not limited for an adoptive parent completing basic or remedial education programs needed to prepare for postsecondary education or employment;

(2) respite care provided for the relief of the child's parent up to 504 hours of respite care annually;

(3) camping up to 14 days per state fiscal year for a child to attend a special needs camp. The camp must be accredited by the American Camp Association as a special needs camp in order to be eligible for camp reimbursement;

(4) postadoption counseling to promote the child's integration into the adoptive family that is provided by the placing agency during the first year following the date of the adoption decree. Reimbursement is limited to 12 sessions of postadoption counseling;

(5) family counseling that is required to meet the child's special needs. Reimbursement is limited to the prorated portion of the counseling fees allotted to the family when the adoptive parent's health insurance or Medicaid pays for the child's counseling but does not cover counseling for the rest of the family members;

(6) home modifications to accommodate the child's special needs upon which eligibility for adoption assistance was approved. Reimbursement is limited to once every five years per child;

(7) vehicle modifications to accommodate the child's special needs upon which eligibility for adoption assistance was approved. Reimbursement is limited to once every five years per family; and

(8) burial expenses up to \$1,000, if the special needs, upon which eligibility for adoption assistance was approved, resulted in the death of the child.

(d) The adoptive parent shall submit statements for expenses incurred between July 1 and June 30 of a given fiscal year to the state adoption assistance unit within 60 days after the end of the fiscal year in order for reimbursement to occur.

Sec. 37. Minnesota Statutes 2012, section 260B.007, subdivision 6, is amended to read:

Subd. 6. **Delinquent child.** (a) Except as otherwise provided in paragraphs (b) and (c), "delinquent child" means a child:

(1) who has violated any state or local law, except as provided in section 260B.225, subdivision 1, and except for juvenile offenders as described in subdivisions 16 to 18;

(2) who has violated a federal law or a law of another state and whose case has been referred to the juvenile court if the violation would be an act of delinquency if committed in this state or a crime or offense if committed by an adult;

(3) who has escaped from confinement to a state juvenile correctional facility after being committed to the custody of the commissioner of corrections; or

(4) who has escaped from confinement to a local juvenile correctional facility after being committed to the facility by the court.

(b) The term delinquent child does not include a child alleged to have committed murder in the first degree after becoming 16 years of age, but the term delinquent child does include a child alleged to have committed attempted murder in the first degree.

(c) The term delinquent child does not include a child ~~under the age of 16 years~~ alleged to have engaged in conduct which would, if committed by an adult, violate any federal, state, or local law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct.

EFFECTIVE DATE. This section is effective August 1, 2014, and applies to offenses committed on or after that date.

Sec. 38. Minnesota Statutes 2012, section 260B.007, subdivision 16, is amended to read:

Subd. 16. **Juvenile petty offender; juvenile petty offense.** (a) "Juvenile petty offense" includes a juvenile alcohol offense, a juvenile controlled substance offense, a violation of section 609.685, or a violation of a local ordinance, which by its terms prohibits conduct by a child under the age of 18 years which would be lawful conduct if committed by an adult.

(b) Except as otherwise provided in paragraph (c), "juvenile petty offense" also includes an offense that would be a misdemeanor if committed by an adult.

(c) "Juvenile petty offense" does not include any of the following:

(1) a misdemeanor-level violation of section 518B.01, 588.20, 609.224, 609.2242, 609.324, subdivision 2 or 3, 609.5632, 609.576, 609.66, 609.746, 609.748, 609.79, or 617.23;

(2) a major traffic offense or an adult court traffic offense, as described in section 260B.225;

(3) a misdemeanor-level offense committed by a child whom the juvenile court previously has found to have committed a misdemeanor, gross misdemeanor, or felony offense; or

(4) a misdemeanor-level offense committed by a child whom the juvenile court has found to have committed a misdemeanor-level juvenile petty offense on two or more prior occasions, unless the county attorney designates the child on the petition as a juvenile petty offender notwithstanding this prior record. As used in this clause, "misdemeanor-level juvenile petty offense" includes a misdemeanor-level offense that would have been a juvenile petty offense if it had been committed on or after July 1, 1995.

(d) A child who commits a juvenile petty offense is a "juvenile petty offender." The term juvenile petty offender does not include a child ~~under the age of 16 years~~ alleged to have violated any law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct which, if committed by an adult, would be a misdemeanor.

EFFECTIVE DATE. This section is effective August 1, 2014, and applies to offenses committed on or after that date.

Sec. 39. Minnesota Statutes 2012, section 260C.007, subdivision 6, is amended to read:

Subd. 6. **Child in need of protection or services.** "Child in need of protection or services" means a child who is in need of protection or services because the child:

(1) is abandoned or without parent, guardian, or custodian;

(2)(i) has been a victim of physical or sexual abuse as defined in section 626.556, subdivision 2, (ii) resides with or has resided with a victim of child abuse as defined in subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as defined in subdivision 15;

(3) is without necessary food, clothing, shelter, education, or other required care for the child's physical or mental health or morals because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(4) is without the special care made necessary by a physical, mental, or emotional condition because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(5) is medically neglected, which includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition. The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration, and medication which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's or physicians' reasonable medical judgment:

(i) the infant is chronically and irreversibly comatose;

(ii) the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or

(iii) the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane;

(6) is one whose parent, guardian, or other custodian for good cause desires to be relieved of the child's care and custody, including a child who entered foster care under a voluntary placement agreement between the parent and the responsible social services agency under section 260C.227;

(7) has been placed for adoption or care in violation of law;

(8) is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of the child's parent, guardian, or other custodian;

(9) is one whose behavior, condition, or environment is such as to be injurious or dangerous to the child or others. An injurious or dangerous environment may include, but is not limited to, the exposure of a child to criminal activity in the child's home;

(10) is experiencing growth delays, which may be referred to as failure to thrive, that have been diagnosed by a physician and are due to parental neglect;

(11) ~~has engaged in prostitution as defined in section 609.321, subdivision 9~~ is a sexually exploited youth;

(12) has committed a delinquent act or a juvenile petty offense before becoming ten years old;

(13) is a runaway;

(14) is a habitual truant;

(15) has been found incompetent to proceed or has been found not guilty by reason of mental illness or mental deficiency in connection with a delinquency proceeding, a certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a proceeding involving a juvenile petty offense; or

(16) has a parent whose parental rights to one or more other children were involuntarily terminated or whose custodial rights to another child have been involuntarily transferred to a relative and there is a case plan prepared by the responsible social services agency documenting a compelling reason why filing the termination of parental rights petition under section 260C.301, subdivision 3, is not in the best interests of the child; ~~or~~.

~~(17) is a sexually exploited youth.~~

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

Sec. 40. Minnesota Statutes 2012, section 260C.007, subdivision 31, is amended to read:

Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an individual who:

(1) is alleged to have engaged in conduct which would, if committed by an adult, violate any federal, state, or local law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

(2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345, 609.3451, 609.3453, 609.352, 617.246, or 617.247;

(3) is a victim of a crime described in United States Code, title 18, section 2260; 2421; 2422; 2423; 2425; 2425A; or 2256; or

(4) is a sex trafficking victim as defined in section 609.321, subdivision 7b.

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

Sec. 41. Minnesota Statutes 2012, section 518A.60, is amended to read:

518A.60 COLLECTION; ARREARS ONLY.

(a) Remedies available for the collection and enforcement of support in this chapter and chapters 256, 257, 518, and 518C also apply to cases in which the child or children for whom support is owed are emancipated and the obligor owes past support or has an accumulated arrearage as of the date of the youngest child's emancipation. Child support arrearages under this section include arrearages for child support, medical support, child care, pregnancy and birth expenses, and unreimbursed medical expenses as defined in section 518A.41, subdivision 1, paragraph (h).

(b) This section applies retroactively to any support arrearage that accrued on or before June 3, 1997, and to all arrearages accruing after June 3, 1997.

(c) Past support or pregnancy and confinement expenses ordered for which the obligor has specific court ordered terms for repayment may not be enforced using drivers' and occupational or professional license suspension, credit bureau reporting, and additional income withholding under section 518A.53, subdivision 10, paragraph (a), unless the obligor fails to comply with the terms of the court order for repayment.

(d) If an arrearage exists at the time a support order would otherwise terminate and section 518A.53, subdivision 10, paragraph (c), does not apply to this section, the arrearage shall be repaid in an amount equal to the current support order until all arrears have been paid in full, absent a court order to the contrary.

(e) If an arrearage exists according to a support order which fails to establish a monthly support obligation in a specific dollar amount, the public authority, if it provides child support services, or the obligee, may establish a payment agreement which shall equal what the obligor would pay for current support after application of section 518A.34, plus an additional 20 percent of the current support obligation, until all arrears have been paid in full. If the obligor fails to enter into or comply with a payment agreement, the public authority, if it provides child support services, or the obligee, may move the district court or child support magistrate, if section 484.702 applies, for an order establishing repayment terms.

(f) If there is no longer a current support order because all of the children of the order are emancipated, the public authority may discontinue child support services and close its case under title IV-D of the Social Security Act if:

(1) the arrearage is under \$500; or

(2) the arrearage is considered unenforceable by the public authority because there have been no collections for three years, and all administrative and legal remedies have been attempted or are determined by the public authority to be ineffective because the obligor is unable to pay, the obligor has no known income or assets, and there is no reasonable prospect that the obligor will be able to pay in the foreseeable future.

(g) At least 60 calendar days before the discontinuation of services under paragraph (f), the public authority must mail a written notice to the obligee and obligor at the obligee's and obligor's last known addresses that the public authority intends to close the child support enforcement case and explaining each party's rights. Seven calendar days after the first notice is mailed, the public authority must mail a second notice under this paragraph to the obligee.

(h) The case must be kept open if the obligee responds before case closure and provides information that could reasonably lead to collection of arrears. If the case is closed, the obligee may later request that the case be reopened by completing a new application for services, if there is a change in circumstances that could reasonably lead to the collection of arrears.

Sec. 42. Laws 1998, chapter 407, article 6, section 116, is amended to read:

Sec. 116. **[256.9872] EBT TRANSACTION COSTS; ~~APPROVAL FROM LEGISLATURE.~~**

The commissioner of human services shall ~~request and receive approval from the legislature before adjusting the payment to~~ not subsidize retailers for electronic benefit transfer transaction costs Supplemental Nutrition Assistance Program transactions.

EFFECTIVE DATE. This section is effective 30 days after the commissioner notifies retailers of the termination of their agreement with the state. The commissioner of human services must notify the revisor of statutes of that date.

Sec. 43. Laws 2011, First Special Session chapter 9, article 1, section 3, the effective date, is amended to read:

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

EFFECTIVE DATE. This section is effective retroactively from January 1, 2013.

Sec. 44. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET EXCLUSION.**

(a) The commissioner of human services shall not count conditional cash transfers made to families participating in a family independence demonstration as income or assets for purposes of determining or redetermining eligibility for child care assistance programs under Minnesota Statutes, chapter 119B; general assistance under Minnesota Statutes, chapter 256D; group residential housing under Minnesota Statutes, chapter 256I; the Minnesota family investment program, work benefit program, or diversionary work program under Minnesota Statutes, chapter 256J, during the duration of the demonstration.

(b) The commissioner of human services shall not count conditional cash transfers made to families participating in a family independence demonstration as income or assets for purposes of determining or redetermining eligibility for medical assistance under Minnesota Statutes, chapter 256B, and MinnesotaCare under Minnesota Statutes, chapter 256L, except that for enrollees subject to a modified adjusted gross income calculation to determine eligibility, the conditional cash transfer payments shall be counted as income if they are included on the enrollee's federal tax return as income, or if the payments can be taken into account in the month of receipt as a lump sum payment.

(c) The commissioner of the Minnesota Housing Finance Agency shall not count conditional cash transfers made to families participating in a family independence demonstration as income or assets for purposes of determining or redetermining eligibility for housing assistance programs under Minnesota Statutes, section 462A.201, during the duration of the demonstration.

(d) For the purposes of this section:

(1) "conditional cash transfer" means a payment made to a participant in a family independence demonstration by a sponsoring organization to incent, support, or facilitate participation; and

(2) "family independence demonstration" means an initiative sponsored or cosponsored by a governmental or nongovernmental organization, the goal of which is to facilitate individualized goal-setting and peer support for cohorts of no more than 12 families each toward the development of financial and nonfinancial assets that enable the participating families to achieve financial independence.

(e) The citizens league shall provide a report to the legislative committees having jurisdiction over human services issues by July 1, 2016, informing the legislature on the progress and outcomes of the demonstration under this section.

Sec. 45. **REDUCTION OF YOUTH HOMELESSNESS.**

(a) The Minnesota Interagency Council on Homelessness established under the authority of Minnesota Statutes, section 462A.29, as it updates its statewide plan to prevent and end homelessness, shall make recommendations on strategies to reduce the number of youth experiencing homelessness and to prevent homelessness for youth who are at risk of becoming homeless.

(b) Recommended strategies must take into consideration, to the extent feasible, issues that contribute to or reduce youth homelessness including, but not limited to, mental health, chemical dependency, trafficking of youth for sex or other purposes, exiting foster care, and involvement in gangs. The recommended strategies must include supportive services as outlined in Minnesota Statutes, section 256K.45, subdivision 5.

(c) The council shall provide an update on the status of its work by December 1, 2014, to the legislative committees with jurisdiction over housing, homelessness, and matters pertaining to youth. If the council determines legislative action is required to implement recommended strategies, the council shall submit proposals to the legislature at the earliest possible opportunity.

Sec. 46. [256J.351] HOUSING ASSISTANCE GRANTS; FORECASTED PROGRAM.

Beginning July 1, 2015, housing assistance grants under Minnesota Statutes, section 256J.35, paragraph (a), must be a forecasted program and the commissioner, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances within fiscal years of each biennium with other forecasted programs of the Department of Human Services. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance committee quarterly about transfers made under this provision.

Sec. 47. PLAN FOR GROUP RESIDENTIAL HOUSING SPECIALTY RATE AND BANKED BEDS.

The commissioner of human services, in consultation with and cooperation of the counties, shall review the statewide number and status of group residential housing beds with rates in excess of the MSA equivalent rate, including banked supplemental service rate beds. The commissioner shall study the type and amount of supplemental services delivered or planned for development, and develop a plan for rate setting criteria and an efficient use of these beds. The commissioner shall review the performance of all programs that receive supplemental service rates. The plan must require that all beds receiving supplemental service rates address critical service needs and must establish quality performance requirements for beds receiving supplemental service rates. The commissioner shall present the written plan no later than February 1, 2014, to the chairs and ranking minority members of the house of representatives and senate finance and policy committees and divisions with jurisdiction over the Department of Human Services.

Sec. 48. REPEALER.

(a) Minnesota Statutes 2012, section 256J.24, is repealed January 1, 2015.

(b) Minnesota Statutes 2012, section 609.093, is repealed effective the day following final enactment.

ARTICLE 4

STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2012, section 245.462, subdivision 20, is amended to read:

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; ~~or~~

(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; or

(7) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger.

Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with the exception of the placement of a Minnesota specialty treatment facility as defined in paragraph (c), must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each pilot shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of the pilot project.

(b) For Minnesota specialty treatment facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.

(c) For purposes of this section, "Minnesota specialty treatment facility" is defined as an intensive rehabilitative mental health service under section 256B.0622, subdivision 2, paragraph (b).

Sec. 3. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the commissioner shall facilitate integration of funds or other resources as needed and requested by each project. These resources may include:

(1) residential services funds administered under Minnesota Rules, parts 9535.2000 to 9535.3000, in an amount to be determined by mutual agreement between the project's managing entity and the commissioner of human services after an examination of the county's historical utilization of facilities located both within and outside of the county and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

(2) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(3) other mental health special project funds;

(4) medical assistance, general assistance medical care, MinnesotaCare and group residential housing if requested by the project's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; ~~and~~

(5) regional treatment center resources consistent with section 246.0136, subdivision 1; and

(6) funds transferred from section 246.18, subdivision 8, for grants to providers to participate in mental health specialty treatment services, awarded to providers through a request for proposal process.

(b) The commissioner shall consider the following criteria in awarding start-up and implementation grants for the pilot projects:

(1) the ability of the proposed projects to accomplish the objectives described in subdivision 2;

(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the projects initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements which are incompatible with the implementation of the pilot project.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules which are incompatible with the implementation of the pilot project.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the pilot project.

Sec. 4. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

Subd. 2. **General provisions.** (a) In the design and implementation of reforms to the mental health system, the commissioner shall:

(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;

(2) bring to the legislature, and the State Advisory Council on Mental Health, by January 15, 2008, recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services as required under subdivision 3, paragraph (a);

(3) withhold implementation of any recommended changes in case management roles, functions, and decision-making authority until after the release of the report due January 15, 2008;

(4) ensure continuity of care for persons affected by these reforms including ensuring client choice of provider by requiring broad provider networks and developing mechanisms to facilitate a smooth transition of service responsibilities;

(5) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(6) ensure client access to applicable protections and appeals; and

(7) make budget transfers necessary to implement the reallocation of services and client responsibilities between counties and health care programs that do not increase the state and county costs and efficiently allocate state funds.

(b) When making transfers under paragraph (a) necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20, does not exceed the value of the services being transferred for the latest 12-month period for which data is available. The commissioner may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur. If case management transfer grants under section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior to repeal, exceeds the value of the services being transferred, the difference becomes an ongoing part of each county's adult and children's mental health grants under sections 245.4661, ~~245.4889~~, and 256E.12.

(c) This appropriation is not authorized to be expended after December 31, 2010, unless approved by the legislature.

Sec. 5. Minnesota Statutes 2012, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a person providing services to children with emotional disturbances. A mental health practitioner must have training and experience in working with children. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and:

(i) has at least 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances; or

(ii) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to children with emotional disturbances, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience;

(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or

(4) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university ~~and has less than 4,000 hours post-master's experience in the treatment of emotional disturbance.~~

Sec. 6. Minnesota Statutes 2012, section 245.4875, subdivision 8, is amended to read:

Subd. 8. **Transition services.** The county board may continue to provide mental health services as defined in sections 245.487 to 245.4889 to persons over 18 years of age, but under 21 years of age, if the person was receiving case management or family community support services prior to age 18, and if one of the following conditions is met:

- (1) the person is receiving special education services through the local school district; ~~or~~
- (2) it is in the best interest of the person to continue services defined in sections 245.487 to 245.4889;
or
- (3) the person is requesting services and the services are medically necessary.

Sec. 7. Minnesota Statutes 2012, section 245.4881, subdivision 1, is amended to read:

Subdivision 1. **Availability of case management services.** (a) The county board shall provide case management services for each child with severe emotional disturbance who is a resident of the county and the child's family who request or consent to the services. Case management services ~~may be continued~~ must be offered to be provided for a child with a serious emotional disturbance who is over the age of 18 consistent with section 245.4875, subdivision 8, or the child's legal representative, provided the child's service needs can be met within the children's service system. Before discontinuing case management services under this subdivision for children between the ages of 17 and 21, a transition plan must be developed. The transition plan must be developed with the child and, with the consent of a child age 18 or over, the child's parent, guardian, or legal representative. The transition plan should include plans for health insurance, housing, education, employment, and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Except as permitted by law and the commissioner under demonstration projects, case management services provided to children with severe emotional disturbance eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs of mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Sec. 8. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:

Subd. 8. **State-operated services account.** (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

- (1) intensive residential treatment services;
- (2) foster care services; and
- (3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are available to the commissioner of human services for the purposes of:

(1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source;

(2) grants to providers participating in mental health specialty treatment services under section 245.4661; and

(3) to fund the operation of the Intensive Residential Treatment Service program in Willmar.

Sec. 9. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision to read:

Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds to the account in subdivision 8 for noncovered allowable costs of a provider certified and licensed under section 256B.0622 and operating under section 246.014.

Sec. 10. Minnesota Statutes 2012, section 246.54, is amended to read:

246.54 LIABILITY OF COUNTY; REIMBURSEMENT.

Subdivision 1. **County portion for cost of care.** (a) Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall equal a percentage of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility according to the following schedule:

- (1) zero percent for the first 30 days;
- (2) 20 percent for days 31 to 60; and
- (3) ~~50~~ 75 percent for any days over 60.

(b) The increase in the county portion for cost of care under paragraph (a), clause (3), shall be imposed when the treatment facility has determined that it is clinically appropriate for the client to be discharged.

(c) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for days 31 to 60, or ~~50~~ 25 percent for days over 60, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the Minnesota Security Hospital ~~or the Minnesota extended treatment options program~~. For services at ~~these facilities~~ the Minnesota Security Hospital, a county's payment shall be made from the county's own sources of revenue and payments ~~shall be paid as follows:~~ Excluding the state-operated forensic transition service, payments to the state from the county shall equal ten percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. For the state-operated forensic transition service, payments to the state from the county shall equal 50 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends in the program. If payments received by the state under sections 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the state-operated forensic transition service, exceed 90 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. If payments received by the state under sections 246.50 to 246.53 for the state-operated forensic transition service exceed 50 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

(b) Regardless of the facility to which the client is committed, subdivision 1 does not apply to the following individuals:

- ~~(1) clients who are committed as mentally ill and dangerous under section 253B.02, subdivision 17;~~
- ~~(2) (1) clients who are committed as sexual psychopathic personalities under section 253B.02, subdivision 18b; and~~
- ~~(3) (2) clients who are committed as sexually dangerous persons under section 253B.02, subdivision 18c.~~

~~For each of the individuals in clauses (1) to (3), the payment by the county to the state shall equal ten percent of the cost of care for each day as determined by the commissioner.~~

Sec. 11. Minnesota Statutes 2012, section 253B.10, subdivision 1, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The commissioner shall prioritize patients being admitted from jail or a correctional institution who are:

(1) ordered confined in a state hospital for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state hospital or other facility pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

Patients described in this paragraph must be admitted to a service operated by the commissioner within 48 hours. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (c).

(c) Upon the arrival of a patient at the designated treatment facility, the head of the facility shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the treatment facility.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the examiners, and the prepetition report shall be provided promptly to the treatment facility.

Sec. 12. Minnesota Statutes 2012, section 254B.13, is amended to read:

254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.

Subdivision 1. **Authorization for navigator pilot projects.** The commissioner may approve and implement navigator pilot projects developed under the planning process required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and enhance coordination of the delivery of chemical health services required under section 254B.03.

Subd. 2. **Program design and implementation.** (a) The commissioner and counties participating in the navigator pilot projects shall continue to work in partnership to refine and implement the navigator pilot projects initiated under Laws 2009, chapter 79, article 7, section 26.

(b) The commissioner and counties participating in the navigator pilot projects shall complete the planning phase ~~by June 30, 2010~~; and, if approved by the commissioner for implementation, enter into agreements governing the operation of the navigator pilot projects ~~with implementation scheduled no earlier than July 1, 2010~~.

Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation in a navigator pilot program, an individual must:

- (1) be a resident of a county with an approved navigator program;
- (2) be eligible for consolidated chemical dependency treatment fund services;
- (3) be a voluntary participant in the navigator program;
- (4) satisfy one of the following items:

(i) have at least one severity rating of three or above in dimension four, five, or six in a comprehensive assessment under Minnesota Rules, part 9530.6422; or

(ii) have at least one severity rating of two or above in dimension four, five, or six in a comprehensive assessment under Minnesota Rules, part 9530.6422, and be currently participating in a Rule 31 treatment program under Minnesota Rules, parts 9530.6405 to 9530.6505, or be within 60 days following discharge after participation in a Rule 31 treatment program; and

(5) have had at least two treatment episodes in the past two years, not limited to episodes reimbursed by the consolidated chemical dependency treatment funds. An admission to an emergency room, a detoxification program, or a hospital may be substituted for one treatment episode if it resulted from the individual's substance use disorder.

(b) New eligibility criteria may be added as mutually agreed upon by the commissioner and participating navigator programs.

Subd. 3. **Program evaluation.** The commissioner shall evaluate navigator pilot projects under this section and report the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over chemical health issues by January 15, 2014. Evaluation of the navigator pilot projects must be based on outcome evaluation criteria negotiated with the navigator pilot projects prior to implementation.

Subd. 4. **Notice of navigator pilot project discontinuation.** Each county's participation in the navigator pilot project may be discontinued for any reason by the county or the commissioner of human services after 30 days' written notice to the other party. ~~Any unspent funds held for the exiting county's pro rata share in the special revenue fund under the authority in subdivision 5, paragraph (d), shall be transferred to the consolidated chemical dependency treatment fund following discontinuation of the pilot project.~~

Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize navigator pilot projects to use chemical dependency treatment funds to pay for nontreatment navigator pilot services:

- (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph (a); and
- (2) by vendors in addition to those authorized under section 254B.05 when not providing chemical dependency treatment services.

(b) For purposes of this section, "nontreatment navigator pilot services" include navigator services, peer support, family engagement and support, housing support, rent subsidies, supported employment, and independent living skills.

(c) State expenditures for chemical dependency services and nontreatment navigator pilot services provided by or through the navigator pilot projects must not be greater than the chemical dependency treatment fund expected share of forecasted expenditures in the absence of the navigator pilot projects. The commissioner may restructure the schedule of payments between the state and participating counties under the local agency share and division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the navigator pilot projects.

~~(d) To the extent that state fiscal year expenditures within a pilot project are less than the expected share of forecasted expenditures in the absence of the pilot projects, the commissioner shall deposit the unexpended funds in a separate account within the consolidated chemical dependency treatment fund, and make these funds available for expenditure by the pilot projects the following year. To the extent that treatment and nontreatment pilot services expenditures within the pilot project exceed the amount expected in the absence of the pilot projects, the pilot project county or counties are responsible for the portion of nontreatment pilot services expenditures in excess of the otherwise expected share of forecasted expenditures.~~

~~(e)~~ (d) The commissioner may waive administrative rule requirements that are incompatible with the implementation of the navigator pilot project, except that any chemical dependency treatment funded under this section must continue to be provided by a licensed treatment provider.

~~(f)~~ (e) The commissioner shall not approve or enter into any agreement related to navigator pilot projects authorized under this section that puts current or future federal funding at risk.

(f) The commissioner shall provide participating navigator pilot projects with transactional data, reports, provider data, and other data generated by county activity to assess and measure outcomes. This information must be transmitted or made available in an acceptable form to participating navigator pilot projects at least once every six months or within a reasonable time following the commissioner's receipt of information from the counties needed to comply with this paragraph.

Subd. 6. **Duties of county board.** The county board, or other county entity that is approved to administer a navigator pilot project, shall:

(1) administer the navigator pilot project in a manner consistent with the objectives described in subdivision 2 and the planning process in subdivision 5;

(2) ensure that no one is denied chemical dependency treatment services for which they would otherwise be eligible under section 254A.03, subdivision 3; and

(3) provide the commissioner with timely and pertinent information as negotiated in agreements governing operation of the navigator pilot projects.

Subd. 7. **Managed care.** An individual who is eligible for the navigator pilot program under subdivision 2a is excluded from mandatory enrollment in managed care until these services are included in the health plan's benefit set.

Subd. 8. **Authorization for continuation of navigator pilots.** The navigator pilot projects implemented pursuant to subdivision 1 are authorized to continue operation after July 1, 2013, under existing agreements governing operation of the pilot projects.

EFFECTIVE DATE. The amendments to subdivisions 1 to 6 and 8 are effective August 1, 2013. Subdivision 7 is effective July 1, 2013.

Sec. 13. **[254B.14] CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL HEALTH CARE.**

Subdivision 1. Authorization for continuum of care pilot projects. The commissioner shall establish chemical dependency continuum of care pilot projects to begin implementing the measures developed with stakeholder input and identified in the report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot projects are intended to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals in Minnesota while reducing duplication of efforts and promoting scientifically supported practices.

Subd. 2. Program implementation. (a) The commissioner, in coordination with representatives of the Minnesota Association of County Social Service Administrators and the Minnesota Inter-County Association, shall develop a process for identifying and selecting interested counties and providers for participation in the continuum of care pilot projects. There shall be three pilot projects; one representing the northern region, one for the metro region, and one for the southern region. The selection process of counties and providers must include consideration of population size, geographic distribution, cultural and racial demographics, and provider accessibility. The commissioner shall identify counties and providers that are selected for participation in the continuum of care pilot projects no later than September 30, 2013.

(b) The commissioner and entities participating in the continuum of care pilot projects shall enter into agreements governing the operation of the continuum of care pilot projects. The agreements shall identify pilot project outcomes and include timelines for implementation and beginning operation of the pilot projects.

(c) Entities that are currently participating in the navigator pilot project are eligible to participate in the continuum of care pilot project subsequent to or instead of participating in the navigator pilot project.

(d) The commissioner may waive administrative rule requirements that are incompatible with implementation of the continuum of care pilot projects.

(e) Notwithstanding section 254A.19, the commissioner may designate noncounty entities to complete chemical use assessments and placement authorizations required under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the discretion of the commissioner.

Subd. 3. Program design. (a) The operation of the pilot projects shall include:

(1) new services that are responsive to the chronic nature of substance use disorder;

(2) telehealth services, when appropriate to address barriers to services;

(3) services that assure integration with the mental health delivery system when appropriate;

(4) services that address the needs of diverse populations; and

(5) an assessment and access process that permits clients to present directly to a service provider for a substance use disorder assessment and authorization of services.

(b) Prior to implementation of the continuum of care pilot projects, a utilization review process must be developed and agreed to by the commissioner, participating counties, and providers. The utilization review process shall be described in the agreements governing operation of the continuum of care pilot projects.

Subd. 4. Notice of project discontinuation. Each entity's participation in the continuum of care pilot project may be discontinued for any reason by the county or the commissioner after 30 days' written notice to the entity.

Subd. 5. Duties of commissioner. (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize chemical dependency treatment funds to pay for nontreatment services

arranged by continuum of care pilot projects. Individuals who are currently accessing Rule 31 treatment services are eligible for concurrent participation in the continuum of care pilot projects.

(b) County expenditures for continuum of care pilot project services shall not be greater than their expected share of forecasted expenditures in the absence of the continuum of care pilot projects.

Subd. 6. **Managed care.** An individual who is eligible for the continuum of care pilot project is excluded from mandatory enrollment in managed care unless these services are included in the health plan's benefit set.

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

Sec. 14. [256.478] HOME AND COMMUNITY-BASED SERVICES TRANSITIONS GRANTS.

(a) The commissioner shall make available home and community-based services transition grants to serve individuals who do not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

(b) For the purposes of this section, the commissioner has the authority to transfer funds between the medical assistance account and the home and community-based services transitions grants account.

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

Sec. 15. [256B.0616] MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a certified family peer specialist who has completed the training under subdivision 5. A family peer specialist cannot provide services to the peer specialist's family.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

Subd. 3. **Eligibility.** Family peer support services may be located in inpatient hospitalization, partial hospitalization, residential treatment, treatment foster care, day treatment, children's therapeutic services and supports, or crisis services.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify family peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists who must be at least 21 years of age and have a high school diploma or its equivalent. The candidates must have raised or are currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

Sec. 16. Minnesota Statutes 2012, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, ~~and independent living,~~ parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician's assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 17. Minnesota Statutes 2012, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** ~~Effective January 1, 2006,~~ Medical assistance covers consultation provided by a psychiatrist, a psychologist, or an advanced practice registered nurse certified in psychiatric mental health via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 18. Minnesota Statutes 2012, section 256B.0625, subdivision 56, is amended to read:

Subd. 56. **Medical service coordination.** (a)(1) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department as an eligible procedure under a state healthcare program for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

(2) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department or inpatient psychiatric unit for a child or young adult up to age 21 with a serious emotional disturbance who has frequented the hospital emergency room two or more times in the previous consecutive three months or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged to a shelter.

(b) Reimbursement must be made in 15-minute increments and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. In-reach community-based service coordination shall seek to connect frequent users with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination in a health care home. For children and young adults with a serious emotional disturbance, in-reach community-based service coordination includes navigating and arranging for community-based services prior to discharge to address a client's mental health, chemical health, social, educational, family support and housing needs, or any other activity targeted at reducing multiple incidents of emergency room use, inpatient readmissions, and other nonmedically necessary health care utilization. In-reach services shall seek to connect them with existing covered services, including targeted case management, waiver case management, care coordination in a health care home, children's therapeutic services and supports, crisis services, and respite care. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c)(1) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, education, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

(2) Hospitals utilizing in-reach service coordinators shall report annually to the commissioner on the number of adults, children, and adolescents served; the postdischarge services which they accessed; and emergency department/psychiatric hospitalization readmissions. The commissioner shall ensure that

services and payments provided under in-reach care coordination do not duplicate services or payments provided under section 256B.0753, 256B.0755, or 256B.0625, subdivision 20.

Sec. 19. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Sec. 20. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Sec. 21. Minnesota Statutes 2012, section 256B.092, is amended by adding a subdivision to read:

Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

(1) are otherwise eligible for the developmental disabilities waiver under this section;

(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;

(3) whose discharge would be significantly delayed without the available waiver allocation; and

(4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

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

Sec. 22. Minnesota Statutes 2012, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

(g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

(h) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision, and revising the client's individual treatment plan.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

(m) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a trained paraprofessional to assist a child retain or generalize psychosocial skills as taught by a mental health professional or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(n) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (6), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

(o) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

~~(p)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

~~(q)~~ (q) "Skills training" means individual, family, or group training, delivered by or under the direction of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the following requirements:

(1) a mental health professional or a mental health practitioner must provide skills training;

(2) the child must always be present during skills training; however, a brief absence of the child for no more than ten percent of the session unit may be allowed to redirect or instruct family members;

(3) skills training delivered to children or their families must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(4) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development and to help the child use in daily life the skills previously taught by a mental health professional or mental health practitioner and to develop or maintain a home environment that supports the child's progressive use skills;

(5) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(i) one mental health professional or one mental health practitioner under supervision of a licensed mental health professional must work with a group of four to eight clients; or

(ii) two mental health professionals or two mental health practitioners under supervision of a licensed mental health professional, or one professional plus one practitioner must work with a group of nine to 12 clients.

Sec. 23. Minnesota Statutes 2012, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

- (1) individual, family, and group psychotherapy;
- (2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;
- (3) crisis assistance;
- (4) mental health behavioral aide services; ~~and~~
- (5) direction of a mental health behavioral aide; ~~;~~
- (6) mental health service plan development;
- (7) clinical care consultation under section 256B.0625, subdivision 62;
- (8) family psychoeducation under section 256B.0625, subdivision 61; and
- (9) services provided by a family peer specialist under section 256B.0616.

(c) Service components in paragraph (b) may be combined to constitute therapeutic programs, including day treatment programs and therapeutic preschool programs.

Sec. 24. Minnesota Statutes 2012, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

- (1) a mental health professional as defined in subdivision 1, paragraph (n); or
- (2) a mental health practitioner as defined in section 245.4871, subdivision 26. The mental health practitioner must work under the clinical supervision of a mental health professional; or
- (3) a mental health behavioral aide working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

(A) A level I mental health behavioral aide must:

- (i) be at least 18 years old;
- (ii) have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and
- (iii) meet preservice and continuing education requirements under subdivision 8.

(B) A level II mental health behavioral aide must:

- (i) be at least 18 years old;

(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and

(iii) meet preservice and continuing education requirements in subdivision 8.

(c) A preschool program multidisciplinary team must include at least one mental health professional and one or more of the following individuals under the clinical supervision of a mental health professional:

(i) a mental health practitioner; or

(ii) a program person, including a teacher, assistant teacher, or aide, who meets the qualifications and training standards of a level I mental health behavioral aide.

(d) A day treatment multidisciplinary team must include at least one mental health professional and one mental health practitioner.

Sec. 25. Minnesota Statutes 2012, section 256B.0943, is amended by adding a subdivision to read:

Subd. 8a. **Level II mental health behavioral aide.** The commissioner of human services, in collaboration with children's mental health providers and the Board of Trustees of the Minnesota State Colleges and Universities, shall develop a certificate program for level II mental health behavioral aides.

Sec. 26. Minnesota Statutes 2012, section 256B.0946, is amended to read:

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subdivision 1. **Required covered service components.** (a) ~~Effective July 1, 2006, upon enactment~~ and subject to federal approval, medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a ~~treatment~~ foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

(b) ~~Intensive treatment services to children with severe emotional disturbance mental illness residing in treatment foster care family settings must meet the relevant standards for mental health services under sections 245.487 to 245.4889. In addition, that comprise specific required service components provided in clauses (1) to (5), are reimbursed by medical assistance must when they~~ meet the following standards:

~~(1) case management service component must meet the standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;~~

(1) psychotherapy provided by a mental health professional as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

~~(2) psychotherapy, crisis assistance, and skills training components must meet the provided according to standards for children's therapeutic services and supports in section 256B.0943; and~~

(3) individual family, and group psychoeducation services under supervision of, defined in subdivision 1a, paragraph (q), provided by a mental health professional; or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

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

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

(d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;

(e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

(f) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370, subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

(g) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

(h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11.

(i) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

(j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

(k) "Foster family setting" means the foster home in which the license holder resides.

(l) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0370, subpart 15.

(m) "Mental health practitioner" has the meaning given in Minnesota Rules, part 9505.0370, subpart 17.

(n) "Mental health professional" has the meaning given in Minnesota Rules, part 9505.0370, subpart 18.

(o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370, subpart 20.

(p) "Parent" has the meaning given in section 260C.007, subdivision 25.

(q) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

(r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370, subpart 27.

(s) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

~~Subd. 2. **Determination of client eligibility.** A client's eligibility to receive treatment foster care under this section shall be determined by~~ An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment; and an evaluation of level of care needed, and development of an individual treatment plan; as defined in paragraphs (a) ~~to (e)~~ and (b).

~~(a) The diagnostic assessment must:~~

~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a psychiatrist, licensed psychologist, or licensed independent clinical social worker that is mental health professional or a clinical trainee;~~

~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

~~(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;~~

~~(4) be performed within 180 days prior to before the start of service; and~~

~~(2) include current diagnoses on all five axes of the client's current mental health status;~~

~~(3) determine whether or not a child meets the criteria for severe emotional disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness in section 245.462, subdivision 20; and~~

~~(4) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means a written summary, including current diagnoses on all five axes, by a mental health professional of the client's current mental status and service needs.~~

~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

~~(b) The evaluation of level of care must be conducted by the placing county with an instrument, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care instruments tools annually and publish on the department's Web site.~~

~~(c) The individual treatment plan must be:~~

~~(1) based on the information in the client's diagnostic assessment;~~

~~(2) developed through a child-centered, family driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific measurable treatment goals and objectives for the client and treatment strategies for the client's family and foster family;~~

~~(3) reviewed at least once every 90 days and revised; and~~

~~(4) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client.~~

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section.

~~(b) For purposes of this section, a provider agency must have an individual placement agreement for each recipient and must be a licensed child placing agency, under Minnesota Rules, parts 9543.0010 to 9543.0150, and either be:~~

~~(1) a county county-operated entity certified by the state;~~

~~(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or~~

~~(3) a noncounty entity under contract with a county board.~~

~~(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.~~

~~(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.~~

Subd. 4. **Eligible provider responsibilities Service delivery payment requirements.** (a) To be an eligible provider for payment under this section, a provider must develop and practice written policies and procedures for treatment foster care services intensive treatment in foster care, consistent with subdivision 1, paragraph (b), clauses (1), (2), and (3) and comply with the following requirements in paragraphs (b) to (n).

~~(b) In delivering services under this section, a treatment foster care provider must ensure that staff caseload size reasonably enables the provider to play an active role in service planning, monitoring, delivering, and reviewing for discharge planning to meet the needs of the client, the client's foster family, and the birth family, as specified in each client's individual treatment plan.~~

~~(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.~~

~~(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.~~

~~(d) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.~~

(e) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(f) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and signed every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph (s).

(g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

(h) Each client must have a crisis assistance plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(i) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

(j) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(k) Treatment must be developmentally and culturally appropriate for the client.

(l) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

(m) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(n) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

Subd. 6. **Excluded services.** (a) Services in clauses (1) to ~~(4)~~ (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

~~(1) treatment foster care services provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;~~

~~(2) service components of children's therapeutic services and supports simultaneously provided by more than one treatment foster care provider;~~

~~(3) home and community-based waiver services; and~~

~~(4) treatment foster care services provided to a child without a level of care determination according to section 245.4885, subdivision 1.~~

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

- (4) medication management;
- (5) children's mental health day treatment services;
- (6) crisis response services under section 256B.0944; and
- (7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

- ~~(1) mental health case management services under section 256B.0625, subdivision 20; and~~
- ~~(2) (1) psychotherapy and skill skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b;~~
- (2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (m);
- (3) home and community-based waiver services;
- (4) mental health residential treatment; and
- (5) room and board costs as defined in section 256I.03, subdivision 6.

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for intensive treatment in foster care services. The rate must be constructed to cover only eligible services delivered to an eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

Sec. 27. Minnesota Statutes 2012, section 256B.49, is amended by adding a subdivision to read:

Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

- (1) are otherwise eligible for the brain injury, community alternatives for disabled individuals, or community alternative care waivers under this section;
- (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;
- (3) whose discharge would be significantly delayed without the available waiver allocation; and
- (4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

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

Sec. 28. Minnesota Statutes 2012, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

Sec. 29. CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICES.

The commissioner of human services shall, in consultation with children's mental health community providers, hospitals providing care to children, children's mental health advocates, and other interested parties, develop recommendations and legislation, if necessary, for the state-operated child and adolescent behavioral health services facility to ensure that:

(1) the facility and the services provided meet the needs of children with serious emotional disturbances, autism spectrum disorders, reactive attachment disorder, PTSD, serious emotional disturbance co-occurring with a developmental disability, borderline personality disorder, schizophrenia, fetal alcohol spectrum disorders, brain injuries, violent tendencies, and complex medical issues;

(2) qualified personnel and staff can be recruited who have specific expertise and training to treat the children in the facility; and

(3) the treatment provided at the facility is high-quality, effective treatment.

Sec. 30. PILOT PROVIDER INPUT SURVEY OF PEDIATRIC SERVICES AND CHILDREN'S MENTAL HEALTH SERVICES.

(a) To assess the efficiency and other operational issues in the management of the health care delivery system, the commissioner of human services shall initiate a provider survey. The pilot survey shall consist of an electronic survey of providers of pediatric home health care services and children's mental health services to identify and measure issues that arise in dealing with the management of medical assistance. To the maximum degree possible, existing technology shall be used and interns sought to analyze the results.

(b) The survey questions must focus on seven key business functions provided by medical assistance contractors: provider inquiries; provider outreach and education; claims processing; appeals; provider

enrollment; medical review; and provider audit and reimbursement. The commissioner must consider the results of the survey in evaluating and renewing managed care and fee-for-service management contracts.

(c) The commissioner shall report by January 15, 2014, the results of the survey to the chairs of the health and human services policy and finance committees and shall make recommendations on the value of implementing an annual survey with a rotating list of provider groups as a component of the continuous quality improvement system for medical assistance.

Sec. 31. MENTALLY ILL AND DANGEROUS COMMITMENTS STAKEHOLDERS GROUP.

(a) The commissioner of human services, in consultation with the state court administrator, shall convene a stakeholder group to develop recommendations for the legislature that address issues raised in the February 2013 Office of the Legislative Auditor report on State-Operated Services for persons committed to the commissioner as mentally ill and dangerous under Minnesota Statutes, section 253B.18. Stakeholders must include representatives from the Department of Human Services, county human services, county attorneys, commitment defense attorneys, the ombudsman for mental health and developmental disabilities, the federal protection and advocacy system, and consumers and advocates for persons with mental illnesses.

(b) The stakeholder group shall provide recommendations in the following areas:

(1) the role of the special review board, including the scope of authority of the special review board and the authority of the commissioner to accept or reject special review board recommendations;

(2) review of special review board decisions by the district court;

(3) annual district court review of commitment, scope of court authority, and appropriate review criteria;

(4) options, including annual court hearing and review, as alternatives to indeterminate commitment under Minnesota Statutes, section 253B.18; and

(5) extension of the right to petition the court under Minnesota Statutes, section 253B.17, to those committed under Minnesota Statutes, section 253B.18. The commissioner of human services and the state court administrator shall provide relevant data for the group's consideration in developing these recommendations, including numbers of proceedings in each category and costs associated with court and administrative proceedings under Minnesota Statutes, section 253B.18.

(c) By January 15, 2014, the commissioner of human services shall submit the recommendations of the stakeholder group to the chairs and ranking minority members of the committees of the legislature with jurisdiction over civil commitment and human services issues.

Sec. 32. STATE ASSISTANCE TO COUNTIES; TRANSITIONS FOR HIGH NEEDS POPULATIONS.

(a) Effective immediately, the commissioner of human services shall work with counties that request assistance to assure timely discharge from Anoka Metro Regional Treatment Center and the Minnesota Security Hospital for individuals who are ready for discharge but for whom the county may not have provider resources or appropriate placement available. Special consideration must be given to uninsured individuals who are not eligible for medical assistance and who may need continued treatment, and individuals with complex needs and other factors that hinder county efforts to place the individual in a safe, affordable setting.

(b) The commissioner shall assure that, given Olmstead court directives and the role family and friends play in treatment progress, metropolitan area residents are asked whether they wished to be placed in an Intensive Residential Treatment Service program at Willmar or Cambridge or to be placed in a location more accessible to family, friends, and health providers.

ARTICLE 5**DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY**

Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a subdivision to read:

Subd. 7b. **Child care provider and recipient fraud investigations.** Data related to child care fraud and recipient fraud investigations are governed by section 245E.01, subdivision 15.

Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 7, is amended to read:

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

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

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

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

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

Sec. 3. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision to read:

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

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

Sec. 4. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. [245E.01] CHILD CARE PROVIDER AND RECIPIENT FRAUD INVESTIGATIONS WITHIN THE CHILD CARE ASSISTANCE PROGRAM.

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

(b) "Applicant" has the meaning given in section 119B.011, subdivision 2.

(c) "Child care assistance program" means any of the assistance programs under chapter 119B.

(d) "Commissioner" means the commissioner of human services.

(e) "Controlling individual" has the meaning given in section 245A.02, subdivision 5a.

(f) "County" means a local county child care assistance program staff or subcontracted staff, or a county investigator acting on behalf of the commissioner.

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

(h) "Financial misconduct" or "misconduct" means an entity's or individual's acts or omissions that result in fraud and abuse or error against the Department of Human Services.

(i) "Identify" means to furnish the full name, current or last known address, phone number, and e-mail address of the individual or business entity.

(j) "License holder" has the meaning given in section 245A.02, subdivision 9.

(k) "Mail" means the use of any mail service with proof of delivery and receipt.

(l) "Provider" means either a provider as defined in section 119B.011, subdivision 19, or a legal unlicensed provider as defined in section 119B.011, subdivision 16.

(m) "Recipient" means a family receiving assistance as defined under section 119B.011, subdivision 13.

(n) "Terminate" means revocation of participation in the child care assistance program.

Subd. 2. **Investigating provider or recipient financial misconduct.** The department shall investigate alleged or suspected financial misconduct by providers and errors related to payments issued by the child care assistance program under this chapter. Recipients, employees, and staff may be investigated when the evidence shows that their conduct is related to the financial misconduct of a provider, license holder, or controlling individual.

Subd. 3. **Scope of investigations.** (a) The department may contact any person, agency, organization, or other entity that is necessary to an investigation.

(b) The department may examine or interview any individual, document, or piece of evidence that may lead to information that is relevant to child care assistance program benefits, payments, and child care provider authorizations. This includes, but is not limited to:

(1) child care assistance program payments;

(2) services provided by the program or related to child care assistance program recipients;

(3) services provided to a provider;

(4) provider financial records of any type;

(5) daily attendance records of the children receiving services from the provider;

(6) billings; and

(7) verification of the credentials of a license holder, controlling individual, employee, staff person, contractor, subcontractor, and entities under contract with the provider to provide services or maintain service and the provider's financial records related to those services.

Subd. 4. **Determination of investigation.** After completing its investigation, the department shall issue one of the following determinations:

(1) no violation of child care assistance requirements occurred;

(2) there is insufficient evidence to show that a violation of child care assistance requirements occurred;

(3) a preponderance of evidence shows a violation of child care assistance program law, rule, or policy; or

(4) there exists a credible allegation of fraud.

Subd. 5. **Actions or administrative sanctions.** (a) After completing the determination under subdivision 4, the department may take one or more of the actions or sanctions specified in this subdivision.

(b) The department may take the following actions:

(1) refer the investigation to law enforcement or a county attorney for possible criminal prosecution;

(2) refer relevant information to the department's licensing division, the child care assistance program, the Department of Education, the federal child and adult care food program, or appropriate child or adult protection agency;

(3) enter into a settlement agreement with a provider, license holder, controlling individual, or recipient; or

(4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction for possible civil action under the Minnesota False Claims Act, chapter 15C.

(c) In addition to section 256.98, the department may impose sanctions by:

(1) pursuing administrative disqualification through hearings or waivers;

(2) establishing and seeking monetary recovery or recoupment; or

(3) issuing an order of corrective action that states the practices that are violations of child care assistance program policies, laws, or regulations, and that they must be corrected.

Subd. 6. **Duty to provide access.** (a) A provider, license holder, controlling individual, employee, staff person, or recipient has an affirmative duty to provide access upon request to information specified under subdivision 8 or the program facility.

(b) Failure to provide access may result in denial or termination of authorizations for or payments to a recipient, provider, license holder, or controlling individual in the child care assistance program.

(c) When a provider fails to provide access, a 15-day notice of denial or termination must be issued to the provider, which prohibits the provider from participating in the child care assistance program. Notice must be sent to recipients whose children are under the provider's care pursuant to Minnesota Rules, part 3400.0185.

(d) If the provider continues to fail to provide access at the expiration of the 15-day notice period, child care assistance program payments to the provider must be denied beginning the 16th day following notice of the initial failure or refusal to provide access. The department may rescind the denial based upon good cause if the provider submits in writing a good cause basis for having failed or refused to provide access. The writing must be postmarked no later than the 15th day following the provider's notice of initial failure to provide access. Additionally, the provider, license holder, or controlling individual must immediately provide complete, ongoing access to the department. Repeated failures to provide access must, after the initial failure or for any subsequent failure, result in termination from participation in the child care assistance program.

(e) The department, at its own expense, may photocopy or otherwise duplicate records referenced in subdivision 8. Photocopying must be done on the provider's premises on the day of the request or other mutually agreeable time, unless removal of records is specifically permitted by the provider. If requested, a provider, license holder, or controlling individual, or a designee, must assist the investigator in duplicating any record, including a hard copy or electronically stored data, on the day of the request.

(f) A provider, license holder, controlling individual, employee, or staff person must grant the department access during the department's normal business hours, and any hours that the program is operated, to examine the provider's program or the records listed in subdivision 8. A provider shall make records available at the provider's place of business on the day for which access is requested, unless the provider and the department both agree otherwise. The department's normal business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state holidays as defined in section 645.44, subdivision 5.

Subd. 7. **Honest and truthful statements.** It shall be unlawful for a provider, license holder, controlling individual, or recipient to:

(1) falsify, conceal, or cover up by any trick, scheme, or device a material fact;

(2) make any materially false, fictitious, or fraudulent statement or representation; or

(3) make or use any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry related to any child care assistance program services that the provider, license holder, or controlling individual supplies or in relation to any child care assistance

payments received by a provider, license holder, or controlling individual or to any fraud investigator or law enforcement officer conducting a financial misconduct investigation.

Subd. 8. **Record retention.** (a) The following records must be maintained, controlled, and made immediately accessible to license holders, providers, and controlling individuals. The records must be organized and labeled to correspond to categories that make them easy to identify so that they can be made available immediately upon request to an investigator acting on behalf of the commissioner at the provider's place of business:

(1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting records;

(2) daily attendance records required by and that comply with section 119B.125, subdivision 6;

(3) billing transmittal forms requesting payments from the child care assistance program and billing adjustments related to child care assistance program payments;

(4) records identifying all persons, corporations, partnerships, and entities with an ownership or controlling interest in the provider's child care business;

(5) employee records identifying those persons currently employed by the provider's child care business or who have been employed by the business at any time within the previous five years. The records must include each employee's name, hourly and annual salary, qualifications, position description, job title, and dates of employment. In addition, employee records that must be made available include the employee's time sheets, current home address of the employee or last known address of any former employee, and documentation of background studies required under chapter 119B or 245C;

(6) records related to transportation of children in care, including but not limited to:

(i) the dates and times that transportation is provided to children for transportation to and from the provider's business location for any purpose. For transportation related to field trips or locations away from the provider's business location, the names and addresses of those field trips and locations must also be provided;

(ii) the name, business address, phone number, and Web site address, if any, of the transportation service utilized; and

(iii) all billing or transportation records related to the transportation.

(b) A provider, license holder, or controlling individual must retain all records in paragraph (a) for at least six years after the last date of service. Microfilm or electronically stored records satisfy the record keeping requirements of this subdivision.

(c) A provider, license holder, or controlling individual who withdraws or is terminated from the child care assistance program must retain the records required under this subdivision and make them available to the department on demand.

(d) If the ownership of a provider changes, the transferor, unless otherwise provided by law or by written agreement with the transferee, is responsible for maintaining, preserving, and upon request from the department, making available the records related to the provider that were generated before the date of the transfer. Any written agreement affecting this provision must be held in the possession of the transferor and transferee. The written agreement must be provided to the department or county immediately upon request, and the written agreement must be retained by the transferor and transferee for six years after the agreement is fully executed.

(e) In the event of an appealed case, the provider must retain all records required in this subdivision for the duration of the appeal or six years, whichever is longer.

(f) A provider's use of electronic record keeping or electronic signatures is governed by chapter 325L.

Subd. 9. **Factors regarding imposition of administrative sanctions.** (a) The department shall consider the following factors in determining the administrative sanctions to be imposed:

- (1) nature and extent of financial misconduct;
 - (2) history of financial misconduct;
 - (3) actions taken or recommended by other state agencies, other divisions of the department, and court and administrative decisions;
 - (4) prior imposition of sanctions;
 - (5) size and type of provider;
 - (6) information obtained through an investigation from any source;
 - (7) convictions or pending criminal charges; and
 - (8) any other information relevant to the acts or omissions related to the financial misconduct.
- (b) Any single factor under paragraph (a) may be determinative of the department's decision of whether and what sanctions are imposed.

Subd. 10. **Written notice of department sanction.** (a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in subdivision 1, paragraph (k).

- (b) The notice shall state:
- (1) the factual basis for the department's determination;
 - (2) the sanction the department intends to take;
 - (3) the dollar amount of the monetary recovery or recoupment, if any;
 - (4) how the dollar amount was computed;
 - (5) the right to dispute the department's determination and to provide evidence;
 - (6) the right to appeal the department's proposed sanction; and
 - (7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.
- (c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:
- (1) the length of the denial or termination;
 - (2) the requirements and procedures for reinstatement; and
 - (3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.
- (d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.
- (e) Unless timely appealed, the effective date of the proposed sanction shall be 30 days after the license holder's, provider's, controlling individual's, or recipient's receipt of the notice. If a timely appeal is made, the proposed sanction shall be delayed pending the final outcome of the appeal. Implementation of a proposed sanction following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of sanction is necessary to protect the health or safety of children in care. The

department may consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.

(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.

Subd. 11. **Appeal of department sanction under this section.** (a) If the department does not pursue a criminal action against a provider, license holder, controlling individual, or recipient for financial misconduct, but the department imposes an administrative sanction under subdivision 5, paragraph (c), any individual or entity against whom the sanction was imposed may appeal the department's administrative sanction under this section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item, if appropriate;

(2) the computation that is believed to be correct, if appropriate;

(3) the authority in the statute or rule relied upon for each disputed item; and

(4) the name, address, and phone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

(b) An appeal is considered timely only if postmarked or received by the department's Appeals Division within 30 days after receiving a notice of department sanction.

(c) Before the appeal hearing, the department may deny or terminate authorizations or payment to the entity or individual if the department determines that the action is necessary to protect the public welfare or the interests of the child care assistance program.

Subd. 12. **Consolidated hearings with licensing sanction.** If a financial misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing sanction exists for which there is an appeal hearing right and the sanction is timely appealed, and the overpayment recovery action and licensing sanction involve the same set of facts, the overpayment recovery action and licensing sanction must be consolidated in the contested case hearing related to the licensing sanction.

Subd. 13. **Grounds for and methods of monetary recovery.** (a) The department may obtain monetary recovery from a provider who has been improperly paid by the child care assistance program, regardless of whether the error was intentional or county error. The department does not need to establish a pattern as a precondition of monetary recovery of erroneous or false billing claims, duplicate billing claims, or billing claims based on false statements or financial misconduct.

(b) The department shall obtain monetary recovery from providers by the following means:

(1) permitting voluntary repayment of money, either in lump-sum payment or installment payments;

(2) using any legal collection process;

(3) deducting or withholding program payments; or

(4) utilizing the means set forth in chapter 16D.

Subd. 14. **Reporting of suspected fraudulent activity.** (a) A person who, in good faith, makes a report of or testifies in any action or proceeding in which financial misconduct is alleged, and who is not involved in, has not participated in, or has not aided and abetted, conspired, or colluded in the financial misconduct, shall have immunity from any liability, civil or criminal, that results by reason of the person's report or testimony. For the purpose of any proceeding, the good faith of any person reporting or testifying under this provision shall be presumed.

(b) If a person that is or has been involved in, participated in, aided and abetted, conspired, or colluded in the financial misconduct reports the financial misconduct, the department may consider that person's report and assistance in investigating the misconduct as a mitigating factor in the department's pursuit of civil, criminal, or administrative remedies.

Subd. 15. **Data privacy.** Data of any kind obtained or created in relation to a provider or recipient investigation under this section is defined, classified, and protected the same as all other data under section 13.46, and this data has the same classification as licensing data.

Subd. 16. **Monetary recovery; random sample extrapolation.** The department is authorized to calculate the amount of monetary recovery from a provider, license holder, or controlling individual based upon extrapolation from a statistical random sample of claims submitted by the provider, license holder, or controlling individual and paid by the child care assistance program. The department's random sample extrapolation shall constitute a rebuttable presumption of the accuracy of the calculation of monetary recovery. If the presumption is not rebutted by the provider, license holder, or controlling individual in the appeal process, the department shall use the extrapolation as the monetary recovery figure. The department may use sampling and extrapolation to calculate the amount of monetary recovery if the claims to be reviewed represent services to 50 or more children in care.

Subd. 17. **Effect of department's monetary penalty determination.** Unless a timely and proper appeal is received by the department, the department's administrative determination or sanction shall be considered a final department determination.

Subd. 18. **Office of Inspector General recoveries.** Overpayment recoveries resulting from child care provider fraud investigations initiated by the department's Office of Inspector General's fraud investigations staff are excluded from the county recovery provision in section 119B.11, subdivision 3.

Sec. 6. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

Subd. 21. Provider enrollment. (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the ~~Minnesota Department of Human Services~~ commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers operating in Minnesota and receiving Medicaid funds, must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner.

(2) At the time of initial enrollment or reenrollment, the provider agency must purchase a performance bond of \$50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including \$300,000, the provider agency must purchase a performance bond of \$50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must purchase a performance bond of \$100,000. The performance bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(h) The Department of Human Services may require a provider to purchase a performance surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The performance bond must be in an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The performance bond must name the

Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

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

Sec. 7. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision to read:

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified by the commissioner, and accompanied by an application fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. Application fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate all providers under this subdivision at least once every five years.

(b) The application fee under this subdivision is \$532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the consumer price index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for re-enrollment when the provider is not enrolled at the time of application of re-enrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or re-enrollment is being submitted.

(c) The application fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state, unless the commissioner is required to rescreen the provider;

(2) providers who are enrolled but are required to submit new applications for purposes of reenrollment;

(3) a provider who enrolls as an individual; and

(4) group practices and clinics that bill on behalf of individually enrolled providers within the practice who have reassigned their billing privileges to the group practice or clinic.

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

Sec. 8. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. Grounds for sanctions against vendors. The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or

claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; and (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. The determination of services not medically necessary may be made by the commissioner in consultation with a peer advisory task force appointed by the commissioner on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 5.

Sec. 9. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Sec. 10. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

- (1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or
- (2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:
 - (i) fraud hotline complaints;
 - (ii) claims data mining; and
 - (iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

- (1) state that payments are being withheld according to paragraph (b);
- (2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;
- (3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;
- (4) identify the types of claims to which the withholding applies; and
- (5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the vendor, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

- (1) state that suspension or termination is the result of the vendor's exclusion from Medicare;
- (2) identify the effective date of the suspension or termination; and
- (3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program.

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

- (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;
- (2) the computation that the vendor believes is correct;
- (3) the authority in statute or rule upon which the vendor relies for each disputed item;
- (4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and
- (5) other information required by the commissioner.

(f) The commissioner may order a vendor to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to \$5,000, whichever is less.

(g) The vendor shall pay the fine assessed on or before the payment date specified. If the vendor fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

Sec. 11. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. Requirements for initial provider enrollment of personal care assistance provider agencies. (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

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

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

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including \$300,000, the provider agency must purchase a performance bond of \$50,000. If the Medicaid revenue in the previous year is over \$300,000, the provider agency must purchase a performance bond of \$100,000. The performance bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

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

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

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

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

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

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

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

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

Sec. 12. Minnesota Statutes 2012, section 299C.093, is amended to read:

299C.093 DATABASE OF REGISTERED PREDATORY OFFENDERS.

The superintendent of the Bureau of Criminal Apprehension shall maintain a computerized data system relating to individuals required to register as predatory offenders under section 243.166. To the degree feasible, the system must include the data required to be provided under section 243.166, subdivisions 4 and 4a, and indicate the time period that the person is required to register. The superintendent shall maintain

this data in a manner that ensures that it is readily available to law enforcement agencies. This data is private data on individuals under section 13.02, subdivision 12, but may be used for law enforcement and corrections purposes. The commissioner of human services has access to the data for state-operated services, as defined in section 246.014, are also authorized to have access to the data for the purposes described in section 246.13, subdivision 2, paragraph (b), and for purposes of conducting background studies under chapter 245C.

Sec. 13. Minnesota Statutes 2012, section 402A.10, is amended to read:

402A.10 DEFINITIONS.

Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 1a. **Balanced set of program measures.** A "balanced set of program measures" is a set of measures that, together, adequately quantify achievement toward a particular program's outcome. As directed by section 402A.16, the Human Services Performance Council must recommend to the commissioner when a particular program has a balanced set of program measures.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Council.** "Council" means the State-County Results, Accountability, and Service Delivery Redesign Council established in section 402A.20.

Subd. 4. **Essential human services or essential services.** "Essential human services" or "essential services" means assistance and services to recipients or potential recipients of public welfare and other services delivered by counties or tribes that are mandated in federal and state law that are to be available in all counties of the state.

Subd. 4a. **Essential human services program.** An "essential human services program" for the purposes of remedies under section 402A.18 means the following programs:

- (1) child welfare, including protection, truancy, minor parent, guardianship, and adoption;
- (2) children's mental health;
- (3) children's disability services;
- (4) public assistance eligibility, including measures related to processing timelines across information services programs;
- (5) MFIP;
- (6) child support;
- (7) chemical dependency;
- (8) adult disability;
- (9) adult mental health;
- (10) adult services such as long-term care; and
- (11) adult protection.

Subd. 4b. **Measure.** A "measure" means a quantitative indicator of a performance outcome.

Subd. 4c. **Performance improvement plan.** A "performance improvement plan" means a plan developed by a county or service delivery authority that describes steps the county or service delivery authority must take to improve performance on a specific measure or set of measures. The performance improvement plan must be negotiated with and approved by the commissioner. The performance

improvement plan must require a specific numerical improvement in the measure or measures on which the plan is based and may include specific programmatic best practices or specific performance management practices that the county must implement.

Subd. 4d. **Performance management system for human services.** A "performance management system for human services" means a process by which performance data for essential human services is collected from counties or service delivery authorities and used to inform a variety of stakeholders and to improve performance over time.

Subd. 5. **Service delivery authority.** "Service delivery authority" means a single county, or consortium of counties operating by execution of a joint powers agreement under section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of the county board of commissioners to participate in the redesign under this chapter or has been assigned by the commissioner pursuant to section 402A.18. A service delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen by resolution of tribal government to participate in redesign under this chapter.

Subd. 6. **Steering committee.** "Steering committee" means the Steering Committee on Performance and Outcome Reforms.

Sec. 14. **[402A.12] ESTABLISHMENT OF A PERFORMANCE MANAGEMENT SYSTEM FOR HUMAN SERVICES.**

By January 1, 2014, the commissioner shall implement a performance management system for essential human services as described in sections 402A.15 to 402A.18 that includes initial performance measures and standards consistent with the recommendations of the Steering Committee on Performance and Outcome Reforms in the December 2012 report to the legislature.

Sec. 15. **[402A.16] HUMAN SERVICES PERFORMANCE COUNCIL.**

Subdivision 1. **Establishment.** By October 1, 2013, the commissioner shall convene a Human Services Performance Council to advise the commissioner on the implementation and operation of the performance management system for human services.

Subd. 2. **Duties.** The Human Services Performance Council shall:

(1) hold meetings at least quarterly that are in compliance with Minnesota's Open Meeting Law under chapter 13D;

(2) annually review the annual performance data submitted by counties or service delivery authorities;

(3) review and advise the commissioner on department procedures related to the implementation of the performance management system and system process requirements and on barriers to process improvement in human services delivery;

(4) advise the commissioner on the training and technical assistance needs of county or service delivery authority and department personnel;

(5) review instances in which a county or service delivery authority has not made adequate progress on a performance improvement plan and make recommendations to the commissioner under section 402A.18;

(6) consider appeals from counties or service delivery authorities that are in the remedies process and make recommendations to the commissioner on resolving the issue;

(7) convene working groups to update and develop outcomes, measures, and performance standards for the performance management system and, on an annual basis, present these recommendations to the commissioner, including recommendations on when a particular essential human service program has a balanced set of program measures in place;

(8) make recommendations on human services administrative rules or statutes that could be repealed in order to improve service delivery;

(9) provide information to stakeholders on the council's role and regularly collect stakeholder input on performance management system performance; and

(10) submit an annual report to the legislature and the commissioner, which includes a comprehensive report on the performance of individual counties or service delivery authorities as it relates to system measures; a list of counties or service delivery authorities that have been required to create performance improvement plans and the areas identified for improvement as part of the remedies process; a summary of performance improvement training and technical assistance activities offered to the county personnel by the department; recommendations on administrative rules or state statutes that could be repealed in order to improve service delivery; recommendations for system improvements, including updates to system outcomes, measures, and standards; and a response from the commissioner.

Subd. 3. **Membership.** (a) Human Services Performance Council membership shall be equally balanced among the following five stakeholder groups: the Association of Minnesota Counties, the Minnesota Association of County Social Service Administrators, the Department of Human Services, tribes and communities of color, and service providers and advocates for persons receiving human services. The Association of Minnesota Counties and the Minnesota Association of County Social Service Administrators shall appoint their own respective representatives. The commissioner of human services shall appoint representatives of the Department of Human Services, tribes and communities of color, and social services providers and advocates. Minimum council membership shall be 15 members, with at least three representatives from each stakeholder group, and maximum council membership shall be 20 members, with four representatives from each stakeholder group.

(b) Notwithstanding section 15.059, Human Services Performance Council members shall be appointed for a minimum of two years, but may serve longer terms at the discretion of their appointing authority.

(c) Notwithstanding section 15.059, members of the council shall receive no compensation for their services.

(d) A commissioner's representative and a county representative from either the Association of Minnesota Counties or the Minnesota Association of County Social Service Administrators shall serve as Human Services Performance Council cochairs.

Subd. 4. **Commissioner duties.** The commissioner shall:

(1) implement and maintain the performance management system for human services;

(2) establish and regularly update the system's outcomes, measures, and standards, including the minimum performance standard for each performance measure;

(3) determine when a particular program has a balanced set of measures;

(4) receive reports from counties or service delivery authorities at least annually on their performance against system measures, provide counties with data needed to assess performance and monitor progress, and provide timely feedback to counties or service delivery authorities on their performance;

(5) implement and monitor the remedies process in section 402A.18;

(6) report to the Human Services Performance Council on county or service delivery authority performance on a semiannual basis;

(7) provide general training and technical assistance to counties or service delivery authorities on topics related to performance measurement and performance improvement;

(8) provide targeted training and technical assistance to counties or service delivery authorities that supports their performance improvement plans; and

(9) provide staff support for the Human Services Performance Council.

Subd. 5. **County or service delivery authority duties.** The counties or service delivery authorities shall:

(1) report performance data to meet performance management system requirements; and

(2) provide training to personnel on basic principles of performance measurement and improvement and participate in training provided by the department.

Sec. 16. Minnesota Statutes 2012, section 402A.18, is amended to read:

402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET PERFORMANCE OUTCOMES.

Subdivision 1. **Underperforming county; specific service.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance ~~outcomes~~ standards for a specific essential ~~service~~ human services program, the commissioner may impose the following remedies and adjust state and federal program allocations accordingly:

(1) voluntary incorporation of the administration and operation of the specific essential ~~service~~ human services program with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of the specific essential ~~service~~ human services program with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of the specific essential ~~service~~ human services program to the commissioner.

Subd. 2. **Underperforming county; more than one-half of services.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance ~~outcomes~~ standards for more than one-half of the defined essential human services programs, the commissioner may impose the following remedies:

(1) voluntary incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for ~~program~~ administration and operation of essential human services programs to the commissioner.

Subd. 2a. **Financial responsibility of underperforming county.** A county subject to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of the ~~essential service~~ or

essential human services program or programs the amount of nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

Subd. 3. **Conditions prior to imposing remedies.** ~~Before the commissioner may impose the remedies authorized under this section, the following conditions must be met:~~

~~(1) the county or service delivery authority determined by the commissioner to be deficient in achieving minimum performance outcomes has the opportunity, in coordination with the council, to develop a program outcome improvement plan. The program outcome improvement plan must be developed no later than six months from the date of the deficiency determination; and~~

~~(2) the council has conducted an assessment of the program outcome improvement plan to determine if the county or service delivery authority has made satisfactory progress toward performance outcomes and has made a recommendation about remedies to the commissioner. The assessment and recommendation must be made to the commissioner within 12 months from the date of the deficiency determination. (a) The commissioner shall notify a county or service delivery authority that it must submit a performance improvement plan if:~~

~~(1) the county or service delivery authority does not meet the minimum performance standard for a measure; or~~

~~(2) the county or service delivery authority does not meet the minimum performance standard for one or more racial or ethnic subgroup for which there is a statistically valid population size for three or more measures, even if the county or service delivery authority met the standard for the overall population.~~

The commissioner must approve the performance improvement plan. The county or service delivery authority may negotiate the terms of the performance improvement plan with the commissioner.

(b) When the department determines that a county or service delivery authority does not meet the minimum performance standard for a given measure, the commissioner must advise the county or service delivery authority that fiscal penalties may result if the performance does not improve. The department must offer technical assistance to the county or service delivery authority. Within 30 days of the initial advisement from the department, the county or service delivery authority may claim and the department may approve an extenuating circumstance that relieves the county or service delivery authority of any further remedy. If a county or service delivery authority has a small number of participants in an essential human services program such that reliable measurement is not possible, the commissioner may approve extenuating circumstances or may average performance over three years.

(c) If there are no extenuating circumstances, the county or service delivery authority must submit a performance improvement plan to the commissioner within 60 days of the initial advisement from the department. The term of the performance improvement plan must be two years, starting with the date the plan is approved by the commissioner. This plan must include a target level for improvement for each measure that did not meet the minimum performance standard. The commissioner must approve the performance improvement plan within 60 days of submittal.

(d) The department must monitor the performance improvement plan for two years. After two years, if the county or service delivery authority meets the minimum performance standard, there is no further remedy. If the county or service delivery authority fails to meet the minimum performance standard, but meets the improvement target in the performance improvement plan, the county or service delivery authority shall modify the performance improvement plan for further improvement and the department shall continue to monitor the plan.

(e) If, after two years of monitoring, the county or service delivery authority fails to meet both the minimum performance standard and the improvement target identified in the performance improvement

plan, the next step of the remedies process shall be invoked by the commissioner. This phase of the remedies process may include:

(1) fiscal penalties for the county or service delivery authority that do not exceed one percent of the county's human services expenditures and that are negotiated in the performance improvement plan, based on what is needed to improve outcomes. Counties or service delivery authorities must reinvest the amount of the fiscal penalty into the essential human services program that was underperforming. A county or service delivery authority shall not be required to pay more than three fiscal penalties in a year; and

(2) the department's provision of technical assistance to the county or service delivery authority that is targeted to address the specific performance issues.

The commissioner shall continue monitoring the performance improvement plan for a third year.

(f) If, after the third year of monitoring, the county or service delivery authority meets the minimum performance standard, there is no further remedy. If the county or service delivery authority fails to meet the minimum performance standard, but meets the improvement target for the performance improvement plan, the county or service delivery authority shall modify the performance improvement plan for further improvement and the department shall continue to monitor the plan.

(g) If, after the third year of monitoring, the county or service delivery authority fails to meet the minimum performance standard and the improvement target identified in the performance improvement plan, the Human Services Performance Council shall review the situation and recommend a course of action to the commissioner.

(h) If the commissioner has determined that a program has a balanced set of program measures and a county or service delivery authority is subject to fiscal penalties for more than one-half of the measures for that program, the commissioner may apply further remedies as described in subdivisions 1 and 2.

Sec. 17. INSTRUCTIONS TO THE COMMISSIONER.

In collaboration with labor organizations, the commissioner of human services shall develop clear and consistent standards for state-operated services programs to:

- (1) address direct service staffing shortages;
- (2) identify and help resolve workplace safety issues; and
- (3) elevate the use and visibility of performance measures and objectives related to overtime use.

ARTICLE 6

HEALTH CARE

Section 1. Minnesota Statutes 2012, section 245.03, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** There is created a Department of Human Services. A commissioner of human services shall be appointed by the governor under the provisions of section 15.06. The commissioner shall be selected on the basis of ability and experience in welfare and without regard to political affiliations. The commissioner ~~shall~~ may appoint up to two ~~deputy commissioner~~ commissioners.

Sec. 2. Minnesota Statutes 2012, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner

under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wraparound subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

(c) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective ~~July 1~~ June 15 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the ~~second~~ previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

(f) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

Sec. 3. Minnesota Statutes 2012, section 256.9657, subdivision 4, is amended to read:

Subd. 4. **Payments into the account.** (a) Payments to the commissioner under ~~subdivisions 1 to 3~~ subdivision 1 must be paid in monthly installments due on the 15th of the month beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. ~~Payments to the commissioner under subdivisions 2 and 3 for fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues earned in the second previous calendar year.~~

(b) Effective October 15, 2014, payment to the commissioner under subdivision 2 must be paid in nine monthly installments due on the 15th of the month beginning October 15, 2014, through June 15 of the following year. The monthly payment must be equal to the annual surcharge divided by nine.

~~(b)~~ (c) Effective October 1, 1995 2014, and each October 1 thereafter, the payments in subdivisions 2 and 3 must be based on revenues earned in the previous calendar year.

~~(c)~~ (d) If the commissioner of health does not provide by August 15 of any year data needed to update the base year for the hospital and or April 15 of any year data needed to update the base year for the health maintenance organization surcharges, the commissioner of human services may estimate base year revenue and use that estimate for the purposes of this section until actual data is provided by the commissioner of health.

~~(d)~~ (e) Payments to the commissioner under subdivision 3a must be paid in monthly installments due on the 15th of the month beginning July 15, 2003. The monthly payment must be equal to the annual surcharge divided by 12.

(f) Payments due in July through September 2014 under subdivision 3 for revenue earned in calendar year 2012 shall be paid in a lump sum on June 15, 2014. On June 15, 2014, each health maintenance organization and community-integrated service network shall pay all payments under subdivision 3 in a lump sum for revenue earned in calendar year 2013. Effective June 15, 2015, and each June 15 thereafter, the payments in subdivision 3 shall be based on revenues earned in the previous calendar year and paid in a lump sum on June 15 of each year.

Sec. 4. Minnesota Statutes 2012, section 256.969, subdivision 29, is amended to read:

Subd. 29. **Reimbursement for the fee increase for the early hearing detection and intervention program.** (a) For admissions occurring on or after July 1, 2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under section 144.125, subdivision 1, that is paid by the hospital for public program recipients. This payment increase shall be in effect until the increase is fully recognized in the base year cost under subdivision 2b. This payment shall be included in payments to contracted managed care organizations.

(b) For admissions occurring on or after July 1, 2013, payment rates shall be adjusted to include the increase to the fee that is effective July 1, 2013, for the early hearing detection and intervention program under section 144.125, subdivision 1, paragraph (d), that is paid by the hospital for medical assistance and MinnesotaCare program enrollees. This payment increase shall be in effect until the increase is fully recognized in the base-year cost under subdivision 2b. This payment shall be included in payments to managed care plans and county-based purchasing plans.

Sec. 5. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision to read:

Subd. 23. **Medical assistance costs for certain inmates.** The commissioner shall execute an interagency agreement with the commissioner of corrections to recover the state cost attributable to medical assistance eligibility for inmates of public institutions admitted to a medical institution on an inpatient basis. The annual amount to be transferred from the Department of Corrections under the agreement must include all eligible state medical assistance costs, including administrative costs incurred by the Department of Human Services, attributable to inmates under state and county jurisdiction admitted to medical institutions on an inpatient basis that are related to the implementation of section 256B.055, subdivision 14, paragraph (c).

Sec. 6. Minnesota Statutes 2012, section 256B.055, subdivision 14, is amended to read:

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the eligibility requirements in section 256B.056, is not eligible for medical assistance, except for covered services received while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues, including costs, related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

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

Sec. 7. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

- (1) admitted for lawful permanent residence according to United States Code, title 8;
- (2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;
- (3) granted asylum according to United States Code, title 8, section 1158;
- (4) granted withholding of deportation according to United States Code, title 8, section 1253(h);
- (5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);
- (6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;
- (ii) organ transplants, stem cell transplants, and related care;
- (iii) services for routine prenatal care;
- (iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;
- (v) elective surgery;
- (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;
- (vii) preventative health care and family planning services;
- ~~(viii) dialysis;~~
- ~~(ix) chemotherapy or therapeutic radiation services;~~
- ~~(x) (viii) rehabilitation services;~~
- ~~(xi) (ix) physical, occupational, or speech therapy;~~
- ~~(xii) (x) transportation services;~~
- ~~(xiii) (xi) case management;~~
- ~~(xiv) (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;~~
- ~~(xv) (xiii) dental services;~~
- ~~(xvi) (xiv) hospice care;~~
- ~~(xvii) (xv) audiology services and hearing aids;~~
- ~~(xviii) (xvi) podiatry services;~~
- ~~(xix) (xvii) chiropractic services;~~
- ~~(xx) (xviii) immunizations;~~
- ~~(xxi) (xix) vision services and eyeglasses;~~
- ~~(xxii) (xx) waiver services;~~
- ~~(xxiii) (xxi) individualized education programs; or~~
- ~~(xxiv) (xxii) chemical dependency treatment.~~

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

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

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law:

(1) dialysis services provided in a hospital or freestanding dialysis facility; and

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment.

(1) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under section 256B.0915, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

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

Sec. 8. Minnesota Statutes 2012, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

- (1) periodontics, limited to periodontal scaling and root planing once every two years;
- (2) general anesthesia; and
- (3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

- (1) posterior fillings are paid at the amalgam rate;
- (2) application of sealants are covered once every five years per permanent molar for children only;
- (3) application of fluoride varnish is covered once every six months; and
- (4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

- (1) house calls or extended care facility calls for on-site delivery of covered services;
- (2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;
- (3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and
- (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

Sec. 9. Minnesota Statutes 2012, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

- (1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lower of: (1) the number of dosage units contained in the manufacturer's original package; and (2) the number of dosage units required to complete the patient's course of therapy.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for

the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider ~~or~~ 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider ~~or~~ the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty

pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

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

Sec. 11. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 28b. Doula services. Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum.

EFFECTIVE DATE. This section is effective July 1, 2014, or upon federal approval, whichever is later, and applies to services provided on or after the effective date.

Sec. 12. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. Medical supplies and equipment. (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

Sec. 13. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 31b. **Preferred diabetic testing supply program.** (a) The commissioner shall implement a point-of-sale preferred diabetic testing supply program by January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform to the limitations established under the program. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred diabetic testing supply list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall maintain an accurate and up-to-date list on the department's Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred diabetic testing supply program drug list after consulting with the Drug Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred diabetic testing supply program as part of the administration of the diabetic testing supply rebate program. Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply list may be subject to prior authorization.

(d) All claims for diabetic testing supplies in categories on the preferred diabetic testing supply list must be submitted by enrolled pharmacy providers using the most current National Council of Prescription Drug Plans electronic claims standard.

(e) For purposes of this subdivision, "preferred diabetic testing supply list" means a list of diabetic testing supplies selected by the commissioner, for which prior authorization is not required.

(f) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Sec. 14. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to read:

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an \$8.50 fee per dose~~ for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Sec. 15. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for vaccines that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 16. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 63. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided

to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

Sec. 17. Minnesota Statutes 2012, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to \$20 upon federal approval;

(3) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a \$12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) effective January 1, 2012, a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and

(5) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waived service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Sec. 18. Minnesota Statutes 2012, section 256B.0756, is amended to read:

256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055, ~~subdivision 15~~, and who reside in Hennepin County or Ramsey County. The commissioner may identify individuals to be enrolled in the Hennepin County pilot program based on zip code in Hennepin County or whether the individuals would benefit from an integrated health care delivery network.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

~~(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.~~

~~(e)~~ (d) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

~~(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.~~

~~(g)~~ (e) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

Sec. 19. Minnesota Statutes 2012, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Hennepin County Medical Center or Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Hennepin County Medical Center and Regions Hospital by those plans. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and the city of St. Paul of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center and the city of St. Paul equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and the city of St. Paul.

(e) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to ~~(e)~~ (d), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

~~(e)~~ (f) The payments in paragraphs (a) to ~~(e)~~ (d) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

Sec. 20. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. Until January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments and after the regional rate adjustments under subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates paid under this section;
and

(4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund \$23,936,000 in fiscal years 2012 and 2013 and ~~\$36,744,000~~ \$49,552,000 in fiscal year 2014 and thereafter.

Sec. 21. Minnesota Statutes 2012, section 256B.69, subdivision 5i, is amended to read:

Subd. 5i. **Administrative expenses.** (a) Managed care plan and county-based purchasing plan administrative costs for a prepaid health plan provided under this section or section 256B.692 must not exceed by more than five percent that prepaid health plan's or county-based purchasing plan's actual calculated administrative spending for the previous calendar year as a percentage of total revenue. The penalty for exceeding this limit must be the amount of administrative spending in excess of 105 percent of the actual calculated amount. The commissioner may waive this penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.

(b) ~~Expenses listed under section 62D.12, subdivision 9a, clause (4), are not allowable administrative expenses for rate-setting purposes under this section, unless approved by the commissioner. The following~~ expenses are not allowable administrative expenses for rate-setting purposes under this section:

(1) charitable contributions made by the managed care plan or the county-based purchasing plan;

(2) any portion of an individual's compensation in excess of \$200,000 paid by the managed care plan or county-based purchasing plan;

(3) any penalties or fines assessed against the managed care plan or county-based purchasing plan;
and

(4) any indirect marketing or advertising expenses of the managed care plan or county-based purchasing plan.

For the purposes of this subdivision, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits.

Sec. 22. Minnesota Statutes 2012, section 256B.69, subdivision 9c, is amended to read:

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner ~~and managed care and county-based purchasing plans that are required to be submitted under this section.~~ The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Effective January 1, 2014, each managed care and county-based purchasing plan must annually quarterly provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) an income statement by program;

(2) financial statement footnotes;

(3) quarterly profitability by program and population group;

(4) a medical liability summary by program and population group;

(5) received but unpaid claims report by program;

(6) services versus payment lags by program for hospital services, outpatient services, physician services, other medical services, and pharmaceutical benefits;

(7) utilization reports that summarize utilization and unit cost information by program for hospitalization services, outpatient services, physician services, and other medical services;

(8) pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services;

(9) subcapitation expenses by population group;

(10) third-party payments by program;

(11) all new, active, and closed subrogation cases by program;

(12) all new, active, and closed fraud and abuse cases by program;

(13) medical loss ratios by program;

(+) (14) administrative expenses by category and subcategory consistent with administrative expense reporting by program that reconcile to other state and federal regulatory agencies, by program;

~~(2)~~ (15) revenues by program, including investment income;

~~(3)~~ (16) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

~~(4)~~ (17) data on the amount of reinsurance or transfer of risk by program; and

~~(5)~~ (18) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans ~~30~~ 15 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have ~~30~~ 15 days to review the report and provide comment to the commissioner.

The quarterly reports shall be submitted to the commissioner no later than 60 days after the end of the previous quarter, except the fourth-quarter report, which shall be submitted by April 1 of each year. The fourth-quarter report shall include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements.

Sec. 23. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children.

The commissioner may limit trend increases to less than the maximum. For calendar year 2014, the commissioner shall reduce the maximum aggregate trend increases by \$47,000,000 in state and federal funds to account for the reductions in administrative expenses in subdivision 5i.

Sec. 24. Minnesota Statutes 2012, section 256B.69, is amended by adding a subdivision to read:

Subd. 34. **Supplemental recovery program.** The commissioner shall conduct a supplemental recovery program for third-party liabilities not recovered by managed care plans and county-based purchasing plans for state public health programs. Any third-party liability identified and recovered by the commissioner more than six months after the date a managed care plan or county-based purchasing plan receives a health care claim shall be retained by the commissioner and deposited in the general fund. The commissioner shall establish a mechanism for managed care plans and county-based purchasing plans to coordinate third-party liability collections efforts with the commissioner to ensure there is no duplication of efforts. The coordination mechanism must be consistent with the reporting requirements in subdivision 9c.

Sec. 25. Minnesota Statutes 2012, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,

rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

Sec. 26. Minnesota Statutes 2012, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

Sec. 27. Minnesota Statutes 2012, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by

the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by ~~30~~ 35 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) city or county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance, ~~general assistance medical care,~~ or MinnesotaCare; ~~and~~

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; ~~and~~

(6) private practicing dentists if:

(i) the dentist's office is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E;

(ii) more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(iii) the dentist does not restrict access or services because of a patient's financial limitations or public assistance status; and

(iv) the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.

~~(c) The commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.~~

~~(d)~~ (c) A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off site at a private dental office if the following requirements are met:

(1) the designated critical access dental clinic is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;

(2) the designated critical access dental clinic is not able to provide the service and refers the patient to the off-site dentist;

(3) the service, if provided at the critical access dental clinic, would be reimbursed at the critical access reimbursement rate;

(4) the dentist and allied dental professionals providing the services off site are licensed and in good standing under chapter 150A;

(5) the dentist providing the services is enrolled as a medical assistance provider;

(6) the critical access dental clinic submits the claim for services provided off site and receives the payment for the services; and

(7) the critical access dental clinic maintains dental records for each claim submitted under this paragraph, including the name of the dentist, the off-site location, and the license number of the dentist and allied dental professionals providing the services.

Sec. 28. Minnesota Statutes 2012, section 256B.76, is amended by adding a subdivision to read:

Subd. 7. Payment for certain primary care services and immunization administration. Payment for certain primary care services and immunization administration services rendered on or after January 1, 2013, through December 31, 2014, shall be made in accordance with section 1902(a)(13) of the Social Security Act.

Sec. 29. Minnesota Statutes 2012, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

Sec. 30. Minnesota Statutes 2012, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, ~~and anesthesia services, and hospice services~~ shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(e)~~ (f) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

Sec. 31. Minnesota Statutes 2012, section 256B.767, is amended to read:

256B.767 MEDICARE PAYMENT LIMIT.

(a) Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service, as adjusted for any changes in Medicare payment rates after July 1, 2010. The commissioner shall implement this section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates under this section by first reducing or eliminating provider rate add-ons.

(b) This section does not apply to services provided by advanced practice certified nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates for advanced practice certified nurse midwives and licensed traditional midwives shall equal and shall not exceed the medical assistance payment rate to physicians for the applicable service.

(c) This section does not apply to mental health services or physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

(d) Effective for durable medical equipment, prosthetics, orthotics, or supplies provided on or after July 1, 2013, through June 30, 2014, the payment rate for items that are subject to the rates established under Medicare's National Competitive Bidding Program shall be equal to the rate that applies to the same item when not subject to the rate established under Medicare's National Competitive Bidding Program. This paragraph does not apply to mail order diabetic supplies and does not apply to items provided to dually eligible recipients when Medicare is the primary payer of the item.

Sec. 32. Laws 2013, chapter 1, section 6, is amended to read:

Sec. 6. **TRANSFER.**

(a) The commissioner of management and budget shall transfer from the health care access fund to the general fund up to \$21,319,000 in fiscal year 2014; up to \$42,314,000 in fiscal year 2015; up to \$56,147,000 in fiscal year 2016; and up to \$64,683,000 in fiscal year 2017.

(b) The commissioner of human services shall determine the difference between the actual or forecasted cost to the medical assistance program of adding 19- and 20-year-olds and parents and relative caretaker populations with income between 100 and 138 percent of the federal poverty guidelines and the cost of adding those populations that was estimated during the 2013 legislative session based on the data from the February 2013 forecast.

(c) For each fiscal year from 2014 to 2017, the commissioner of human services shall certify and report to the commissioner of management and budget the actual or forecasted cost difference of adding 19- and 20-year-olds and parents and relative caretaker populations with income between 100 and 138 percent of the federal poverty guidelines, as determined under paragraph (b), to the commissioner of management and budget at least four weeks prior to the release of a forecast under Minnesota Statutes, section 16A.103, of each fiscal year.

(d) No later than three weeks before the release of the forecast under Minnesota Statutes, section 16A.103, the commissioner of management and budget shall reduce the health care access fund transfer in paragraph (a), by the cumulative differences in costs reported by the commissioner of human services under paragraph (c). If, for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is positive, no change is made to the appropriation. If, for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is less than the amount of the original appropriation, the appropriation for that year must be zero.

Sec. 33. **REQUEST FOR INFORMATION; EMERGENCY MEDICAL ASSISTANCE AND THE UNINSURED STUDY.**

(a) The commissioner of human services, in consultation with safety net hospitals, nonprofit health care coverage programs, nonprofit community clinics, counties, and other interested parties, shall identify alternatives and make recommendations for providing coordinated and cost-effective health care and coverage to individuals who:

(1) meet eligibility standards for emergency medical assistance; or

(2) are uninsured and ineligible for other state public health care programs, have incomes below 400 percent of the federal poverty level, and are ineligible for premium credits through the Minnesota Insurance Marketplace as defined under Minnesota Statutes, section 62V.02.

(b) The commissioner of human services shall issue a request for information to help identify options for coverage of medically necessary services not eligible for federal financial participation for emergency medical assistance recipients and medically necessary services for individuals who are uninsured and ineligible for other state public health care programs or coverage through the Minnesota Insurance Marketplace. The request for information shall provide:

(1) the identification of services, including community-based medical, dental, and behavioral health services, necessary to reduce emergency department and inpatient hospital utilization for these recipients;

(2) delivery system options, including for each option how the system would be organized to promote care coordination and cost-effectiveness, and how the system would be available statewide;

(3) funding options and payment mechanisms to encourage providers to manage the delivery of care to these populations at a lower cost of care and with better patient outcomes than the current system;

(4) how the funding and delivery of services will be coordinated with the services covered under emergency medical assistance;

(5) options for administration of eligibility determination and service delivery; and

(6) evaluation methods to measure cost-effectiveness and health outcomes that take into consideration the social determinants of health care for recipients participating in this alternative coverage option.

(c) The commissioner shall issue a request for information by August 1, 2013, and respondents to the request must submit information to the commissioner by October 1, 2013.

(d) The commissioner shall incorporate the information obtained through the request for information described in paragraph (b) and information collected by the commissioner of health and other relevant sources related to the uninsured in this state when developing recommendations.

(e) The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services and finance by January 15, 2014.

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

Sec. 34. REQUEST FOR INFORMATION; EMERGENCY MEDICAL ASSISTANCE.

(a) The commissioner of human services shall issue a request for information (RFI) to identify and develop options for a program to provide emergency medical assistance recipients with coverage for medically necessary services not eligible for federal financial participation. The RFI must focus on providing coverage for nonemergent services for recipients who have two or more chronic conditions and have had two or more hospitalizations covered by emergency medical assistance in a one-year period.

(b) The RFI must be issued by August 1, 2013, and require respondents to submit information to the commissioner by November 1, 2013. The RFI must request information on:

(1) services necessary to reduce emergency department and inpatient hospital use for emergency medical assistance recipients;

(2) methods of service delivery that promote efficiency and cost-effectiveness, and provide statewide access;

(3) funding options for the services to be covered under the program;

(4) coordination of service delivery and funding with services covered under emergency medical assistance;

(5) options for program administration; and

(6) methods to evaluate the program, including evaluation of cost-effectiveness and health outcomes for those emergency medical assistance recipients eligible for coverage of additional services under the program.

(c) The commissioner shall make information submitted in response to the RFI available on the agency Web site. The commissioner, based on the responses to the RFI, shall submit recommendations on providing emergency medical assistance recipients with coverage for nonemergent services, as described in paragraph (a), to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2014.

Sec. 35. DENTAL ACCESS AND REIMBURSEMENT REPORT.

Subdivision 1. **Study.** (a) The commissioner of human services shall study the current oral health and dental services delivery system for state public health care programs to improve access and ensure cost-effective delivery of services. The commissioner shall make recommendations on modifying the delivery of services and reimbursement methods, including modifications to the critical access dental provider payments under Minnesota Statutes, section 256B.76, subdivision 4.

(b) The commissioner shall consult with dental providers enrolled in Minnesota health care programs, including providers who serve substantial numbers of low-income and uninsured patients and are currently receiving enhanced critical access dental provider payments.

Subd. 2. **Service delivery and reimbursement methods.** The recommendations must address:

(1) targeting state funding and critical access dental payments to improve access to oral health services for individuals enrolled in Minnesota health care programs who are not receiving timely and appropriate dental services;

(2) encouraging the use of cost-effective service delivery methods, workforce innovations, and the delivery of preventive services, including, but not limited to, dental sealants that will reduce dental disease and future costs of treatment;

(3) improving access in all geographic areas of the state;

(4) encouraging the use of tele-dentistry and mobile dental equipment to serve underserved patients and communities;

(5) evaluating the use of a single administrator delivery model;

(6) compensating providers for the added costs to providers of serving low-income and underserved patients and populations who experience the greatest oral health disparities in terms of incidence of oral health disease and access to and utilization of needed oral health services;

(7) encouraging coordination of oral health care with other health care services;

(8) preventing overtreatment, fraud, and abuse; and

(9) reducing administrative costs for the state and for dental providers.

Subd. 3. **Report.** The commissioner shall submit a report on the recommendations to the chairs and ranking minority members of the of the legislative committees and divisions with jurisdiction over health and human services policy and finance by December 15, 2013.

ARTICLE 7

CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 144.0724, subdivision 6, is amended to read:

Subd. 6. Penalties for late or nonsubmission. (a) A facility that fails to complete or submit an assessment for a RUG-III or RUG-IV classification within seven days of the time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

(b) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than 1.0 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the commissioner of human services for a reduction in the total penalty

amount. The commissioner of human services, in consultation with the commissioner of health, may, at the sole discretion of the commissioner of human services, limit the penalty for residents covered by medical assistance to 15 days.

Sec. 2. Minnesota Statutes 2012, section 144A.071, subdivision 4b, is amended to read:

Subd. 4b. **Licensed beds on layaway status.** A licensed and certified nursing facility may lay away, upon prior written notice to the commissioner of health, licensed and certified beds. A nursing facility may not discharge a resident in order to lay away a bed. Notice to the commissioner shall be given 60 days prior to the effective date of the layaway. Beds on layaway shall have the same status as voluntarily delicensed and decertified beds and shall not be subject to license fees and license surcharge fees. In addition, beds on layaway may be removed from layaway at any time on or after ~~one year~~ six months after the effective date of layaway in the facility of origin, with a 60-day notice to the commissioner. A nursing facility that removes beds from layaway may not place beds on layaway status for ~~one year~~ six months after the effective date of the removal from layaway. The commissioner may approve the immediate removal of beds from layaway if necessary to provide access to those nursing home beds to residents relocated from other nursing homes due to emergency situations or closure. In the event approval is granted, the ~~one-year~~ six-month restriction on placing beds on layaway after a removal of beds from layaway shall not apply. Beds may remain on layaway for up to ten years. The commissioner may approve placing and removing beds on layaway at any time during renovation or construction related to a moratorium project approved under this section or section 144A.073. Nursing facilities are not required to comply with any licensure or certification requirements for beds on layaway status.

Sec. 3. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. Exceptions to the moratorium include:

- (1) foster care settings that are required to be registered under chapter 144D;
- (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, and determined to be needed by the commissioner under paragraph (b);
- (3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center; ~~or~~ restructuring of state-operated services that limits the capacity of state-operated facilities; or, allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;
- (4) new foster care licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or
- (5) new foster care licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county

board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

~~(c) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:~~

~~(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;~~

~~(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and~~

~~(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.~~

~~(c)~~ (c) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for foster care settings where the physical location is not the primary residence of the license holder, if the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

~~(d)~~ (d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph ~~(c)~~ (c) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or

(2) the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a.

~~(e)~~ (e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph ~~(c)~~ (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase

the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1 ~~of each~~, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

~~(g)~~ (f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

~~(h)~~ (g) License holders of foster care homes identified under paragraph ~~(g)~~ (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.

Sec. 4. Minnesota Statutes 2012, section 252.291, is amended by adding a subdivision to read:

Subd. 2b. Nicollet County facility project. The commissioner of health shall certify one additional bed in an intermediate care facility for persons with developmental disabilities in Nicollet County.

Sec. 5. Minnesota Statutes 2012, section 256.9657, subdivision 3a, is amended to read:

Subd. 3a. ~~ICF/MR~~ ICF/DD license surcharge. (a) Effective July 1, 2003, each non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4, paragraph (d). The annual surcharge shall be \$1,040 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The facility must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. The commissioner may reduce, and may subsequently restore, the surcharge under this subdivision based on the commissioner's determination of a permissible surcharge.

(b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to \$3,679 per licensed bed.

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

Sec. 6. Minnesota Statutes 2012, section 256B.0915, subdivision 3a, is amended to read:

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

fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment.

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

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

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraph (a).

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

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

Sec. 7. Minnesota Statutes 2012, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3j. **Individual community living support.** Upon federal approval, there is established a new service called individual community living support (ICLS) that is available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor have any interest in the recipient's housing. ICLS must be delivered in a single-family home or apartment where the service recipient or their family owns or rents, as demonstrated by a lease agreement, and maintains control over the individual unit. Case managers or care coordinators must develop individual ICLS plans in consultation with the client using a tool developed by the commissioner. The commissioner shall establish payment rates and mechanisms to align payments with the type and amount of service provided, assure statewide uniformity for payment rates, and assure cost-effectiveness. Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and Human Services to avoid conflict with provider regulatory standards pursuant to section 144A.43 and chapter 245D.

Sec. 8. Minnesota Statutes 2012, section 256B.0916, is amended by adding a subdivision to read:

Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending in excess of the allocation made by the commissioner. In the event a county or tribal agency spends in excess of the

allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner. The plan must state the actions the agency will take to correct their overspending for the year following the period when the overspending occurred. Failure to correct overspending shall result in recoupment of spending in excess of the allocation. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

Sec. 9. Minnesota Statutes 2012, section 256B.092, subdivision 7, is amended to read:

Subd. 7. **Screening teams.** (a) For persons with developmental disabilities, screening teams shall be established which shall evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. The evaluation shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The screening team shall make an evaluation of need within 60 working days of a request for service by a person with a developmental disability, and within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities.

(b) The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition.

(c) County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services.

(d) For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waived services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional.

(e) For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs.

(f) The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. With the permission of the person being screened or the person's designated legal representative, the person's current provider of services may submit a written report outlining their recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The screening team must notify the provider of the date by which this information is to be submitted. This information must be provided to the screening team and the person or the person's legal representative and must be considered prior to the finalization of the screening.

(g) Upon federal approval, if during an assessment or reassessment the recipient is determined to be able to have the recipient's needs met through alternative services in a less restrictive setting, the case manager shall help the recipient develop a plan to transition to an appropriate less restrictive setting.

~~(g)~~ (h) No member of the screening team shall have any direct or indirect service provider interest in the case.

~~(h)~~ (i) Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.

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

Sec. 10. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

- (1) providers of residential support services must own or control the residential site;
- (2) the residential site must not be the primary residence of the license holder;
- (3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;
- (4) the provider of residential support services must provide supervision, training, and assistance as described in the person's coordinated service and support plan; and
- (5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph ~~(g)~~ (f), are considered registered under this section.

Sec. 11. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:

Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for developmental disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

- (1) no longer require the intensity of services provided where they are currently living; or
- (2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

- (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;
- (2) are moving from an institution due to bed closures;
- (3) experience a sudden closure of their current living arrangement;
- (4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

~~(b) (c) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.~~

~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner in sections 256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

Sec. 12. Minnesota Statutes 2012, section 256B.092, is amended by adding a subdivision to read:

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

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

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

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

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

Sec. 13. **[256B.0922] ESSENTIAL COMMUNITY SUPPORTS.**

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

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

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) 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;

(4) meets the financial eligibility criteria for the alternative care program under section 256B.0913, subdivision 4;

(5) has a community support plan; and

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

(i) caregiver support;

(ii) homemaker support;

(iii) chores;

(iv) a personal emergency response device or system;

(v) home-delivered meals; or

(vi) community living assistance as defined by the commissioner.

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

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

(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Subd. 2. **Essential community supports for people in transition.** (a) Essential community supports under subdivision 1 are also available to an individual who:

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

(2) meets one of the following criteria:

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

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

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

(4) has an assessed need for one or more of the supportive services offered under essential community supports under subdivision 1, paragraph (b), clause (6).

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

(b) Additional onetime case management is available for participants under paragraph (a), not to exceed \$600 per person to be used within one authorization period not to exceed 12 months. This service is provided in addition to the essential community supports benefit described under subdivision 1, paragraph (b).

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

Sec. 14. **[256B.0949] AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**

Subdivision 1. Purpose. This section creates a new benefit to provide early intensive intervention to a child with an autism spectrum disorder diagnosis. This benefit must provide coverage for diagnosis, multidisciplinary assessment, ongoing progress evaluation, and medically necessary treatment of autism spectrum disorder.

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

(b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) "Child" means a person under the age of 18.

(d) "Commissioner" means the commissioner of human services, unless otherwise specified.

(e) "Early intensive intervention benefit" means autism treatment options based in behavioral and developmental science, which may include modalities such as applied behavior analysis, developmental treatment approaches, and naturalistic and parent training models.

(f) "Generalizable goals" means results or gains that are observed during a variety of activities with different people, such as providers, family members, other adults, and children, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(g) "Mental health professional" has the meaning given in section 245.4871, subdivision 27, clauses (1) to (6).

Subd. 3. Initial eligibility. This benefit is available to a child enrolled in medical assistance who:

(1) has an autism spectrum disorder diagnosis;

(2) has had a diagnostic assessment described in subdivision 5, which recommends early intensive intervention services; and

(3) meets the criteria for medically necessary autism early intensive intervention services.

Subd. 4. Diagnosis. (a) A diagnosis must:

(1) be based upon current DSM criteria including direct observations of the child and reports from parents or primary caregivers; and

(2) be completed by both a licensed physician or advanced practice registered nurse and a mental health professional.

(b) Additional diagnostic assessment information may be considered including from special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy.

(c) If the commissioner determines there are access problems or delays in diagnosis for a geographic area due to the lack of qualified professionals, the commissioner shall waive the requirement in paragraph (a), clause (2), for two professionals and allow a diagnosis to be made by one professional for that geographic area. This exception must be limited to a specific period of time until, with stakeholder input as described in subdivision 8, there is a determination of an adequate number of professionals available to require two professionals for each diagnosis.

Subd. 5. **Diagnostic assessment.** The following information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the child:

(1) an assessment of the child's developmental skills, functional behavior, needs, and capacities based on direct observation of the child which must be administered by a licensed mental health professional and may also include observations from family members, school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as the child's physician, rehabilitation therapists, licensed school personnel, or mental health professionals; and

(2) an assessment of parental or caregiver capacity to participate in therapy including the type and level of parental or caregiver involvement and training recommended.

Subd. 6. **Treatment plan.** (a) Each child's treatment plan must be:

(1) based on the diagnostic assessment information specified in subdivisions 4 and 5;

(2) coordinated with medically necessary occupational, physical, and speech and language therapies, special education, and other services the child and family are receiving;

(3) family-centered;

(4) culturally sensitive; and

(5) individualized based on the child's developmental status and the child's and family's identified needs.

(b) The treatment plan must specify the:

(1) child's goals which are developmentally appropriate, functional, and generalizable;

(2) treatment modality;

(3) treatment intensity;

(4) setting; and

(5) level and type of parental or caregiver involvement.

(c) The treatment must be supervised by a professional with expertise and training in autism and child development who is a licensed physician, advanced practice registered nurse, or mental health professional.

(d) The treatment plan must be submitted to the commissioner for approval in a manner determined by the commissioner for this purpose.

(e) Services authorized must be consistent with the child's approved treatment plan.

Services included in the treatment plan must meet all applicable requirements for medical necessity and coverage.

Subd. 7. **Ongoing eligibility.** (a) An independent progress evaluation conducted by a licensed mental health professional with expertise and training in autism spectrum disorder and child development must be completed after each six months of treatment, or more frequently as determined by the commissioner,

to determine if progress is being made toward achieving generalizable goals and meeting functional goals contained in the treatment plan.

(b) The progress evaluation must include:

(1) the treating provider's report;

(2) parental or caregiver input;

(3) an independent observation of the child which can be performed by the child's licensed special education staff;

(4) any treatment plan modifications; and

(5) recommendations for continued treatment services.

(c) Progress evaluations must be submitted to the commissioner in a manner determined by the commissioner for this purpose.

(d) A child who continues to achieve generalizable goals and treatment goals as specified in the treatment plan is eligible to continue receiving this benefit.

(e) A child's treatment shall continue during the progress evaluation using the process determined under subdivision 8, clause (8). Treatment may continue during an appeal pursuant to section 256.045.

Subd. 8. **Refining the benefit with stakeholders.** The commissioner must develop the implementation details of the benefit in consultation with stakeholders and consider recommendations from the Health Services Advisory Council, the Department of Human Services Autism Spectrum Disorder Advisory Council, the Legislative Autism Spectrum Disorder Task Force, and the Interagency Task Force of the Departments of Health, Education, and Human Services. The commissioner must release these details for a 30-day public comment period prior to submission to the federal government for approval. The implementation details must include, but are not limited to, the following components:

(1) a definition of the qualifications, standards, and roles of the treatment team, including recommendations after stakeholder consultation on whether board-certified behavior analysts and other types of professionals trained in autism spectrum disorder and child development should be added as mental health or other professionals for treatment supervision or other functions under medical assistance;

(2) development of initial, uniform parameters for comprehensive multidisciplinary diagnostic assessment information and progress evaluation standards;

(3) the design of an effective and consistent process for assessing parent and caregiver capacity to participate in the child's early intervention treatment and methods of involving the parents and caregivers in the treatment of the child;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform a comprehensive, multidisciplinary diagnostic assessment and progress evaluation processes and standards to support quality improvement of early intensive intervention services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, and Education;

(6) evaluation, on an ongoing basis, of research regarding the program and treatment modalities provided to children under this benefit;

(7) determination of the availability of licensed physicians, nurse practitioners, and mental health professionals with expertise and training in autism spectrum disorder throughout the state to assess whether there are sufficient professionals to require involvement of both a physician or nurse practitioner and a mental

health professional to provide access and prevent delay in the diagnosis and treatment of young children, so as to implement subdivision 4, and to ensure treatment is effective, timely, and accessible; and

(8) development of the process for the progress evaluation that will be used to determine the ongoing eligibility, including necessary documentation, timelines, and responsibilities of all parties.

Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered treatment options as needed based on outcome data and other evidence.

(b) Before the changes become effective, the commissioner must provide public notice of the changes, the reasons for the change, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's Web site.

Subd. 10. **Coordination between agencies.** The commissioners of human services and education must develop the capacity to coordinate services and information including diagnostic, functional, developmental, medical, and educational assessments; service delivery; and progress evaluations across health and education sectors.

Subd. 11. **Federal approval of the autism benefit.** The provisions of subdivision 9 shall apply to state plan services under Title XIX of the Social Security Act when federal approval is granted under a 1915(i) waiver or other authority which allows children eligible for medical assistance through the TEFRA option under section 256B.055, subdivision 12, to qualify and includes children eligible for medical assistance in families over 150 percent of the federal poverty guidelines.

EFFECTIVE DATE. Subdivisions 1 to 7 and 9, are effective upon federal approval consistent with subdivision 11, but no earlier than March 1, 2014. Subdivisions 8, 10, and 11 are effective July 1, 2013.

Sec. 15. Minnesota Statutes 2012, section 256B.095, is amended to read:

256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.

(a) Effective July 1, 1998, a quality assurance system for persons with developmental disabilities, which includes an alternative quality assurance licensing system for programs, is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona Counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system or may continue regulation of these programs under the licensing system operated by the commissioner. ~~The project expires on June 30, 2014.~~

(b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to participate in the quality assurance system established under paragraph (a). The commission established under section 256B.0951 may, at its option, allow additional counties to participate in the system.

(c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a) may establish a quality assurance system under this section. A new system established under this section shall have the same rights and duties as the system established under paragraph (a). A new system shall be governed by a commission under section 256B.0951. The commissioner shall appoint the initial commission members based on recommendations from advocates, families, service providers, and counties in the geographic area included in the new system. Counties that choose to participate in a new system shall have the duties assigned under section 256B.0952. The new system shall establish a quality assurance process under section 256B.0953. The provisions of section 256B.0954 shall apply to a new system established under this paragraph. The commissioner shall delegate authority to a new system established under this paragraph according to section 256B.0955.

(d) Effective July 1, 2007, the quality assurance system may be expanded to include programs for persons with disabilities and older adults.

(e) Effective July 1, 2013, a provider of service located in a county listed in paragraph (a) that is a non-opted-in county may opt in to the quality assurance system provided the county where services are provided indicates its agreement with a county with a delegation agreement with the Department of Human Services.

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

Sec. 16. Minnesota Statutes 2012, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The Quality Assurance Commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. ~~Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, 2014.~~

Sec. 17. Minnesota Statutes 2012, section 256B.0951, subdivision 4, is amended to read:

Subd. 4. **Commission's authority to recommend variances of licensing standards.** The commission may recommend to the commissioners of human services and health variances from the standards governing licensure of programs for persons with ~~developmental~~ disabilities in order to improve the quality of services by implementing an alternative ~~developmental~~ disabilities licensing system if the commission determines that the alternative licensing system does not adversely affect the health or safety of persons being served by the licensed program nor compromise the qualifications of staff to provide services.

Sec. 18. Minnesota Statutes 2012, section 256B.0952, subdivision 1, is amended to read:

Subdivision 1. **Notification.** Counties or providers shall give notice to the commission and commissioners of human services and health of intent to join the alternative quality assurance licensing system. A county or provider choosing to participate in the alternative quality assurance licensing system commits to participate for three years.

Sec. 19. Minnesota Statutes 2012, section 256B.0952, subdivision 5, is amended to read:

Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised of county staff; providers; consumers, families, and their legal representatives; members of advocacy organizations; and other involved community members. Team members must satisfactorily complete the training program approved by the commission and must demonstrate performance-based competency. Team members are not considered to be county employees for purposes of workers' compensation, unemployment insurance, or state retirement laws solely on the basis of participation on a quality assurance team. ~~The county may pay~~ A per diem may be paid to team members for time spent on alternative quality assurance process matters. All team members may be reimbursed for expenses related to their participation in the alternative process.

Sec. 20. Minnesota Statutes 2012, section 256B.0955, is amended to read:

256B.0955 DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.

(a) Effective July 1, 1998, the commissioner of human services shall delegate authority to perform licensing functions and activities, in accordance with section 245A.16, to counties participating in the alternative quality assurance licensing system. The commissioner shall not license or reimburse a facility, program, or service for persons with developmental disabilities in a county that participates in the alternative quality assurance licensing system if the commissioner has received from the appropriate county notification that the facility, program, or service has been reviewed by a quality assurance team and has failed to qualify for licensure.

(b) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951 at facilities, programs, and services governed by the alternative quality assurance licensing system. The role of such random inspections shall be to verify that the alternative quality assurance licensing system protects the safety and well-being of consumers and maintains the availability of high-quality services for persons with developmental disabilities.

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

Sec. 21. Minnesota Statutes 2012, section 256B.097, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Sec. 22. Minnesota Statutes 2012, section 256B.097, subdivision 3, is amended to read:

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first ~~two~~ four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, ~~2013~~ 2014, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system ~~by July 1, 2013~~.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Sec. 23. Minnesota Statutes 2012, section 256B.431, subdivision 44, is amended to read:

Subd. 44. **Property rate increase increases for a facility in Bloomington effective November 1, 2010 certain nursing facilities.** (a) Notwithstanding any other law to the contrary, money available for moratorium projects under section 144A.073, subdivision 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception project for a nursing facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total property rate adjustment of \$19.33.

(b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow \$1,129,463 of a completed construction project to increase the property payment rate. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increase in the replacement-cost-new limit.

(c) Effective July 1, 2012, any nursing facility in Dakota County licensed for 61 beds shall have their replacement-cost-new limit under subdivision 17e adjusted to allow \$1,407,624 of a completed construction project to increase their property payment rate. Effective September 1, 2013, or later, their replacement-cost-new limit under subdivision 17e shall be adjusted to allow \$1,244,599 of a completed construction project to increase the property payment rate. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increase in the replacement-cost-new limit.

(d) Effective July 1, 2013, or later, any boarding care facility in Hennepin County licensed for 101 beds shall be allowed to receive a property rate adjustment for a construction project that takes action to come into compliance with Minnesota Department of Labor and Industry elevator upgrade requirements, with costs below the minimum threshold under subdivision 16. Only costs related to the construction project that brings the facility into compliance with the elevator requirements shall be allowed. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance program.

EFFECTIVE DATE. Paragraph (b) is effective retroactively from June 1, 2012. Paragraph (c) is effective retroactively from July 1, 2012.

Sec. 24. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, ~~and~~ October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Sec. 25. Minnesota Statutes 2012, section 256B.434, is amended by adding a subdivision to read:

Subd. 19a. **Nursing facility rate adjustments beginning September 1, 2013.** A total of a five percent average rate adjustment shall be provided as described under this subdivision and under section 256B.441, subdivision 46b.

(a) Beginning September 1, 2013, the commissioner shall make available to each nursing facility reimbursed under this section a 3.75 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) The commissioner shall allow as compensation-related costs all costs for:

(1) wage and salary increases effective after May 25, 2013;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective September 1, 2013. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(e) The commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:

(1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct-care employees;

(2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2013, and prior to April 1, 2014; and

(3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent, and dated after May 25, 2013. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this statute have been met. The rate adjustment shall be effective September 1, 2013. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

(g) The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on August 31, 2013. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility

program participation under section 256B.441, subdivision 55a, critical access nursing facility program participation under section 256B.441, subdivision 63, or performance-based incentive payment program participation under subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on August 31, 2013.

Sec. 26. Minnesota Statutes 2012, section 256B.434, is amended by adding a subdivision to read:

Subd. 19b. **Nursing facility rate adjustments beginning October 1, 2015.** A total of a 3.2 percent average rate adjustment shall be provided as described under this subdivision and under section 256B.441, subdivision 46c.

(a) Beginning October 1, 2015, the commissioner shall make available to each nursing facility reimbursed under this section a 2.4 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) The commissioner shall allow as compensation-related costs all costs for:

(1) wage and salary increases effective after May 25, 2015;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective October 1, 2015. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application,

excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(e) The commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:

(1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct-care employees;

(2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2015, and prior to April 1, 2016; and

(3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2015.

Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this statute have been met. The rate adjustment shall be effective October 1, 2015. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

(g) The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on September 30, 2015. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256B.441, subdivision 55a, critical access nursing facility program participation under section 256B.441, subdivision 63, or performance-based incentive payment program participation under subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on September 30, 2015.

Sec. 27. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's ~~total operating external fixed~~ payment rate.

~~(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an operating payment rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.~~

~~(d)~~ (c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

~~(e)~~ (d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

~~(f)~~ (e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

~~(g)~~ (f) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

~~(h) Beginning~~ (g) ~~Between~~ July 16, 2011, and June 30, 2013, the commissioner shall ~~no longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

Sec. 28. Minnesota Statutes 2012, section 256B.439, subdivision 1, is amended to read:

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement a quality ~~profile system~~ profiles for nursing facilities and, beginning not later than July 1, 2004, ~~other providers of long-term care services~~ 2014, for home and community-based services providers, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. For purposes of this section, home and community-based services providers are defined as providers of home and community-based services under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, and intermediate care facilities for persons with developmental disabilities providers under section 256B.5013. To the extent possible, quality profiles must be developed for providers of services to older adults and people with disabilities, regardless of payor source, for the purposes of providing information to consumers. The system quality profiles must be developed and implemented to the extent possible without the collection of significant amounts of new data. To the extent possible, the system using existing data sets maintained by the commissioners of health and human services to the extent possible. The profiles must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The system profiles must be designed to provide information on quality to:

- (1) consumers and their families to facilitate informed choices of service providers;
- (2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and
- (3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

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

Sec. 29. Minnesota Statutes 2012, section 256B.439, subdivision 2, is amended to read:

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

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

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

Sec. 30. Minnesota Statutes 2012, section 256B.439, is amended by adding a subdivision to read:

Subd. 2a. **Quality measurement tools for home and community-based services.** (a) The commissioners shall identify and apply quality measurement tools to:

- (1) emphasize service quality and its relationship to quality of life; and
- (2) address the needs of various users of home and community-based services.

(b) The tools must include, but not be limited to, surveys of consumers of home and community-based services. The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond state and federal requirements, for purposes of this subdivision.

Sec. 31. Minnesota Statutes 2012, section 256B.439, is amended by adding a subdivision to read:

Subd. 3a. **Consumer surveys for home and community-based services.** Following identification of the quality measurement tool, and within the limits of the appropriation, the commissioner shall conduct surveys of home and community-based services consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioner, surveys may be conducted by an alternative method. Surveys must be conducted periodically to update quality profiles of individual service providers.

Sec. 32. Minnesota Statutes 2012, section 256B.439, is amended by adding a subdivision to read:

Subd. 5. **Implementation of home and community-based services performance-based incentive payment program.** By April 1, 2014, the commissioner shall develop incentive-based grants for home and community-based services providers for achieving outcomes specified in a contract. The commissioner may solicit proposals from home and community-based services providers and implement those that, on a competitive basis, best meet the state's policy objectives. The commissioner shall determine the types of home and community-based services providers that will participate in the program. The determination of participating provider types may be revised annually by the commissioner. The commissioner shall limit the amount of any incentive-based grants and the number of grants under this subdivision to operate the incentive payments within funds appropriated for this purpose. The grant agreements may specify various levels of payment for various levels of performance. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

- (1) provide more efficient, higher quality services;

- (2) encourage home and community-based services providers to innovate;
- (3) equip home and community-based services providers with organizational tools and expertise to improve their quality;
- (4) incentivize home and community-based services providers to invest in better services; and
- (5) disseminate successful performance improvement strategies statewide.

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

Subd. 6. **Calculation of home and community-based services quality score.** (a) The commissioner shall determine a quality score for each participating home and community-based services provider using quality measures established in subdivisions 1 and 2a, according to methods determined by the commissioner in consultation with stakeholders and experts. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with a maximum number of points available and number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

Sec. 34. Minnesota Statutes 2012, section 256B.439, is amended by adding a subdivision to read:

Subd. 7. **Calculation of home and community-based services quality add-on.** Effective July 1, 2015, the commissioner shall determine the quality add-on payment for participating home and community-based services providers. The payment rate for the quality add-on shall be a variable amount based on each provider's quality score as determined in subdivisions 1 and 2a. The commissioner shall limit the types of home and community-based services providers that may receive the quality add-on and the amount of the quality add-on payments to operate the quality add-on within funds appropriated for this purpose and based on the availability of the quality measures.

Sec. 35. Minnesota Statutes 2012, section 256B.441, subdivision 44, is amended to read:

Subd. 44. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with a maximum number of points available and number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The scores determined for all quality measures shall be totaled. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) For the initial rate year under the new payment system, the quality measures shall include:

- (1) staff turnover;
- (2) staff retention;
- (3) use of pool staff;
- (4) quality indicators from the minimum data set; and
- (5) survey deficiencies.

(d) For rate years beginning after October 1, 2006, when making revisions to the quality measures or method for calculating scores, the commissioner shall publish the methodology in the State Register at least 15 months prior to the start of the rate year for which the revised methodology is to be used for rate-setting purposes. The quality score used to determine payment rates shall be established for a rate year using data submitted in the statistical and cost report from the associated reporting year, and using data from other sources related to a period beginning no more than six months prior to the associated reporting year. Beginning July 1, 2013, the quality score shall be a value between zero and 100, using data as provided in the Minnesota nursing home report card, with 50 percent derived from the Minnesota quality indicators score, 40 percent derived from the resident quality of life score, and ten percent derived from the state inspection results score.

(e) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph (d), or the methodology for computing the total quality score, effective July 1 of any year beginning in 2014, with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Sec. 36. Minnesota Statutes 2012, section 256B.441, is amended by adding a subdivision to read:

Subd. 46b. **Calculation of quality add-on, with an average value of 1.25 percent, effective September 1, 2013.** (a) The commissioner shall determine quality add-ons to the operating payment rates for each facility. The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on August 31, 2013. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on August 31, 2013.

(b) For each facility, the commissioner shall compute a quality factor by subtracting 40 from the most recent quality score computed under subdivision 44, and then dividing by 60. If the quality factor is less than zero, the commissioner shall use the value zero.

(c) The quality add-ons shall be the operating payment rates determined in paragraph (a), multiplied by the quality factor determined in paragraph (b), and then multiplied by 3.2 percent. The commissioner shall implement the quality add-ons effective September 1, 2013.

Sec. 37. Minnesota Statutes 2012, section 256B.441, is amended by adding a subdivision to read:

Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.** The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments shall be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d). Beginning October 1, 2015, annual rate adjustments provided under this subdivision shall be effective for one year, starting October 1 and ending the following September 30.

Sec. 38. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:

Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community alternatives for disabled individuals, and brain injury waiver services, as of January 1, 2010. The statewide priorities must

include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

- (1) no longer require the intensity of services provided where they are currently living; or
- (2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

- (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;
- (2) are moving from an institution due to bed closures;
- (3) experience a sudden closure of their current living arrangement;
- (4) require protection from confirmed abuse, neglect, or exploitation;
- (5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or
- (6) meet other priorities established by the department.

~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner in sections 256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

Sec. 39. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

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

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

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

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

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

Sec. 40. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:

Subd. 15. Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan. (a) Each recipient of home and community-based waived services shall be provided a copy of the written coordinated service and support plan which meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or brain injury waived services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph ~~(f)~~ (e), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.

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

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

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

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

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

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

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

Subd. 26. **Excess allocations.** County and tribal agencies will be responsible for authorizations in excess of the allocation made by the commissioner. In the event a county or tribal agency authorizes in excess of the allocation made by the commissioner for a given allocation period, the county or tribal agency must submit a corrective action plan to the commissioner. The plan must state the actions the agency will take to correct their overspending for the year following the period when the overspending occurred. Failure to correct overauthorizations shall result in recoupment of authorizations in excess of the allocation. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

Sec. 43. Minnesota Statutes 2012, section 256B.492, is amended to read:

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

(a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

- (1) an individual's own home or family home;
- (2) a licensed adult foster care setting of up to five people; and

(3) community living settings as defined in section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units, and no more than the greater of four or 25 percent of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Persons with AIDS Program.

(b) The settings in paragraph (a) must not:

(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of or adjacent to a public or private institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability, unless required by the Housing Opportunities for Persons with AIDS Program;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of July 1, 2012, and the setting does not meet the criteria of this section.

(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).

(e) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

Sec. 44. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:

Subd. 2. **Planned closure process needs determination.** The commissioner shall announce and implement a program for planned closure of adult foster care homes. Planned closure shall be the preferred method for achieving necessary budgetary savings required by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph (d) (c). If additional closures are required to achieve the necessary savings, the commissioner shall use the process and priorities in section 245A.03, subdivision 7, paragraph (d) (c).

Sec. 45. Minnesota Statutes 2012, section 256B.501, is amended by adding a subdivision to read:

Subd. 14. **Rate adjustment for ICF/DD in Cottonwood County.** The commissioner of health shall decertify three beds in an intermediate care facility for persons with developmental disabilities with 21 certified beds located in Cottonwood County. The total payment rate shall be \$282.62 per bed, per day.

Sec. 46. Minnesota Statutes 2012, section 256B.5012, is amended by adding a subdivision to read:

Subd. 14. **Rate increase effective June 1, 2013.** For rate periods beginning on or after June 1, 2013, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by \$7.81 per day. The increase shall not be subject to any annual percentage increase.

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

Sec. 47. Minnesota Statutes 2012, section 256B.5012, is amended by adding a subdivision to read:

Subd. 15. **ICF/DD rate increases effective April 1, 2014.** (a) Notwithstanding subdivision 12, for each facility reimbursed under this section, for the rate period beginning April 1, 2014, the commissioner shall increase operating payments equal to one percent of the operating payment rates in effect on March 31, 2014.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate, but excluding the property-related payment rate in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Sec. 48. Minnesota Statutes 2012, section 256B.69, is amended by adding a subdivision to read:

Subd. 32a. **Initiatives to improve early screening, diagnosis, and treatment of children with autism spectrum disorder and other developmental conditions.** (a) The commissioner shall require managed care plans and county-based purchasing plans, as a condition of contract, to implement strategies that facilitate access for young children between the ages of one and three years to periodic developmental and social-emotional screenings, as recommended by the Minnesota Interagency Developmental Screening Task Force, and that those children who do not meet milestones are provided access to appropriate evaluation

and assessment, including treatment recommendations, expected to improve the child's functioning, with the goal of meeting milestones by age five.

(b) The following information from encounter data provided to the commissioner shall be reported on the department's public Web site for each managed care plan and county-based purchasing plan annually by July 31 of each year beginning in 2014:

(1) the number of children who received a diagnostic assessment;

(2) the total number of children ages one to six with a diagnosis of autism spectrum disorder who received treatments;

(3) the number of children identified under clause (2) reported by each 12-month age group beginning with age one and ending with age six; and

(4) the types of treatments provided to children identified under clause (2) listed by billing code, including the number of units billed for each child.

(c) The managed care plans and county-based purchasing plans shall also report on any barriers to providing screening, diagnosis, and treatment of young children between the ages of one and three years, any strategies implemented to address those barriers, and make recommendations on how to measure and report on the effectiveness of the strategies implemented to facilitate access for young children to provide developmental and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

Sec. 49. **[256B.85] COMMUNITY FIRST SERVICES AND SUPPORTS.**

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

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

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

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

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

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

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

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

(1) Level I behavior;

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

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

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

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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

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

(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day;

or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(f) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, paragraph (a), clause (3), that replace the need for human assistance.

(g) "Community first services and supports service delivery plan" or "service delivery plan" means a written summary of the services and supports, that is based on the community support plan identified in section 256B.0911 and coordinated services and support plan and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined by the participant to meet the assessed needs, using a person-centered planning process.

(h) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(i) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child may not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(j) "Extended CFSS" means CFSS services and supports under the agency-provider model included in a service plan through one of the home and community-based services waivers authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.

(k) "Financial management services contractor or vendor" means a qualified organization having a written contract with the department to provide services necessary to use the budget model under subdivision 13, that include but are not limited to: participant education and technical assistance; CFSS service delivery planning and budgeting; billing, making payments, and monitoring of spending; and assisting the participant in fulfilling employer-related requirements in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6.

(l) "Budget model" means a service delivery method of CFSS that allows the use of an individualized CFSS service delivery plan and service budget and provides assistance from the financial management services contractor to facilitate participant employment of support workers and the acquisition of supports and goods.

(m) "Health-related procedures and tasks" means procedures and tasks related to the specific needs of an individual that can be delegated or assigned by a state-licensed healthcare or mental health professional and performed by a support worker.

(n) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(o) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(p) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker may not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(q) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice. The participant's representative must have no financial interest in the provision of any services included in the participant's service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:

(1) being available while care is provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;

(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed;
and

(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.

(r) "Person-centered planning process" means a process that is directed by the participant to plan for services and supports. The person-centered planning process must:

(1) include people chosen by the participant;

(2) provide necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

(3) be timely and occur at time and locations of convenience to the participant;

(4) reflect cultural considerations of the participant;

(5) include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning;

(6) provide the participant choices of the services and supports they receive and the staff providing those services and supports;

(7) include a method for the participant to request updates to the plan; and

(8) record the alternative home and community-based settings that were considered by the participant.

(s) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same provider.

(t) "Support specialist" means a professional with the skills and ability to assist the participant using either the agency provider model under subdivision 11 or the flexible spending model under subdivision 13, in services including but not limited to assistance regarding:

(1) the development, implementation, and evaluation of the CFSS service delivery plan under subdivision 6;

(2) recruitment, training, or supervision, including supervision of health-related tasks or behavioral supports appropriately delegated or assigned by a health care professional, and evaluation of support workers; and

(3) facilitating the use of informal and community supports, goods, or resources.

(u) "Support worker" means an employee of the agency provider or of the participant who has direct contact with the participant and provides services as specified within the participant's service delivery plan.

(v) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is a recipient of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a recipient of the alternative care program under section 256B.0913;

(3) is a waiver recipient as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a participant's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911;

(2) is not a recipient under the family support grant under section 252.32;

(3) lives in the person's own apartment or home including a family foster care setting licensed under chapter 245A, but not in corporate foster care under chapter 245A; or a noncertified boarding care or boarding and lodging establishments under chapter 157.

Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit or other services available through alternative care.

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivision 3a;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports; and

(3) be completed using the format established by the commissioner.

(b) A participant who is residing in a facility may be assessed and choose CFSS for the purpose of using CFSS to return to the community as described in subdivisions 3 and 7, paragraph (a), clause (5).

(c) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's certified assessor as defined in section 256B.0911 to the participant and the agency-provider or financial management services provider chosen by the participant within 40 calendar days and must include the participant's right to appeal under section 256.045, subdivision 3.

(d) The lead agency assessor may request a temporary authorization for CFSS services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this provision shall have no bearing on a future authorization.

Subd. 6. **Community first services and support service delivery plan.** (a) The CFSS service delivery plan must be developed, implemented, and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a support specialist. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the community support plan under section 256B.0911, subdivision 3, or the coordinated services and support plan identified in section 256B.0915, subdivision 6, if applicable. The CFSS service delivery plan must be reviewed by the participant and the agency-provider or financial management services contractor at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the agency-provider or financial management services contractor selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the means to address the clinical and support needs as identified through an assessment of functional needs;

(5) include individually identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by all individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan; and

(13) prevent the provision of unnecessary or inappropriate care.

(d) The total units of agency-provider services or the budget allocation amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service authorization. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount unless a change in condition is assessed and authorized by the certified assessor and documented in the community support plan, coordinated services and supports plan, and service delivery plan.

Subd. 7. **Community first services and supports; covered services.** Within the service unit authorization or budget allocation, services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan;

(ii) increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance. An assessment of behaviors must meet the criteria in this clause. A recipient qualifies as having a need for assistance due to behaviors if the recipient's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

(i) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for recipients who are verbally aggressive or resistive to care so that time needed to perform activities of daily living is increased;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) transition costs, including:

(i) deposits for rent and utilities;

(ii) first month's rent and utilities;

(iii) bedding;

(iv) basic kitchen supplies;

(v) other necessities, to the extent that these necessities are not otherwise covered under any other funding that the participant is eligible to receive; and

(vi) other required necessities for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for persons with developmental disabilities to a community-based home setting where the participant resides; and

(7) services by a support specialist defined under subdivision 2 that are chosen by the participant.

Subd. 8. Determination of CFSS service methodology. (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin, except for the assessments established in section 256B.0911. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the recipient's home care rating described in subdivision 8, paragraphs (d) and (e), and any additional service units for which the person qualifies as described in subdivision 8, paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a recipient:

(1) the total number of dependencies of activities of daily living as defined in subdivision 2, paragraph (b);

(2) the presence of complex health-related needs as defined in subdivision 2, paragraph (e); and

(3) the presence of Level I behavior as defined in subdivision 2, paragraph (d), clause (1).

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(i) P home care rating requires Level 1 behavior or one to three dependencies in ADLs and qualifies one for five service units;

(ii) Q home care rating requires Level 1 behavior and one to three dependencies in ADLs and qualifies one for six service units;

(iii) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies one for seven service units;

(iv) S home care rating requires four to six dependencies in ADLs and qualifies one for ten service units;

(v) T home care rating requires four to six dependencies in ADLs and Level 1 behavior and qualifies one for 11 service units;

(vi) U home care rating requires four to six dependencies in ADLs and a complex health need and qualifies one for 14 service units;

(vii) V home care rating requires seven to eight dependencies in ADLs and qualifies one for 17 service units;

(viii) W home care rating requires seven to eight dependencies in ADLs and Level 1 behavior and qualifies one for 20 service units;

(ix) Z home care rating requires seven to eight dependencies in ADLs and a complex health related need and qualifies one for 30 service units; and

(x) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). Recipients who meet the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and other home care services are limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a recipient's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in subdivision 2, paragraph (h);

(2) 30 additional minutes per day for each complex health-related function as defined in subdivision 2, paragraph (e); and

(3) 30 additional minutes per day for each behavior issue as defined in subdivision 2, paragraph (d).

Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for payment under this section include those that:

(1) are not authorized by the certified assessor or included in the written service delivery plan;

(2) are provided prior to the authorization of services and the approval of the written CFSS service delivery plan;

(3) are duplicative of other paid services in the written service delivery plan;

(4) supplant natural unpaid supports that appropriately meet a need in the service plan, are provided voluntarily to the participant and are selected by the participant in lieu of other services and supports;

(5) are not effective means to meet the participant's needs; and

(6) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act.

(b) Additional services, goods, or supports that are not covered include:

(1) those that are not for the direct benefit of the participant, except that services for caregivers such as training to improve the ability to provide CFSS are considered to directly benefit the participant if chosen by the participant and approved in the support plan;

(2) any fees incurred by the participant, such as Minnesota health care programs fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage;

(4) room and board costs for the participant with the exception of allowable transition costs in subdivision 7, clause (6);

(5) services, supports, or goods that are not related to the assessed needs;

(6) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(7) assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports listed in subdivision 7;

(8) medical supplies and equipment;

(9) environmental modifications, except as specified in subdivision 7;

(10) expenses for travel, lodging, or meals related to training the participant, the participant's representative, legal representative, or paid or unpaid caregivers that exceed \$500 in a 12-month period;

(11) experimental treatments;

(12) any service or good covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(13) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. The condition must be identified in the participant's CFSS plan and monitored by a physician enrolled in a Minnesota health care program;

(14) vacation expenses other than the cost of direct services;

(15) vehicle maintenance or modifications not related to the disability, health condition, or physical need; and

(16) tickets and related costs to attend sporting or other recreational or entertainment events.

Subd. 10. **Provider qualifications and general requirements.** Agency-providers delivering services under the agency-provider model under subdivision 11 or financial management service (FMS) contractors under subdivision 13 shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards;

(2) comply with medical assistance provider enrollment requirements;

(3) demonstrate compliance with law and policies of CFSS as determined by the commissioner;

(4) comply with background study requirements under chapter 245C;

(5) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers and support specialists;

(6) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family member, or participants' representatives;

(7) pay support workers and support specialists based upon actual hours of services provided;

(8) withhold and pay all applicable federal and state payroll taxes;

(9) make arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(10) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided using a format established by the commissioner;

(11) report maltreatment as required under sections 626.556 and 626.557; and

(12) provide the participant with a copy of the service-related rights under subdivision 19 at the start of services and supports.

Subd. 11. **Agency-provider model.** (a) The agency-provider model is limited to the services provided by support workers and support specialists who are employed by an agency-provider that is licensed according to chapter 245A or meets other criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's service delivery plan.

(c) A participant may use authorized units of CFSS services as needed within a service authorization that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the support specialist and the reasonable costs associated with the support specialist must not be used in making this calculation.

(f) The agency-provider model must be used by individuals who have been restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

Subd. 12. **Requirements for enrollment of CFSS provider agencies.** (a) All CFSS provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the CFSS provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider agency's Medicaid revenue in the previous calendar year is less than or equal to \$300,000, the provider agency must purchase a performance bond of \$50,000. If the provider agency's Medicaid revenue in the previous calendar year is greater than \$300,000, the provider agency must purchase a performance bond of \$100,000. The performance bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of \$20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the CFSS provider agency's organization identifying the names or all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the CFSS provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the CFSS provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the CFSS provider agency's time sheet if the time sheet varies from the standard time sheet for CFSS services approved by the commissioner, and a letter requesting approval of the CFSS provider agency's nonstandard time sheet; and

(ii) the CFSS provider agency's template for the CFSS care plan;

(9) a list of all training and classes that the CFSS provider agency requires of its staff providing CFSS services;

(10) documentation that the CFSS provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the agency will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for employee personal care assistant wages and benefits: 72.5 percent of revenue from CFSS providers. The revenue generated by the support specialist and the reasonable costs associated with the support specialist shall not be used in making this calculation; and

(14) documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular CFSS recipient or for another CFSS provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS provider agencies shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. CFSS provider agency billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. CFSS provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision.

Subd. 13. **Budget model.** (a) Under the budget model participants can exercise more responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Under this model, participants may use their budget allocation to:

(1) directly employ support workers;

(2) obtain supports and goods as defined in subdivision 7; and

(3) choose a range of support assistance services from the financial management services (FMS) contractor related to:

(i) assistance in managing the budget to meet the service delivery plan needs, consistent with federal and state laws and regulations;

(ii) the employment, training, supervision, and evaluation of workers by the participant;

(iii) acquisition and payment for supports and goods; and

(iv) evaluation of individual service outcomes as needed for the scope of the participant's degree of control and responsibility.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) The FMS contractor shall not provide CFSS services and supports under the agency-provider service model. The FMS contractor shall provide service functions as determined by the commissioner that include but are not limited to:

(1) information and consultation about CFSS;

(2) assistance with the development of the service delivery plan and budget model as requested by the participant;

(3) billing and making payments for budget model expenditures;

(4) assisting participants in fulfilling employer-related requirements according to Internal Revenue Code Procedure 70-6, section 3504, Agency Employer Tax Liability, regulation 137036-08, which includes assistance with filing and paying payroll taxes, and obtaining worker compensation coverage;

(5) data recording and reporting of participant spending; and

(6) other duties established in the contract with the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing their employer responsibilities regarding support workers. The support worker shall not be considered the employee of the financial management services contractor.

(d) A participant who requests to purchase goods and supports along with support worker services under the agency-provider model must use the budget model with a service delivery plan that specifies the amount of services to be authorized to the agency-provider and the expenditures to be paid by the FMS contractor.

(e) The FMS contractor shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

(2) provide the participant and the targeted case manager, if applicable, with a monthly written summary of the spending for services and supports that were billed against the spending budget;

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under the Internal Revenue Service Revenue Code Procedure 70-6, Section 35-4, Agency Employer Tax Liability for vendor or fiscal employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(4) have current and adequate liability insurance and bonding and sufficient cash flow as determined by the commissioner and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting;

(5) assume fiscal accountability for state funds designated for the program; and

(6) maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the commissioner. Claims submitted by the FMS contractor to the

commissioner for payment must correspond with services, amounts, and time periods as authorized in the participant's spending budget and service plan.

(f) The commissioner of human services shall:

(1) establish rates and payment methodology for the FMS contractor;

(2) identify a process to ensure quality and performance standards for the FMS contractor and ensure statewide access to FMS contractors; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS contractors.

(g) The commissioner of human services shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under the following circumstances that include but are not limited to:

(1) when a participant has been restricted by the Minnesota restricted recipient program, the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative cannot manage participant responsibilities under the budget model. The commissioner must develop policies for determining if a participant is unable to manage responsibilities under a budget model.

(h) A participant may appeal under section 256.045, subdivision 3, in writing to the department to contest the department's decision under paragraph (c), clause (3), to remove or exclude the participant from the budget model.

Subd. 14. **Participant's responsibilities under budget model.** (a) A participant using the budget model must use an FMS contractor or vendor that is under contract with the department. Upon a determination of eligibility and completion of the assessment and community support plan, the participant shall choose a FMS contractor from a list of eligible vendors maintained by the department.

(b) When the participant, participant's representative, or legal representative chooses to be the employer of the support worker, they are responsible for the hiring and supervision of the support worker, including, but not limited to, recruiting, interviewing, training, scheduling, and discharging the support worker consistent with federal and state laws and regulations.

(c) In addition to the employer responsibilities in paragraph (b), the participant, participant's representative, or legal representative is responsible for:

(1) tracking the services provided and all expenditures for goods or other supports;

(2) preparing and submitting time sheets, signed by both the participant and support worker, to the FMS contractor on a regular basis and in a timely manner according to the FMS contractor's procedures;

(3) notifying the FMS contractor within ten days of any changes in circumstances affecting the CFSS service plan or in the participant's place of residence including, but not limited to, any hospitalization of the participant or change in the participant's address, telephone number, or employment;

(4) notifying the FMS contractor of any changes in the employment status of each participant support worker; and

(5) reporting any problems resulting from the quality of services rendered by the support worker to the FMS contractor. If the participant is unable to resolve any problems resulting from the quality of service

rendered by the support worker with the assistance of the FMS contractor, the participant shall report the situation to the department.

Subd. 15. **Documentation of support services provided.** (a) Support services provided to a participant by a support worker employed by either an agency-provider or the participant acting as the employer must be documented daily by each support worker, on a time sheet form approved by the commissioner. All documentation may be Web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider or the participant and the FMS contractor selected by the participant to provide assistance with meeting the participant's employer obligations and kept in the recipient's health record.

(b) The activity documentation must correspond to the written service delivery plan and be reviewed by the agency provider or the participant and the FMS contractor when the participant is acting as the employer of the support worker.

(c) The time sheet must be on a form approved by the commissioner documenting time the support worker provides services in the home. The following criteria must be included in the time sheet:

- (1) full name of the support worker and individual provider number;
- (2) provider name and telephone numbers, if an agency-provider is responsible for delivery services under the written service plan;
- (3) full name of the participant;
- (4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;
- (5) signatures of the participant or the participant's representative;
- (6) personal signature of the support worker;
- (7) any shared care provided, if applicable;
- (8) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and
- (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that:

- (i) the support worker is not disqualified under section 245C.14; or
- (ii) is disqualified, but the support worker has received a set-aside of the disqualification under section 245C.22;
- (2) have the ability to effectively communicate with the participant or the participant's representative;
- (3) have the skills and ability to provide the services and supports according to the person's CFSS service delivery plan and respond appropriately to the participant's needs;
- (4) not be a participant of CFSS, unless the support services provided by the support worker differ from those provided to the support worker;

(5) complete the basic standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Support worker training must include successful completion of the

following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(6) complete training and orientation on the participant's individual needs; and

(7) maintain the privacy and confidentiality of the participant, and not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) lacks the skills, knowledge, or ability to adequately or safely perform the required work;

(2) fails to provide the authorized services required by the participant employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

Subd. 17. **Support specialist requirements and payments.** The commissioner shall develop qualifications, scope of functions, and payment rates and service limits for a support specialist that may provide additional or specialized assistance necessary to plan, implement, arrange, augment, or evaluate services and supports.

Subd. 18. **Service unit and budget allocation requirements and limits.** (a) For the agency-provider model, services will be authorized in units of service. The total service unit amount must be established based upon the assessed need for CFSS services, and must not exceed the maximum number of units available as determined under subdivision 8.

(b) For the budget model, the budget allocation allowed for services and supports is established by multiplying the number of units authorized under subdivision 8 by the payment rate established by the commissioner.

Subd. 19. **Support system.** (a) The commissioner shall provide information, consultation, training, and assistance to ensure the participant is able to manage the services and supports and budgets, if applicable. This support shall include individual consultation on how to select and employ workers, manage responsibilities under CFSS, and evaluate personal outcomes.

(b) The commissioner shall provide assistance with the development of risk management agreements.

Subd. 20. **Service-related rights.** (a) Participants must be provided with adequate information, counseling, training, and assistance, as needed, to ensure that the participant is able to choose and manage services, models, and budgets. This support shall include information regarding:

(1) person-centered planning;

- (2) the range and scope of individual choices;
- (3) the process for changing plans, services and budgets;
- (4) the grievance process;
- (5) individual rights;
- (6) identifying and assessing appropriate services;
- (7) risks and responsibilities; and
- (8) risk management.

(b) The commissioner must ensure that the participant has a copy of the most recent community support plan and service delivery plan.

(c) A participant who appeals a reduction in previously authorized CFSS services may continue previously authorized services pending an appeal in accordance with section 256.045.

(d) If the units of service or budget allocation for CFSS are reduced, denied, or terminated, the commissioner must provide notice of the reasons for the reduction in the participant's notice of denial, termination, or reduction.

(e) If all or part of a service delivery plan is denied approval, the commissioner must provide a notice that describes the basis of the denial.

Subd. 21. **Development and Implementation Council.** The commissioner shall establish a Development and Implementation Council of which the majority of members are individuals with disabilities, elderly individuals, and their representatives. The commissioner shall consult and collaborate with the council when developing and implementing this section for at least the first five years of operation. The commissioner, in consultation with the council, shall provide recommendations on how to improve the quality and integrity of CFSS, reduce the paper documentation required in subdivisions 10, 12, and 15, make use of electronic means of documentation and online reporting in order to reduce administrative costs and improve training to the legislative chairs of the health and human services policy and finance committees by February 1, 2014.

Subd. 22. **Quality assurance and risk management system.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing CFSS, including those that (1) recognize the roles and responsibilities of those involved in obtaining CFSS, and (2) ensure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. Risk management measures must include background studies, and backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for CFSS participants.

(c) Performance assessment measures, such as a participant's satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the council established in subdivision 21.

(d) Data reporting requirements will be developed in consultation with the council established in subdivision 21.

Subd. 23. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the agency provider or FMS contractor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to

records is cause for immediate suspension of payment and terminating the agency provider's enrollment according to section 256B.064 or terminating the FMS contract.

Subd. 24. **CFSS agency-providers; background studies.** CFSS agency-providers enrolled to provide personal care assistance services under the medical assistance program shall comply with the following:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in chapter 245C. This applies to currently enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS agency-provider. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies on owners managing employees; or

(ii) the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set-aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all support specialists; and

(3) a background study must be initiated and completed for all support workers.

Subd. 25. **Commissioner recommendations required.** In consultation with the Development and Implementation Council described in subdivision 21 and other stakeholders, the commissioner shall develop recommendations for revisions to subdivisions 12, 15, and 16, that promote self-direction in the following areas:

(1) CFSS provider and support worker enrollment, qualification, and disqualification criteria;

(2) documentation requirements that are consistent with state and federal requirements; and

(3) provisions to maintain program integrity and assure fiscal accountability for goods and services purchased through CFSS.

The recommendations shall be provided to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by November 15, 2013.

EFFECTIVE DATE. This section is effective upon federal approval but no earlier than April 1, 2014. The service will begin 90 days after federal approval or April 1, 2014, whichever is later. The commissioner of human services shall notify the revisor of statutes when this occurs.

Sec. 50. Minnesota Statutes 2012, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of \$68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f)(1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g).

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision

10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. In a multifamily building of more than four units, the maximum number of units that may be used by recipients of this program shall be the greater of four units or 25 percent of the units in the building, unless required by the Housing Opportunities for Persons with AIDS Program. In multifamily buildings of four or fewer units, all of the units may be used by recipients of this program. When housing is controlled by the service provider, the individual may choose the individual's own service provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is controlled by the service provider, the service provider shall implement a plan with the recipient to transition the lease to the recipient's name. Within two years of signing the initial lease, the service provider shall transfer the lease entered into under this subdivision to the recipient. In the event the landlord denies this transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.

Sec. 51. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 3, as amended by Laws 2012, chapter 247, article 4, section 43, is amended to read:

Subd. 3. Forecasted Programs

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MFIP/DWP Grants

	Appropriations by Fund	
General	84,680,000	91,978,000
Federal TANF	84,425,000	75,417,000

(b) MFIP Child Care Assistance Grants 55,456,000 30,923,000

(c) General Assistance Grants 49,192,000 46,938,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at \$203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than \$6,689,812 in fiscal year 2012 and \$6,729,812 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using

the allocation method specified in Minnesota Statutes, section 256D.06.

(d) Minnesota Supplemental Aid Grants	38,095,000	39,120,000
(e) Group Residential Housing Grants	121,080,000	129,238,000
(f) MinnesotaCare Grants	295,046,000	317,272,000

This appropriation is from the health care access fund.

(g) Medical Assistance Grants	4,501,582,000	4,437,282,000
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Managed Care Incentive Payments. The commissioner shall not make managed care incentive payments for expanding preventive services during fiscal years beginning July 1, 2011, and July 1, 2012.

Reduction of Rates for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, lead agencies must reduce rates in effect on January 1, 2011, by ten percent for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI. Lead agencies shall consult with providers to review individual service plans and identify changes or modifications to reduce the utilization of services while maintaining the health and safety of the individual receiving services. Lead agencies must adjust contracts within 60 days of the effective date. If federal waiver approval is obtained under the long-term care realignment waiver application submitted on February 13, 2012, and federal financial participation is authorized for the alternative care program, the commissioner shall adjust this payment rate reduction from ten to five percent for services rendered on or after July 1, 2012, or the first day of the month following federal approval, whichever is later. Effective August 1, 2013, this provision does not apply to individuals whose primary diagnosis is mental illness and who are living in foster care settings where the license holder is also (1) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in Minnesota Statutes, section 256B.0623; (2) a mental health center or mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or (3) a provider of intensive residential

treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670.

Reduction of Lead Agency Waiver Allocations to Implement Rate Reductions for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, the commissioner shall reduce lead agency waiver allocations to implement the reduction of rates for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI.

Reduce customized living and 24-hour customized living component rates. Effective July 1, 2011, the commissioner shall reduce elderly waiver customized living and 24-hour customized living component service spending by five percent through reductions in component rates and service rate limits. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, subdivisions 6a and 23, to reflect reductions in component spending for customized living services and 24-hour customized living services under Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h, for the contract period beginning January 1, 2012. To implement the reduction specified in this provision, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a ten percent reduction for the specified services for the period January 1, 2012, to June 30, 2012, and a five percent reduction for those services on or after July 1, 2012.

Limit Growth in the Developmental Disability Waiver. The commissioner shall limit growth in the developmental disability waiver to six diversion allocations per month beginning July 1, 2011, through June 30, 2013, and 15 diversion allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations shall be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, 256B.092, subdivision 12. The limits do not include conversions from intermediate care facilities for persons with developmental disabilities. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Limit Growth in the Community Alternatives for Disabled Individuals Waiver. The commissioner

shall limit growth in the community alternatives for disabled individuals waiver to 60 allocations per month beginning July 1, 2011, through June 30, 2013, and 85 allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations must be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, section 256B.49, subdivision 11a. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the closure or downsizing of a residential facility or nursing facility to serve directly affected individuals on the community alternatives for disabled individuals waiver. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Personal Care Assistance Relative Care. The commissioner shall adjust the capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, to reflect the rate reductions for personal care assistance provided by a relative pursuant to Minnesota Statutes, section 256B.0659, subdivision 11. This rate reduction is effective July 1, 2013.

(h) Alternative Care Grants	46,421,000	46,035,000
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Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) Chemical Dependency Entitlement Grants	94,675,000	93,298,000
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EFFECTIVE DATE. This section is effective August 1, 2013.

Sec. 52. Laws 2012, chapter 247, article 6, section 4, is amended to read:

Sec. 4. BOARD OF NURSING HOME ADMINISTRATORS	\$	-0-	\$ 10,000
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Administrative Services Unit. This appropriation is to provide a grant to the Minnesota Ambulance Association to coordinate and prepare an assessment of the extent and costs of uncompensated care as a direct result of emergency responses on interstate highways in Minnesota. The study will collect appropriate information from medical response units and ambulance services regulated under Minnesota

Statutes, chapter 144E, and to the extent possible, firefighting agencies. In preparing the assessment, the Minnesota Ambulance Association shall consult with its membership, the Minnesota Fire Chiefs Association, the Office of the State Fire Marshal, and the Emergency Medical Services Regulatory Board. The findings of the assessment will be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over health and public safety by January 1, 2013. This is a onetime appropriation.

Sec. 53. RECOMMENDATIONS FOR CONCENTRATION LIMITS ON HOME AND COMMUNITY-BASED SETTINGS.

The commissioner of human services shall consult with the Minnesota Olmstead subcabinet, advocates, providers, and city representatives to develop recommendations on concentration limits on home and community-based settings, as defined in Minnesota Statutes, section 256B.492, as well as any other exceptions to the definition. The recommendations must be consistent with Minnesota's Olmstead plan. The recommendations and proposed legislation must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2014.

Sec. 54. TRAINING OF AUTISM SERVICE PROVIDERS.

The commissioners of health and human services shall ensure that the departments' autism-related service providers receive training in culturally appropriate approaches to serving the Somali, Latino, Hmong, and Indigenous American Indian communities, and other cultural groups experiencing a disproportionate incidence of autism.

Sec. 55. DIRECTION TO COMMISSIONER; SPOUSAL DISREGARD.

The commissioner of human services shall request authority, in whatever form is necessary, from the federal Centers for Medicare and Medicaid Services to allow persons under age 65 participating in the home and community-based services waivers to continue to use the disregard of the nonassisted spouse's income and assets instead of the spousal impoverishment provisions under the federal Patient Protection and Affordable Care Act, Public Law 111-148, section 2404, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, or regulations or guidance issued under, those acts.

Sec. 56. DIRECTION TO COMMISSIONER; ABA.

By January 1, 2014, the commissioner of human services shall apply to the federal Centers for Medicare and Medicaid Services for a waiver or other authority to provide applied behavioral analysis services to children with autism spectrum disorder and related conditions under the medical assistance program.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 57. RECOMMENDATIONS ON RAISING THE ASSET LIMITS FOR SENIORS AND PERSONS WITH DISABILITIES.

The commissioner of human services shall consult with interested stakeholders to develop recommendations and a request for a federal 1115 demonstration waiver in order to increase the asset limit for individuals eligible for medical assistance due to disability or age who are not residing in a nursing facility, intermediate care facility for persons with developmental disabilities, or other institution whose costs for room and board are covered by medical assistance or state funds. The recommendations must be provided to the legislative committees and divisions with jurisdiction over health and human services policy and finance by February 1, 2014.

Sec. 58. NURSING HOME LEVEL OF CARE REPORT.

(a) The commissioner of human services shall report on the impact of the modification to the nursing facility level of care to be implemented January 1, 2014, including the following:

(1) the number of individuals who lose eligibility for home and community-based services waivers under Minnesota Statutes, sections 256B.0915 and 256B.49, and alternative care under Minnesota Statutes, section 256B.0913;

(2) the number of individuals who lose eligibility for medical assistance; and

(3) for individuals reported under clauses (1) and (2), and to the extent possible:

(i) their living situation before and after nursing facility level of care implementation; and

(ii) the programs or services they received before and after nursing facility level of care implementation, including, but not limited to, personal care assistant services and essential community supports.

(b) The commissioner of human services shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information required under paragraph (a). A preliminary report shall be submitted on October 1, 2014, and a final report shall be submitted February 15, 2015.

Sec. 59. ASSISTIVE TECHNOLOGY EQUIPMENT FOR HOME AND COMMUNITY-BASED SERVICES WAIVERS FUNDING DEVELOPMENT.

(a) For the purposes of this section, "assistive technology equipment" includes computer tablets, passive sensors, and other forms of technology allowing increased safety and independence, and used by those receiving services through a home and community-based services waiver under Minnesota Statutes, sections 256B.0915, 256B.092, and 256B.49.

(b) The commissioner of human services shall develop recommendations for assistive technology equipment funding to enable individuals receiving services identified in paragraph (a) to live in the least restrictive setting possible. In developing the funding, the commissioner shall examine funding for the following:

(1) an assessment process to match the appropriate assistive technology equipment with the waiver recipient, including when the recipient's condition changes or progresses;

(2) the use of monitoring services, if applicable, to the assistive technology equipment identified in clause (1);

(3) the leasing of assistive technology equipment as a possible alternative to purchasing the equipment; and

(4) ongoing support services, such as technological support.

(c) The commissioner shall provide the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance a recommendation for implementing an assistive technology equipment program as developed in paragraph (b) by February 1, 2014.

Sec. 60. **PROVIDER RATE AND GRANT INCREASE EFFECTIVE APRIL 1, 2014.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by one percent for the rate period beginning April 1, 2014, for services rendered on or after those dates. County or tribal contracts for services specified in this section must be amended to pass through these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waived services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) waived services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) brain injury waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waived services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service, formerly funded under Minnesota Statutes 2010, chapter 256M;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(12) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256M;

(13) consumer support grants under Minnesota Statutes, section 256.476;

(14) family support grants under Minnesota Statutes, section 252.32;

(15) housing access grants under Minnesota Statutes, sections 256B.0658 and 256B.0917, subdivision 14;

(16) self-advocacy grants under Laws 2009, chapter 101;

(17) technology grants under Laws 2009, chapter 79;

(18) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917, and 256B.0928;
and

(19) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9; and Laws 1997, First Special Session chapter 5, section 20.

(c) A managed care plan receiving state payments for the services in this section must include these increases in their payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a one percent increase for the specified services for the period beginning April 1, 2014.

(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

Sec. 61. SAFETY NET FOR HOME AND COMMUNITY-BASED SERVICES WAIVERS.

The commissioner of human services shall submit a request by December 31, 2013, to the federal government to amend the home and community-based services waivers for individuals with disabilities authorized under Minnesota Statutes, section 256B.49, to modify the financial management of the home and community-based services waivers to provide a state-administered safety net when costs for an individual increase above an identified threshold. The implementation of the safety net may result in a decreased allocation for individual counties, tribes, or collaboratives of counties or tribes, but must not result in a net decreased statewide allocation.

Sec. 62. SHARED LIVING MODEL.

The commissioner of human services shall develop and promote a shared living model option for individuals receiving services through the home and community-based services waivers for individuals with disabilities, authorized under Minnesota Statutes, section 256B.092 or 256B.49, as an option for individuals who require 24-hour assistance. The option must be a companion model with a limit of one or two individuals receiving support in the home, planned respite for the caregiver, and the availability of intensive training and support on the needs of the individual or individuals. Any necessary amendments to implement the model must be submitted to the federal government by December 31, 2013.

Sec. 63. MONEY FOLLOWS THE PERSON GRANT.

The commissioner of human services shall submit to the federal government all necessary waiver amendments to implement the Money Follows the Person federal grant by December 31, 2013.

Sec. 64. REPEALER.

Minnesota Statutes 2012, sections 256B.0917, subdivision 14; 256B.096, subdivisions 1, 2, 3, and 4; 256B.14, subdivision 3a; and 256B.5012, subdivision 13, and Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012, chapter 247, article 4, section 42, and Laws 2012, chapter 298, section 3, are repealed.

ARTICLE 8**WAIVER PROVIDER STANDARDS**

Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a subdivision to read:

Subd. 7c. **Human services license holders.** Section 245D.095, subdivision 3, requires certain license holders to protect service recipient records in accordance with specified provisions of this chapter.

Sec. 2. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:

Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47, an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or a hospice provider licensed under sections 144A.75 to 144A.755.

Sec. 3. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:

Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this subdivision, "health care facility" means a facility:

(1) licensed by the commissioner of health as a hospital, boarding care home or supervised living facility under sections 144.50 to 144.58, or a nursing home under chapter 144A;

(2) registered by the commissioner of health as a housing with services establishment as defined in section 144D.01; or

(3) licensed by the commissioner of human services as a residential facility under chapter 245A to provide adult foster care, adult mental health treatment, chemical dependency treatment to adults, or residential services to persons with ~~developmental~~ disabilities.

(b) Prior to admission to a health care facility, a person required to register under this section shall disclose to:

(1) the health care facility employee processing the admission the person's status as a registered predatory offender under this section; and

(2) the person's corrections agent, or if the person does not have an assigned corrections agent, the law enforcement authority with whom the person is currently required to register, that inpatient admission will occur.

(c) A law enforcement authority or corrections agent who receives notice under paragraph (b) or who knows that a person required to register under this section is planning to be admitted and receive, or has been admitted and is receiving health care at a health care facility shall notify the administrator of the facility and deliver a fact sheet to the administrator containing the following information: (1) name and physical description of the offender; (2) the offender's conviction history, including the dates of conviction; (3) the risk level classification assigned to the offender under section 244.052, if any; and (4) the profile of likely victims.

(d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care facility receives a fact sheet under paragraph (c) that includes a risk level classification for the offender, and if the facility admits the offender, the facility shall distribute the fact sheet to all residents at the facility. If the facility determines that distribution to a resident is not appropriate given the resident's medical, emotional, or mental status, the facility shall distribute the fact sheet to the patient's next of kin or emergency contact.

Sec. 4. **[245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**

Subdivision 1. Rules. The commissioner of human services shall, within 24 months of enactment of this section, adopt rules governing the use of positive support strategies, safety interventions, and emergency use of manual restraint in facilities and services licensed under chapter 245D.

Subd. 2. Data collection. (a) The commissioner shall, with stakeholder input, develop data collection elements specific to incidents of emergency use of manual restraint and positive support transition plans for persons receiving services from providers governed under chapter 245D effective January 1, 2014. Providers shall report the data in a format and at a frequency determined by the commissioner of human services. Providers shall submit the data to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

(b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures identified in Minnesota Rules, part 9525.2740, in a format and at a frequency determined by the commissioner. Providers shall submit the data to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

Sec. 5. Minnesota Statutes 2012, section 245.91, is amended by adding a subdivision to read:

Subd. 3a. Emergency use of manual restraint. "Emergency use of manual restraint" has the meaning given in section 245D.02, subdivision 8a, and applies to services licensed under chapter 245D.

Sec. 6. Minnesota Statutes 2012, section 245.94, subdivision 2, is amended to read:

Subd. 2. Matters appropriate for review. (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client or reports of emergency use of manual restraint as identified in section 245D.061, served by an agency, facility, or program, or actions of an agency, facility, or program that:

- (1) may be contrary to law or rule;
- (2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;
- (3) may be mistaken in law or arbitrary in the ascertainment of facts;
- (4) may be unclear or inadequately explained, when reasons should have been revealed;
- (5) may result in abuse or neglect of a person receiving treatment;
- (6) may disregard the rights of a client or other individual served by an agency or facility;
- (7) may impede or promote independence, community integration, and productivity for clients; or
- (8) may impede or improve the monitoring or evaluation of services provided to clients.

(b) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

Sec. 7. Minnesota Statutes 2012, section 245.94, subdivision 2a, is amended to read:

Subd. 2a. Mandatory reporting. Within 24 hours after a client suffers death or serious injury, the agency, facility, or program director shall notify the ombudsman of the death or serious injury. The emergency use of manual restraint must be reported to the ombudsman as required under section 245D.061,

subdivision 10. The ombudsman is authorized to receive identifying information about a deceased client according to Code of Federal Regulations, title 42, section 2.15, paragraph (b).

Sec. 8. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:

Subd. 10. **Nonresidential program.** "Nonresidential program" means care, supervision, rehabilitation, training or habilitation of a person provided outside the person's own home and provided for fewer than 24 hours a day, including adult day care programs; and chemical dependency or chemical abuse programs that are located in a nursing home or hospital and receive public funds for providing chemical abuse or chemical dependency treatment services under chapter 254B. Nonresidential programs include home and community-based services ~~and semi-independent living services~~ for persons with ~~developmental disabilities or persons age 65 and older~~ that are provided in or outside of a person's own home under chapter 245D.

Sec. 9. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:

Subd. 14. **Residential program.** "Residential program" means a program that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation, or treatment outside a person's own home, including a program in an intermediate care facility for four or more persons with developmental disabilities; and chemical dependency or chemical abuse programs that are located in a hospital or nursing home and receive public funds for providing chemical abuse or chemical dependency treatment services under chapter 254B. Residential programs include home and community-based services for persons with ~~developmental disabilities or persons age 65 and older~~ that are provided in or outside of a person's own home under chapter 245D.

Sec. 10. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. Exceptions to the moratorium include:

- (1) foster care settings that are required to be registered under chapter 144D;
- (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);
- (3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities;
- (4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or
- (5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall

consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:

(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;

(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and

(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.

(d) ~~When a foster care recipient~~ an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for adult foster care settings where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (f) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

(e) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (d) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or

(2) the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(f) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (d) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and

statewide data and information. By February 1 of each year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

(g) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(h) License holders of foster care homes identified under paragraph (g) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. ~~These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.~~

Sec. 11. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall prohibit a program that is excluded from licensure under subdivision 2, paragraph (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any application received from such an excluded provider is processed in the same manner as all other applications for child care center licensure.

Sec. 12. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

Subd. 9. **Permitted services by an individual who is related.** Notwithstanding subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a person receiving supported living services may provide licensed services to that person if:

(1) the person who receives supported living services received these services in a residential site on July 1, 2005;

(2) the services under clause (1) were provided in a corporate foster care setting for adults and were funded by the developmental disabilities home and community-based services waiver defined in section 256B.092;

(3) the individual who is related obtains and maintains both a license under chapter 245B or successor licensing requirements for the provision of supported living services and an adult foster care license under Minnesota Rules, parts 9555.5105 to 9555.6265; and

(4) the individual who is related is not the guardian of the person receiving supported living services.

Sec. 13. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:

Subd. 3. **Implementation.** (a) The commissioner shall implement the responsibilities of this chapter according to the timelines in paragraphs (b) and (c) only within the limits of available appropriations or other administrative cost recovery methodology.

(b) The licensure of home and community-based services according to this section shall be implemented January 1, 2014. License applications shall be received and processed on a phased-in

schedule as determined by the commissioner beginning July 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that the application is complete according to section 245A.04.

(c) Within the limits of available appropriations or other administrative cost recovery methodology, implementation of compliance monitoring must be phased in after January 1, 2014.

(1) Applicants who do not currently hold a license issued under ~~this chapter~~ chapter 245B must receive an initial compliance monitoring visit after 12 months of the effective date of the initial license for the purpose of providing technical assistance on how to achieve and maintain compliance with the applicable law or rules governing the provision of home and community-based services under chapter 245D. If during the review the commissioner finds that the license holder has failed to achieve compliance with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing review report with recommendations for achieving and maintaining compliance.

(2) Applicants who do currently hold a license issued under this chapter must receive a compliance monitoring visit after 24 months of the effective date of the initial license.

(d) Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend or revoke a license or issue a fine at any time under section 245A.07, or ~~make issue~~ issue correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

Sec. 14. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was requested and which was not set aside under section 245C.22, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. When the licensing sanction or denial of a license is based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

(b) Except for family child care and child foster care, reconsideration of a maltreatment determination under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder is based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction. In these cases, a fair hearing shall not be conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d. The scope of the contested case hearing must include the maltreatment determination, disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of

the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

(c) In consolidated contested case hearings regarding sanctions issued in family child care, child foster care, family adult day services, ~~and adult foster care,~~ and community residential settings, the county attorney shall defend the commissioner's orders in accordance with section 245A.16, subdivision 4.

(d) The commissioner's final order under subdivision 5 is the final agency action on the issue of maltreatment and disqualification, including for purposes of subsequent background studies under chapter 245C and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(e) When consolidated hearings under this subdivision involve a licensing sanction based on a previous maltreatment determination for which the commissioner has issued a final order in an appeal of that determination under section 256.045, or the individual failed to exercise the right to appeal the previous maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is conclusive on the issue of maltreatment. In such cases, the scope of the administrative law judge's review shall be limited to the disqualification and the licensing sanction or denial of a license. In the case of a denial of a license or a licensing sanction issued to a facility based on a maltreatment determination regarding an individual who is not the license holder or a household member, the scope of the administrative law judge's review includes the maltreatment determination.

(f) The hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge, if:

(1) a maltreatment determination or disqualification, which was not set aside under section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07;

(2) the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245C.03; and

(3) the individual has a hearing right under section 245C.27.

(g) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07 is based on a disqualification for which reconsideration was requested and was not set aside under section 245C.22, and the individual otherwise has no hearing right under section 245C.27, the scope of the administrative law judge's review shall include the denial or sanction and a determination whether the disqualification should be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In determining whether the disqualification should be set aside, the administrative law judge shall consider the factors under section 245C.22, subdivision 4, to determine whether the individual poses a risk of harm to any person receiving services from the license holder.

(h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction under section 245A.07 is based on the termination of a variance under section 245C.30, subdivision 4, the scope of the administrative law judge's review shall include the sanction and a determination whether the disqualification should be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In determining whether the disqualification should be set aside, the administrative law judge shall consider the factors under section 245C.22, subdivision 4, to determine whether the individual poses a risk of harm to any person receiving services from the license holder.

Sec. 15. Minnesota Statutes 2012, section 245A.10, is amended to read:

245A.10 FEES.

Subdivision 1. **Application or license fee required, programs exempt from fee.** (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation of applications and inspection of programs which are licensed under this chapter.

(b) Except as provided under subdivision 2, no application or license fee shall be charged for child foster care, adult foster care, ~~or family and group family child care, or a community residential setting.~~

Subd. 2. **County fees for background studies and licensing inspections.** (a) For purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed \$100 annually. A county agency may also charge a license fee to an applicant or license holder not to exceed \$50 for a one-year license or \$100 for a two-year license.

(b) A county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed \$100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

- (1) in cases of financial hardship;
- (2) if the county has a shortage of providers in the county's area;
- (3) for new providers; or
- (4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

(e) For purposes of adult foster care and child foster care licensing, and licensing the physical plant of a community residential setting, under this chapter, a county agency may charge a fee to a corporate applicant or corporate license holder to recover the actual cost of licensing inspections, not to exceed \$500 annually.

(f) Counties may elect to reduce or waive the fees in paragraph (e) under the following circumstances:

- (1) in cases of financial hardship;
- (2) if the county has a shortage of providers in the county's area; or
- (3) for new providers.

Subd. 3. **Application fee for initial license or certification.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a \$500 application fee with each new application required under this subdivision. An applicant for an initial day services facility license under chapter 245D shall submit a \$250 application fee with each new application. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license to provide services at a specific location.

(1) ~~For a license to provide residential-based habilitation services to persons with developmental disabilities under chapter 245B, an applicant shall submit an application for each county in which the services will be provided. Upon licensure, the license holder may provide services to persons in that~~

~~county plus no more than three persons at any one time in each of up to ten additional counties. A license holder in one county may not provide services under the home and community-based waiver for persons with developmental disabilities to more than three people in a second county without holding a separate license for that second county. Applicants or licensees providing services under this clause to not more than three persons remain subject to the inspection fees established in section 245A.10, subdivision 2, for each location. The license issued by the commissioner must state the name of each additional county where services are being provided to persons with developmental disabilities. A license holder must notify the commissioner before making any changes that would alter the license information listed under section 245A.04, subdivision 7, paragraph (a), including any additional counties where persons with developmental disabilities are being served. For a license to provide home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application to provide services statewide. Notwithstanding paragraph (a), applications received by the commissioner between July 1, 2013, and December 31, 2013, for licensure of services provided under chapter 245D must include an application fee that is equal to the annual license renewal fee under subdivision 4, paragraph (b), or \$500, whichever is less. Applications received by the commissioner after January 1, 2014, must include the application fee required under paragraph (a). Applicants who meet the modified application criteria identified in section 245A.042, subdivision 2, are exempt from paying an application fee.~~

~~(2) For a license to provide supported employment, crisis respite, or semi-independent living services to persons with developmental disabilities under chapter 245B, an applicant shall submit a single application to provide services statewide.~~

~~(3) For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.~~

~~(4) (3) For a license for a private agency to provide foster care or adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application to provide services statewide.~~

~~(c) The initial application fee charged under this subdivision does not include the temporary license surcharge under section 16E.22.~~

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	\$200
25 to 49 persons	\$300
50 to 74 persons	\$400
75 to 99 persons	\$500
100 to 124 persons	\$600
125 to 149 persons	\$700
150 to 174 persons	\$800
175 to 199 persons	\$900
200 to 224 persons	\$1,000
225 or more persons	\$1,100

~~(b) A day training and habilitation program serving persons with developmental disabilities or related conditions shall pay an annual nonrefundable license fee based on the following schedule:~~

Licensed Capacity	License Fee
1 to 24 persons	\$800
25 to 49 persons	\$1,000
50 to 74 persons	\$1,200
75 to 99 persons	\$1,400
100 to 124 persons	\$1,600
125 to 149 persons	\$1,800
150 or more persons	\$2,000

~~Except as provided in paragraph (c), when a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons:~~

~~(c) When a day training and habilitation program serving persons with developmental disabilities or related conditions seeks a single license allowed under section 245B.07, subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed capacity for each location.~~

~~(d) A program licensed to provide supported employment services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$650.~~

~~(e) A program licensed to provide crisis respite services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$700.~~

~~(f) A program licensed to provide semi-independent living services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$700.~~

~~(g) A program licensed to provide residential-based habilitation services under the home and community-based waiver for persons with developmental disabilities shall pay an annual license fee that includes a base rate of \$690 plus \$60 times the number of clients served on the first day of July of the current license year.~~

~~(h) A residential program certified by the Department of Health as an intermediate care facility for persons with developmental disabilities (ICF/MR) and a noncertified residential program licensed to provide health or rehabilitative services for persons with developmental disabilities shall pay an annual nonrefundable license fee based on the following schedule:~~

Licensed Capacity	License Fee
1 to 24 persons	\$535
25 to 49 persons	\$735
50 or more persons	\$935

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require

licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

<u>License Holder Annual Revenue</u>	<u>License Fee</u>
<u>less than or equal to \$10,000</u>	<u>\$200</u>
<u>greater than \$10,000 but less than or equal to \$25,000</u>	<u>\$300</u>
<u>greater than \$25,000 but less than or equal to \$50,000</u>	<u>\$400</u>
<u>greater than \$50,000 but less than or equal to \$100,000</u>	<u>\$500</u>
<u>greater than \$100,000 but less than or equal to \$150,000</u>	<u>\$600</u>
<u>greater than \$150,000 but less than or equal to \$200,000</u>	<u>\$800</u>
<u>greater than \$200,000 but less than or equal to \$250,000</u>	<u>\$1,000</u>
<u>greater than \$250,000 but less than or equal to \$300,000</u>	<u>\$1,200</u>
<u>greater than \$300,000 but less than or equal to \$350,000</u>	<u>\$1,400</u>
<u>greater than \$350,000 but less than or equal to \$400,000</u>	<u>\$1,600</u>
<u>greater than \$400,000 but less than or equal to \$450,000</u>	<u>\$1,800</u>
<u>greater than \$450,000 but less than or equal to \$500,000</u>	<u>\$2,000</u>
<u>greater than \$500,000 but less than or equal to \$600,000</u>	<u>\$2,250</u>
<u>greater than \$600,000 but less than or equal to \$700,000</u>	<u>\$2,500</u>
<u>greater than \$700,000 but less than or equal to \$800,000</u>	<u>\$2,750</u>
<u>greater than \$800,000 but less than or equal to \$900,000</u>	<u>\$3,000</u>
<u>greater than \$900,000 but less than or equal to \$1,000,000</u>	<u>\$3,250</u>
<u>greater than \$1,000,000 but less than or equal to \$1,250,000</u>	<u>\$3,500</u>
<u>greater than \$1,250,000 but less than or equal to \$1,500,000</u>	<u>\$3,750</u>

<u>greater than \$1,500,000 but less than or equal to \$1,750,000</u>	<u>\$4,000</u>
<u>greater than \$1,750,000 but less than or equal to \$2,000,000</u>	<u>\$4,250</u>
<u>greater than \$2,000,000 but less than or equal to \$2,500,000</u>	<u>\$4,500</u>
<u>greater than \$2,500,000 but less than or equal to \$3,000,000</u>	<u>\$4,750</u>
<u>greater than \$3,000,000 but less than or equal to \$3,500,000</u>	<u>\$5,000</u>
<u>greater than \$3,500,000 but less than or equal to \$4,000,000</u>	<u>\$5,500</u>
<u>greater than \$4,000,000 but less than or equal to \$4,500,000</u>	<u>\$6,000</u>
<u>greater than \$4,500,000 but less than or equal to \$5,000,000</u>	<u>\$6,500</u>
<u>greater than \$5,000,000 but less than or equal to \$7,500,000</u>	<u>\$7,000</u>
<u>greater than \$7,500,000 but less than or equal to \$10,000,000</u>	<u>\$8,500</u>
<u>greater than \$10,000,000 but less than or equal to \$12,500,000</u>	<u>\$10,000</u>
<u>greater than \$12,500,000 but less than or equal to \$15,000,000</u>	<u>\$14,000</u>
<u>greater than \$15,000,000</u>	<u>\$18,000</u>

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(†)(c) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	\$600
25 to 49 persons	\$800
50 to 74 persons	\$1,000
75 to 99 persons	\$1,200
100 or more persons	\$1,400

~~(j)~~ (d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	\$760
25 to 49 persons	\$960
50 or more persons	\$1,160

~~(k)~~ (e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	\$1,000
25 to 49 persons	\$1,100
50 to 74 persons	\$1,200
75 to 99 persons	\$1,300
100 or more persons	\$1,400

~~(l)~~ (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	\$2,525
25 or more persons	\$2,725

~~(m)~~ (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	\$450
25 to 49 persons	\$650
50 to 74 persons	\$850

75 to 99 persons	\$1,050
100 or more persons	\$1,250

~~(h)~~ (h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

~~(i)~~ (i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of \$875.

~~(j)~~ (j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	\$500
25 to 49 persons	\$700
50 to 74 persons	\$900
75 to 99 persons	\$1,100
100 or more persons	\$1,300

~~(k)~~ (k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

~~(l)~~ (l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Subd. 6. **License not issued until license or certification fee is paid.** The commissioner shall not issue a license or certification until the license or certification fee is paid. The commissioner shall send a bill for the license or certification fee to the billing address identified by the license holder. If the license holder does not submit the license or certification fee payment by the due date, the commissioner shall send the license holder a past due notice. If the license holder fails to pay the license or certification fee by the due date on the past due notice, the commissioner shall send a final notice to the license holder informing the license holder that the program license will expire on December 31 unless the license fee is paid before December 31. If a license expires, the program is no longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2, must not operate after the expiration date. After a license expires, if the former license holder wishes to provide licensed services, the former license holder must submit a new license application and application fee under subdivision 3.

Subd. 7. **Human services licensing fees to recover expenditures.** Notwithstanding section 16A.1285, subdivision 2, related to activities for which the commissioner charges a fee, the commissioner must plan to fully recover direct expenditures for licensing activities under this chapter over a five-year period. The commissioner may have anticipated expenditures in excess of anticipated revenues in a biennium by using surplus revenues accumulated in previous bienniums.

Subd. 8. **Deposit of license fees.** A human services licensing account is created in the state government special revenue fund. Fees collected under subdivisions 3 and 4 must be deposited in the

human services licensing account and are annually appropriated to the commissioner for licensing activities authorized under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 16. Minnesota Statutes 2012, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (f).

(b) ~~An adult foster care~~ The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a ~~foster care provider~~ facility with a licensed capacity of five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed ~~foster care provider~~ facility is located.

(d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth bed for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed ~~foster care provider~~ facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of a fifth bed for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed ~~foster care provider~~ facility is ~~licensed~~ located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the ~~foster care home~~ facility; and

(4) individuals living in the ~~foster care home~~ facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

- (1) the facility meets the physical environment requirements in the adult foster care licensing rule;
 - (2) the five-bed living arrangement is specified for each resident in the resident's:
 - (i) individualized plan of care;
 - (ii) individual service plan under section 256B.092, subdivision 1b, if required; or
 - (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;
 - (3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and
 - (4) the facility was licensed for adult foster care before March 1, 2011.
- (g) The commissioner shall not issue a new adult foster care license under paragraph (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (f).

Sec. 17. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

Subd. 7. Adult foster care; variance for alternate overnight supervision. (a) The commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts requiring a caregiver to be present in an adult foster care home during normal sleeping hours to allow for alternative methods of overnight supervision. The commissioner may grant the variance if the local county licensing agency recommends the variance and the county recommendation includes documentation verifying that:

- (1) the county has approved the license holder's plan for alternative methods of providing overnight supervision and determined the plan protects the residents' health, safety, and rights;
- (2) the license holder has obtained written and signed informed consent from each resident or each resident's legal representative documenting the resident's or legal representative's agreement with the alternative method of overnight supervision; and
- (3) the alternative method of providing overnight supervision, which may include the use of technology, is specified for each resident in the resident's: (i) individualized plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if required; or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required.

(b) To be eligible for a variance under paragraph (a), the adult foster care license holder must not have had a conditional license issued under section 245A.06, or any other licensing sanction issued under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home.

(c) A license holder requesting a variance under this subdivision to utilize technology as a component of a plan for alternative overnight supervision may request the commissioner's review in the absence of a county recommendation. Upon receipt of such a request from a license holder, the commissioner shall review the variance request with the county.

(d) A variance granted by the commissioner according to this subdivision before January 1, 2014, to a license holder for an adult foster care home must transfer with the license when the license converts to a community residential setting license under chapter 245D. The terms and conditions of the variance remain in effect as approved at the time the variance was granted.

Sec. 18. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:

Subd. 7a. **Alternate overnight supervision technology; adult foster care license and community residential setting licenses.** (a) The commissioner may grant an applicant or license holder an adult foster care or community residential setting license for a residence that does not have a caregiver in the residence during normal sleeping hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder when an incident occurs that may jeopardize the health, safety, or rights of a foster care recipient. The applicant or license holder must comply with all other requirements under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under chapter 245D, and the requirements under this subdivision. The license printed by the commissioner must state in bold and large font:

(1) that the facility is under electronic monitoring; and

(2) the telephone number of the county's common entry point for making reports of suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

(b) Applications for a license under this section must be submitted directly to the Department of Human Services licensing division. The licensing division must immediately notify the ~~host county and lead county contract agency and the host county~~ licensing agency. The licensing division must collaborate with the county licensing agency in the review of the application and the licensing of the program.

(c) Before a license is issued by the commissioner, and for the duration of the license, the applicant or license holder must establish, maintain, and document the implementation of written policies and procedures addressing the requirements in paragraphs (d) through (f).

(d) The applicant or license holder must have policies and procedures that:

(1) establish characteristics of target populations that will be admitted into the home, and characteristics of populations that will not be accepted into the home;

(2) explain the discharge process when a ~~foster care recipient~~ resident served by the program requires overnight supervision or other services that cannot be provided by the license holder due to the limited hours that the license holder is on site;

(3) describe the types of events to which the program will respond with a physical presence when those events occur in the home during time when staff are not on site, and how the license holder's response plan meets the requirements in paragraph (e), clause (1) or (2);

(4) establish a process for documenting a review of the implementation and effectiveness of the response protocol for the response required under paragraph (e), clause (1) or (2). The documentation must include:

(i) a description of the triggering incident;

(ii) the date and time of the triggering incident;

(iii) the time of the response or responses under paragraph (e), clause (1) or (2);

(iv) whether the response met the resident's needs;

(v) whether the existing policies and response protocols were followed; and

(vi) whether the existing policies and protocols are adequate or need modification.

When no physical presence response is completed for a three-month period, the license holder's written policies and procedures must require a physical presence response drill to be conducted for which the effectiveness of the response protocol under paragraph (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

(5) establish that emergency and nonemergency phone numbers are posted in a prominent location in a common area of the home where they can be easily observed by a person responding to an incident who is not otherwise affiliated with the home.

(e) The license holder must document and include in the license application which response alternative under clause (1) or (2) is in place for responding to situations that present a serious risk to the health, safety, or rights of ~~people receiving foster care services in the home~~ residents served by the program:

(1) response alternative (1) requires only the technology to provide an electronic notification or alert to the license holder that an event is underway that requires a response. Under this alternative, no more than ten minutes will pass before the license holder will be physically present on site to respond to the situation; or

(2) response alternative (2) requires the electronic notification and alert system under alternative (1), but more than ten minutes may pass before the license holder is present on site to respond to the situation. Under alternative (2), all of the following conditions are met:

(i) the license holder has a written description of the interactive technological applications that will assist the license holder in communicating with and assessing the needs related to the care, health, and safety of the foster care recipients. This interactive technology must permit the license holder to remotely assess the well being of the ~~foster care recipient~~ resident served by the program without requiring the initiation of the foster care recipient. Requiring the foster care recipient to initiate a telephone call does not meet this requirement;

(ii) the license holder documents how the remote license holder is qualified and capable of meeting the needs of the foster care recipients and assessing foster care recipients' needs under item (i) during the absence of the license holder on site;

(iii) the license holder maintains written procedures to dispatch emergency response personnel to the site in the event of an identified emergency; and

(iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual service plan coordinated service and support plan~~ under section sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, if required, or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time, which may be greater than ten minutes, for the license holder to be on site for that ~~foster care recipient~~ resident.

(f) Each ~~foster care recipient's~~ resident's placement agreement, individual service agreement, and plan must clearly state that the adult foster care or community residential setting license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents served by the program under paragraph (e), clause (1) or (2); and a signed informed consent from each ~~foster care recipient~~ resident served by the program or the person's legal representative documenting the person's or legal representative's agreement with placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

- (1) how any electronic monitoring is incorporated into the alternative supervision system;
- (2) the backup system for any electronic monitoring in times of electrical outages or other equipment malfunctions;
- (3) how the caregivers or direct support staff are trained on the use of the technology;
- (4) the event types and license holder response times established under paragraph (e);

(5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy related to electronic monitoring and related to any electronically recorded data generated by the monitoring system. A ~~foster care recipient~~ resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring. The consent form must explain where and how the electronically recorded data is stored, with whom it will be shared, and how long it is retained; and

(6) the risks and benefits of the alternative overnight supervision system.

The written explanations under clauses (1) to (6) may be accomplished through cross-references to other policies and procedures as long as they are explained to the person giving consent, and the person giving consent is offered a copy.

(g) Nothing in this section requires the applicant or license holder to develop or maintain separate or duplicative policies, procedures, documentation, consent forms, or individual plans that may be required for other licensing standards, if the requirements of this section are incorporated into those documents.

(h) The commissioner may grant variances to the requirements of this section according to section 245A.04, subdivision 9.

(i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and contractors affiliated with the license holder.

(j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to remotely determine what action the license holder needs to take to protect the well-being of the foster care recipient.

(k) The commissioner shall evaluate license applications using the requirements in paragraphs (d) to (f). The commissioner shall provide detailed application forms, including a checklist of criteria needed for approval.

(l) To be eligible for a license under paragraph (a), the adult foster care or community residential setting license holder must not have had a conditional license issued under section 245A.06 or any licensing sanction under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home or community residential setting.

(m) The commissioner shall review an application for an alternative overnight supervision license within 60 days of receipt of the application. When the commissioner receives an application that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant, the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05. The commissioner shall complete subsequent review within 30 days.

(n) Once the application is considered complete under paragraph (m), the commissioner will approve or deny an application for an alternative overnight supervision license within 60 days.

(o) For the purposes of this subdivision, "supervision" means:

(1) oversight by a caregiver or direct support staff as specified in the individual resident's place agreement or coordinated service and support plan and awareness of the resident's needs and activities; and

(2) the presence of a caregiver or direct support staff in a residence during normal sleeping hours, unless a determination has been made and documented in the individual's coordinated service and support

plan that the individual does not require the presence of a caregiver or direct support staff during normal sleeping hours.

Sec. 19. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:

Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care or community residential setting license holder who creates, collects, records, maintains, stores, or discloses any individually identifiable recipient data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:

(1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and

(2) the Minnesota Government Data Practices Act as codified in chapter 13.

(b) For purposes of licensure, the license holder shall be monitored for compliance with the following data privacy and security provisions:

(1) the license holder must control access to data on ~~foster care recipients~~ residents served by the program according to the definitions of public and private data on individuals under section 13.02; classification of the data on individuals as private under section 13.46, subdivision 2; and control over the collection, storage, use, access, protection, and contracting related to data according to section 13.05, in which the license holder is assigned the duties of a government entity;

(2) the license holder must provide each ~~foster care recipient~~ resident served by the program with a notice that meets the requirements under section 13.04, in which the license holder is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the recipient individual that the license holder uses electronic monitoring and, if applicable, that recording technology is used;

(3) the license holder must not install monitoring cameras in bathrooms;

(4) electronic monitoring cameras must not be concealed from the ~~foster care recipients~~ residents served by the program; and

(5) electronic video and audio recordings of ~~foster care recipients~~ residents served by the program shall be stored by the license holder for five days unless: (i) a ~~foster care recipient~~ resident served by the program or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or (ii) the recording captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or a crime under chapter 609. When requested by a recipient resident served by the program or when a recording captures an incident or event of alleged maltreatment or a crime, the license holder must maintain the recording in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in section 626.557, subdivision 12b.

(c) The commissioner shall develop, and make available to license holders and county licensing workers, a checklist of the data privacy provisions to be monitored for purposes of licensure.

Sec. 20. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing

requirements for residential support services to the legislature by January 15, 2012, as a component of the quality outcome standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

(b) Providers licensed under chapter 245B, and providing, contracting, or arranging for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105 to 9555.6265; ~~or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340;~~ and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b)~~ section 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

Sec. 21. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06, or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment; ~~and~~

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours; ~~and~~

(7) variances for community residential setting licenses under chapter 245D.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) County agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

(f) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

Sec. 22. Minnesota Statutes 2012, section 245D.02, is amended to read:

245D.02 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them in this section.

Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given in section 245A.02, subdivision 2b.

Subd. 2a. **Authorized representative.** "Authorized representative" means a parent, family member, advocate, or other adult authorized by the person or the person's legal representative, to serve as a representative in connection with the provision of services licensed under this chapter. This authorization must be in writing or by another method that clearly indicates the person's free choice. The authorized representative must have no financial interest in the provision of any services included in the person's service delivery plan and must be capable of providing the support necessary to assist the person in the use of home and community-based services licensed under this chapter.

Subd. 2b. **Aversive procedure.** "Aversive procedure" means the application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior.

Subd. 2c. **Aversive stimulus.** "Aversive stimulus" means an object, event, or situation that is presented immediately following a behavior in an attempt to suppress the behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines.

Subd. 3. **Case manager.** "Case manager" means the individual designated to provide waiver case management services, care coordination, or long-term care consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions.

Subd. 3a. **Certification.** "Certification" means the commissioner's written authorization for a license holder to provide specialized services based on certification standards in section 245D.33. The term certification and its derivatives have the same meaning and may be substituted for the term licensure and its derivatives in this chapter and chapter 245A.

Subd. 3b. **Chemical restraint.** "Chemical restraint" means the administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement and is not a standard treatment or dosage for the person's medical or psychological condition.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subd. 4a. **Community residential setting.** "Community residential setting" means a residential program as identified in section 245A.11, subdivision 8, where residential supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant of the facility licensed according to this chapter, and the license holder does not reside in the facility.

Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.

Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated service and support plan addendum" means the documentation that this chapter requires of the license holder for each person receiving services.

Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265, where the license holder does not live in the home.

Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the ability and the will to respond to the unique needs of a person that arise from the person's culture and the ability to use the person's culture as a resource or tool to assist with the intervention and help meet the person's needs.

Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed according to this chapter at which persons receive day services licensed under this chapter from the license holder's direct support staff for a cumulative total of more than 30 days within any 12-month period and the license holder is the owner, lessor, or tenant of the facility.

Subd. 5. **Department.** "Department" means the Department of Human Services.

Subd. 5a. **Deprivation procedure.** "Deprivation procedure" means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Oftentimes the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.

Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02, subdivision 11, and is used interchangeably with the term "direct support service."

Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means employees of the license holder who have direct contact with persons served by the program and includes temporary staff or subcontractors, regardless of employer, providing program services for hire under the control of the license holder who have direct contact with persons served by the program.

Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary daily operation of the program including, but not limited to, fires, severe weather, natural disasters, power failures, or other events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site for more than 24 hours.

Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual restraint" means using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own, do not constitute an emergency.

Subd. 8b. **Expanded support team.** "Expanded support team" means the members of the support team defined in subdivision 46, and a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working with the person and included in the team at the request of the person or the person's legal representative.

Subd. 8c. **Family foster care.** "Family foster care" means a child foster family setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265, where the license holder lives in the home.

Subd. 9. **Health services.** "Health services" means any service or treatment consistent with the physical and mental health needs of the person, such as medication administration and monitoring, medical, dental, nutritional, health monitoring, wellness education, and exercise.

Subd. 10. **Home and community-based services.** "Home and community-based services" means the services ~~subject to the provisions of this chapter~~ identified in section 245D.03, subdivision 1, and as defined in:

(1) the federal ~~federally~~ approved waiver plans governed by United States Code, title 42, sections 1396 et seq., or the state's alternative care program according to section 256B.0913, including the waivers for persons with disabilities under section 256B.49, subdivision 11, including the brain injury (BI) waiver; plan; the community alternative care (CAC) waiver; plan; the community alternatives for disabled individuals (CADI) waiver; plan; the developmental disability (DD) waiver; plan under section 256B.092, subdivision 5; the elderly waiver (EW); and plan under section 256B.0915, subdivision 1; or successor plans respective to each waiver; or

(2) the alternative care (AC) program under section 256B.0913.

Subd. 11. **Incident.** "Incident" means an occurrence ~~that affects the~~ which involves a person and requires the program to make a response that is not a part of the program's ordinary provision of services to a that person, and includes any of the following:

(1) serious injury of a person as determined by section 245.91, subdivision 6;

(2) a person's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition, or the mental health status of a person that requires calling the program to call 911 or a mental health crisis intervention team, physician treatment, or hospitalization;

(4) any mental health crisis that requires the program to call 911 or a mental health crisis intervention team;

(5) an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department;

~~(4)~~ (6) a person's unauthorized or unexplained absence from a program;

~~(5)~~ (7) physical aggression conduct by a person receiving services against another person receiving services that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;

(i) is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;

(ii) places the person in actual and reasonable fear of harm;

(iii) places the person in actual and reasonable fear of damage to property of the person; or

(iv) substantially disrupts the orderly operation of the program;

~~(6)~~ (8) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14; or

(9) any emergency use of manual restraint as identified in section 245D.061; or

~~(7)~~ (10) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.556 or 626.557.

Subd. 11a. **Intermediate care facility for persons with developmental disabilities or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a residential program licensed to serve four or more persons with developmental disabilities under section 252.28 and chapter 245A and licensed as a supervised living facility under chapter 144, which together are certified by the Department of Health as an intermediate care facility for persons with developmental disabilities.

Subd. 11b. **Least restrictive alternative.** "Least restrictive alternative" means the alternative method for providing supports and services that is the least intrusive and most normalized given the level of supervision and protection required for the person. This level of supervision and protection allows risk taking to the extent that there is no reasonable likelihood that serious harm will happen to the person or others.

Subd. 12. **Legal representative.** "Legal representative" means the parent of a person who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about services for a person. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

Subd. 13. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 14. **Licensed health professional.** "Licensed health professional" means a person licensed in Minnesota to practice those professions described in section 214.01, subdivision 2.

Subd. 15. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 15a. **Manual restraint.** "Manual restraint" means physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.

Subd. 15b. **Mechanical restraint.** Except for devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement, or the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition, "mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.

Subd. 16. **Medication.** "Medication" means a prescription drug or over-the-counter drug. For purposes of this chapter, "medication" includes dietary supplements.

~~Subd. 17. **Medication administration.** "Medication administration" means performing the following set of tasks to ensure a person takes both prescription and over-the-counter medications and treatments according to orders issued by appropriately licensed professionals, and includes the following:~~

- ~~(1) checking the person's medication record;~~
- ~~(2) preparing the medication for administration;~~
- ~~(3) administering the medication to the person;~~
- ~~(4) documenting the administration of the medication or the reason for not administering the medication; and~~

~~(5) reporting to the prescriber or a nurse any concerns about the medication, including side effects, adverse reactions, effectiveness, or the person's refusal to take the medication or the person's self-administration of the medication.~~

~~Subd. 18. **Medication assistance.** "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, which includes either of the following:~~

~~(1) bringing to the person and opening a container of previously set up medications and emptying the container into the person's hand or opening and giving the medications in the original container to the person, or bringing to the person liquids or food to accompany the medication; or~~

~~(2) providing verbal or visual reminders to perform regularly scheduled treatments and exercises.~~

~~Subd. 19. **Medication management.** "Medication management" means the provision of any of the following:~~

~~(1) medication-related services to a person;~~

~~(2) medication setup;~~

~~(3) medication administration;~~

~~(4) medication storage and security;~~

~~(5) medication documentation and charting;~~

~~(6) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;~~

~~(7) coordination of medication refills;~~

~~(8) handling changes to prescriptions and implementation of those changes;~~

~~(9) communicating with the pharmacy; or~~

~~(10) coordination and communication with prescriber.~~

~~For the purposes of this chapter, medication management does not mean "medication therapy management services" as identified in section 256B.0625, subdivision 13h.~~

~~Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response providers provider as identified in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children.~~

~~Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.~~

~~Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription."~~

~~Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by the person that can be observed, measured, and determined reliable and valid.~~

~~Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision 11.~~

~~Subd. 23. **Person with a disability.** "Person with a disability" means a person determined to have a disability by the commissioner's state medical review team as identified in section 256B.055, subdivision 7, the Social Security Administration, or the person is determined to have a developmental disability as defined in Minnesota Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section 252.27, subdivision 1a.~~

Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter 147.

Subd. 23b. **Positive support transition plan.** "Positive support transition plan" means the plan required in section 245D.06, subdivision 5, paragraph (b), to be developed by the expanded support team to implement positive support strategies to:

(1) eliminate the use of prohibited procedures as identified in section 245D.06, subdivision 5, paragraph (a);

(2) avoid the emergency use of manual restraint as identified in section 245D.061; and

(3) prevent the person from physically harming self or others.

Subd. 24. **Prescriber.** "Prescriber" means a licensed practitioner as defined in section 151.01, subdivision 23; person who is authorized under section 148.235; 151.01, subdivision 23; or 151.37 to prescribe drugs. For the purposes of this chapter, the term "prescriber" is used interchangeably with "physician."

Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section 151.01, subdivision 17 ~~16~~.

Subd. 26. **Program.** "Program" means either the nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14.

Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Subd. 28. **Restraint.** "Restraint" means ~~physical or mechanical~~ manual restraint as defined in subdivision 15a or mechanical restraint as defined in subdivision 15b, or any other form of restraint that results in limiting of the free and normal movement of body or limbs.

Subd. 29. **Seclusion.** "Seclusion" means separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if he or she chooses the placement of a person alone in a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room.

Subd. 29a. **Self-determination.** "Self-determination" means the person makes decisions independently, plans for the person's own future, determines how money is spent for the person's supports, and takes responsibility for making these decisions. If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act.

Subd. 29b. **Semi-independent living services.** "Semi-independent living services" has the meaning given in section 252.275.

Subd. 30. **Service.** "Service" means care, training, supervision, counseling, consultation, or medication assistance assigned to the license holder in the coordinated service and support plan.

Subd. 31. **Service plan.** "Service plan" means the individual service plan or individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions, and includes any support plans or service needs identified as a result of long-term care consultation, or a support team meeting that includes the participation of the person, the person's legal representative, and case manager, or assigned to a license holder through an authorized service agreement.

Subd. 32. **Service site.** "Service site" means the location where the service is provided to the person, including, but not limited to, a facility licensed according to chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's own home; or a community-based location.

~~Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a person served by the facility, agency, or program.~~

Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning given in Minnesota Rules, part 4665.0100, subpart 10.

Subd. 33b. **Supervision.** (a) "Supervision" means:

(1) oversight by direct support staff as specified in the person's coordinated service and support plan or coordinated service and support plan addendum and awareness of the person's needs and activities;

(2) responding to situations that present a serious risk to the health, safety, or rights of the person while services are being provided; and

(3) the presence of direct support staff at a service site while services are being provided, unless a determination has been made and documented in the person's coordinated service and support plan or coordinated service and support plan addendum that the person does not require the presence of direct support staff while services are being provided.

(b) For the purposes of this definition, "while services are being provided," means any period of time during which the license holder will seek reimbursement for services.

Subd. 34. **Support team.** "Support team" means the service planning team identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14.

Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an ongoing activity to a room, either locked or unlocked, or otherwise separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if the person chooses. For the purpose of chapter 245D, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out" does not include a person voluntarily moving from an ongoing activity to an unlocked room or otherwise separating from a situation or social contact with others if the person chooses. For the purposes of this definition, "voluntarily" means without being forced, compelled, or coerced.

~~Subd. 35. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or the United States, and includes any instrumentality of a unit of government.~~

Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than medications, ordered or prescribed by a licensed health or mental health professional, provided to a person to cure, rehabilitate, or ease symptoms.

Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to a person served by the license holder.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 23. Minnesota Statutes 2012, section 245D.03, is amended to read:

245D.03 APPLICABILITY AND EFFECT.

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of the following basic support services: and intensive support services.

~~(1) housing access coordination as defined under the current BI, CADI, and DD waiver plans or successor plans;~~

~~(2) respite services as defined under the current CADI, BI, CAC, DD, and EW waiver plans or successor plans when the provider is an individual who is not an employee of a residential or nonresidential program licensed by the Department of Human Services or the Department of Health that is otherwise providing the respite service;~~

~~(3) behavioral programming as defined under the current BI and CADI waiver plans or successor plans;~~

~~(4) specialist services as defined under the current DD waiver plan or successor plans;~~

~~(5) companion services as defined under the current BI, CADI, and EW waiver plans or successor plans, excluding companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

~~(6) personal support as defined under the current DD waiver plan or successor plans;~~

~~(7) 24-hour emergency assistance, on-call and personal emergency response as defined under the current CADI and DD waiver plans or successor plans;~~

~~(8) night supervision services as defined under the current BI waiver plan or successor plans;~~

~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW waiver plans or successor plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only;~~

~~(10) independent living skills training as defined under the current BI and CADI waiver plans or successor plans;~~

~~(11) prevocational services as defined under the current BI and CADI waiver plans or successor plans;~~

~~(12) structured day services as defined under the current BI waiver plan or successor plans; or~~

~~(13) supported employment as defined under the current BI and CADI waiver plans or successor plans;~~

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and safety of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community alternatives for disabled individuals, developmental disability, and elderly waiver plans;

(2) companion services as defined under the brain injury, community alternatives for disabled individuals, and elderly waiver plans, excluding companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community alternatives for disabled individuals and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan; and

(6) homemaker services as defined under the community alternatives for disabled individuals, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and safety of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community alternatives for disabled individuals waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(iii) semi-independent living services;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community alternatives for disabled individuals waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided in a supervised living facility that is certified by the Department of Health as an ICF/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.40 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(5) supported employment as defined under the brain injury, developmental disability, and community alternatives for disabled individuals waiver plans.

Subd. 2. **Relationship to other standards governing home and community-based services.** (a) A license holder governed by this chapter is also subject to the licensure requirements under chapter 245A.

~~(b) A license holder concurrently providing child foster care services licensed according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed under this chapter is exempt from section 245D.04 as it applies to the person. A corporate or family child foster care site controlled by a license holder and providing services governed by this chapter is exempt from compliance with section 245D.04. This exemption applies to foster care homes where at least one resident is receiving residential supports and services licensed according to this chapter. This chapter does not apply to corporate or family child foster care homes that do not provide services licensed under this chapter.~~

~~(c) A family adult foster care site controlled by a license holder and providing services governed by this chapter is exempt from compliance with Minnesota Rules, parts 9555.6185; 9555.6225; 9555.6245; 9555.6255; and 9555.6265. These exemptions apply to family adult foster care homes where at least one resident is receiving residential supports and services licensed according to this chapter. This chapter does not apply to family adult foster care homes that do not provide services licensed under this chapter.~~

~~(d) A license holder providing services licensed according to this chapter in a supervised living facility is exempt from compliance with sections 245D.04; 245D.05, subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).~~

~~(e) A license holder providing residential services to persons in an ICF/DD is exempt from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09, subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.~~

~~(e) (f) A license holder concurrently providing home care homemaker services registered licensed according to sections 144A.43 to 144A.49 to the same person receiving home management services licensed under this chapter and registered according to chapter 144A is exempt from compliance with section 245D.04 as it applies to the person.~~

~~(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557, subdivision 14, paragraph (b).~~

~~(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing structured day, prevocational, or supported employment services under this chapter and day training and habilitation or supported employment services licensed under chapter 245B within the same program is exempt from compliance with this chapter when the license holder notifies the commissioner in writing that the requirements under chapter 245B will be met for all persons receiving these services from the program. For the purposes of this paragraph, if the license holder has obtained approval from the commissioner for an alternative inspection status according to section 245B.031, that approval will apply to all persons receiving services in the program.~~

~~(g) Nothing in this chapter prohibits a license holder from concurrently serving persons without disabilities or people who are or are not age 65 and older, provided this chapter's standards are met as well as other relevant standards.~~

~~(h) The documentation required under sections 245D.07 and 245D.071 must meet the individual program plan requirements identified in section 256B.092 or successor provisions.~~

Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant a variance to any of the requirements in this chapter, except sections 245D.04, ~~and 245D.10, subdivision 4, paragraph (b)~~ 245D.06, subdivision 4, paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and information rights of persons.

~~Subd. 4. **License holders with multiple 245D licenses.** (a) When a person changes service from one license to a different license held by the same license holder, the license holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).~~

~~(b) When a staff person begins providing direct service under one or more licenses held by the same license holder, other than the license for which staff orientation was initially provided according to section 245D.09, subdivision 4, the license holder is exempt from those staff orientation requirements, except the staff person must review each person's service plan and medication administration procedures in accordance with section 245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.~~

Subd. 5. **Program certification.** An applicant or a license holder may apply for program certification as identified in section 245D.33.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 24. Minnesota Statutes 2012, section 245D.04, is amended to read:

245D.04 SERVICE RECIPIENT RIGHTS.

Subdivision 1. **License holder responsibility for individual rights of persons served by the program.** The license holder must:

(1) provide each person or each person's legal representative with a written notice that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of those rights within five working days of service initiation and annually thereafter;

(2) make reasonable accommodations to provide this information in other formats or languages as needed to facilitate understanding of the rights by the person and the person's legal representative, if any;

(3) maintain documentation of the person's or the person's legal representative's receipt of a copy and an explanation of the rights; and

(4) ensure the exercise and protection of the person's rights in the services provided by the license holder and as authorized in the coordinated service and support plan.

Subd. 2. **Service-related rights.** A person's service-related rights include the right to:

(1) participate in the development and evaluation of the services provided to the person;

(2) have services and supports identified in the coordinated service and support plan and the coordinated service and support plan addendum provided in a manner that respects and takes into consideration the person's preferences according to the requirements in sections 245D.07 and 245D.071;

(3) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(4) know, in advance, limits to the services available from the license holder, including the license holder's knowledge, skill, and ability to meet the person's service and support needs;

(5) know conditions and terms governing the provision of services, including the license holder's admission criteria and policies and procedures related to temporary service suspension and service termination;

(6) a coordinated transfer to ensure continuity of care when there will be a change in the provider;

(7) know what the charges are for services, regardless of who will be paying for the services, and be notified of changes in those charges;

~~(7)~~ (8) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the person or other private party may have to pay; and

~~(8)~~ (9) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the person's coordinated service and support plan; or coordinated service and support plan addendum.

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except for emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.06;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice;

(14) personal privacy; and

(15) engage in chosen activities.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication; ~~and~~

(3) have use of and free access to common areas in the residence; and

(4) privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom.

(c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a), clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan for the person and or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 25. Minnesota Statutes 2012, section 245D.05, is amended to read:

245D.05 HEALTH SERVICES.

Subdivision 1. **Health needs.** (a) The license holder is responsible for providing meeting health services service needs assigned in the coordinated service and support plan and or the coordinated service and support plan addendum, consistent with the person's health needs. The license holder is responsible for promptly notifying the person or the person's legal representative, if any, and the case manager of changes in a person's physical and mental health needs affecting assigned health services service needs assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, when discovered by the license holder, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

(b) When assigned in the service plan, If responsibility for meeting the person's health service needs has been assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder is required to must maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow in order to:

(1) provide medication administration, assistance or medication assistance, or medication management administration according to this chapter;

(2) monitor health conditions according to written instructions from the person's physician or a licensed health professional;

(3) assist with or coordinate medical, dental, and other health service appointments; or

(4) use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from ~~the person's physician or~~ a licensed health professional.

Subd. 1a. **Medication setup.** For the purposes of this subdivision, "medication setup" means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration when the license holder is assigned responsibility for medication assistance or medication administration in the coordinated service and support plan or the coordinated service and support plan addendum. A prescription label or the prescriber's written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber. The license holder must document in the person's medication administration record: dates of setup, name of medication, quantity of dose, times to be administered, and route of administration at time of setup; and, when the person will be away from home, to whom the medications were given.

Subd. 1b. **Medication assistance.** If responsibility for medication assistance is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that the requirements of subdivision 2, paragraph (b), have been met when staff provides medication assistance to enable a person to self-administer medication or treatment when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person. For the purposes of this subdivision, "medication assistance" means any of the following:

(1) bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person;

(2) bringing to the person liquids or food to accompany the medication; or

(3) providing reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

Subd. 2. **Medication administration.** (a) If responsibility for medication administration is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must implement the following medication administration procedures to ensure a person takes medications and treatments as prescribed:

(1) checking the person's medication record;

(2) preparing the medication as necessary;

(3) administering the medication or treatment to the person;

(4) documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and

(5) reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

(b)(1) The license holder must ensure that the ~~following criteria~~ requirements in clauses (2) to (4) have been met before ~~staff that is not a licensed health professional administers~~ administering medication or treatment;

(+)(2) The license holder must obtain written authorization ~~has been obtained~~ from the person or the person's legal representative to administer medication or treatment ~~orders~~; and must obtain reauthorization annually as needed. If the person or the person's legal representative refuses to authorize the license holder to administer medication, the medication must not be administered. The refusal to authorize medication administration must be reported to the prescriber as expeditiously as possible.

~~(2)~~ (3) The staff person ~~has completed~~ responsible for administering the medication or treatment must complete medication administration training according to section 245D.09, subdivision 4, paragraph 4a, paragraphs (a) and (c), clause (2); and, as applicable to the person, paragraph (d).

~~(3) The medication or treatment will be administered under administration procedures established for the person in consultation with a licensed health professional. written instruction from the person's physician may constitute the medication administration procedures. A prescription label or the prescriber's order for the prescription is sufficient to constitute written instructions from the prescriber. A licensed health professional may delegate medication administration procedures.~~

~~(4) For a license holder providing intensive support services, the medication or treatment must be administered according to the license holder's medication administration policy and procedures as required under section 245D.11, subdivision 2, clause (3).~~

~~(b)~~ (c) The license holder must ensure the following information is documented in the person's medication administration record:

(1) the information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes directions for the person's name, description of the medication or treatment to be provided, and the frequency and other information needed to safely and correctly administering administer the medication or treatment to ensure effectiveness;

(2) information on any ~~discomforts~~; risks; or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;

(3) the possible consequences if the medication or treatment is not taken or administered as directed;

(4) instruction ~~from the prescriber~~ on when and to whom to report the following:

(i) if the a dose of medication or treatment is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person; and

(ii) the occurrence of possible adverse reactions to the medication or treatment;

(5) notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and

(6) notation of when a medication or treatment is started, administered, changed, or discontinued.

~~(c) The license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed with the person or the person's legal representative and the staff administering the medication to identify medication administration issues or errors. At a minimum, the review must be conducted every three months or more often if requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct medication administration issues or errors. If issues or concerns are identified related to the medication itself, the license holder must report those as required under subdivision 4.~~

~~Subd. 3. **Medication assistance.** The license holder must ensure that the requirements of subdivision 2, paragraph (a), have been met when staff provides assistance to enable a person to self-administer medication when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person.~~

~~Subd. 4. **Reviewing and reporting medication and treatment issues.** The following medication administration issues must be reported to the person or the person's legal representative and case manager as they occur or following timelines established in the person's service plan or as requested in writing by~~

~~the person or the person's legal representative, or the case manager.~~ (a) When assigned responsibility for medication administration, the license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify medication administration errors. At a minimum, the review must be conducted every three months, or more frequently as directed in the coordinated service and support plan or coordinated service and support plan addendum or as requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct patterns of medication administration errors when identified.

(b) If assigned responsibility for medication assistance or medication administration, the license holder must report the following to the person's legal representative and case manager as they occur or as otherwise directed in the coordinated service and support plan or the coordinated service and support plan addendum:

(1) any reports made to the person's physician or prescriber required under subdivision 2, paragraph ~~(b)~~ (c), clause (4);

(2) a person's refusal or failure to take or receive medication or treatment as prescribed; or

(3) concerns about a person's self-administration of medication or treatment.

Subd. 5. **Injectable medications.** Injectable medications may be administered according to a prescriber's order and written instructions when one of the following conditions has been met:

(1) a registered nurse or licensed practical nurse will administer the subcutaneous or intramuscular injection;

(2) a supervising registered nurse with a physician's order has delegated the administration of subcutaneous injectable medication to an unlicensed staff member and has provided the necessary training; or

(3) there is an agreement signed by the license holder, the prescriber, and the person or the person's legal representative specifying what subcutaneous injections may be given, when, how, and that the prescriber must retain responsibility for the license holder's giving the injections. A copy of the agreement must be placed in the person's service recipient record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 26. **[245D.051] PSYCHOTROPIC MEDICATION USE AND MONITORING.**

Subdivision 1. **Conditions for psychotropic medication administration.** (a) When a person is prescribed a psychotropic medication and the license holder is assigned responsibility for administration of the medication in the person's coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that the requirements in paragraphs (b) to (d) and section 245D.05, subdivision 2, are met.

(b) Use of the medication must be included in the person's coordinated service and support plan or in the coordinated service and support plan addendum and based on a prescriber's current written or electronically recorded prescription.

(c) The license holder must develop, implement, and maintain the following documentation in the person's coordinated service and support plan addendum according to the requirements in sections 245D.07 and 245D.071:

(1) a description of the target symptoms that the psychotropic medication is to alleviate; and

(2) documentation methods the license holder will use to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medication if required by the prescriber. The license holder must collect and report on medication and symptom-related data as instructed by the prescriber. The license holder must provide the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

For the purposes of this section, "target symptom" refers to any perceptible diagnostic criteria for a person's diagnosed mental disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or successive editions that has been identified for alleviation.

Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the person's legal representative refuses to authorize the administration of a psychotropic medication as ordered by the prescriber, the license holder must follow the requirement in section 245D.05, subdivision 2, paragraph (b), clause (2). After reporting the refusal to the prescriber, the license holder must follow any directives or orders given by the prescriber. A court order must be obtained to override the refusal. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A decision to terminate services must be reached in compliance with section 245D.10, subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 27. Minnesota Statutes 2012, section 245D.06, is amended to read:

245D.06 PROTECTION STANDARDS.

Subdivision 1. **Incident response and reporting.** (a) The license holder must respond to all incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person.

(b) The license holder must maintain information about and report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, ~~or~~ within 24 hours of discovery or receipt of information that an incident occurred, unless the license holder has reason to know that the incident has already been reported, or as otherwise directed in a person's coordinated service and support plan or coordinated service and support plan addendum. An incident of suspected or alleged maltreatment must be reported as required under paragraph (d), and an incident of serious injury or death must be reported as required under paragraph (e).

(c) When the incident involves more than one person, the license holder must not disclose personally identifiable information about any other person when making the report to each person and case manager unless the license holder has the consent of the person.

(d) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment. The license holder must disclose the nature of the activity or occurrence reported and the agency that received the report.

(e) The license holder must report the death or serious injury of the person ~~to the legal representative, if any, and case manager,~~ as required in paragraph (b) and to the Department of Human Services Licensing Division, and the Office of Ombudsman for Mental Health and Developmental Disabilities as required under section 245.94, subdivision 2a, within 24 hours of the death, or receipt of information that the death occurred, unless the license holder has reason to know that the death has already been reported.

(f) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to the Department of Health, Office of Health Facility Complaints, and the Office of Ombudsman for Mental Health and

Developmental Disabilities, as required under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to know that the death has already been reported.

(f) (g) The license holder must conduct a an internal review of incident reports of deaths and serious injuries that occurred while services were being provided and that were not reported by the program as alleged or suspected maltreatment, for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. The review must include an evaluation of whether related policies and procedures were followed, whether the policies and procedures were adequate, whether there is a need for additional staff training, whether the reported event is similar to past events with the persons or the services involved, and whether there is a need for corrective action by the license holder to protect the health and safety of persons receiving services. Based on the results of this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

(h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b), within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061.

Subd. 2. **Environment and safety.** The license holder must:

(1) ensure the following when the license holder is the owner, lessor, or tenant of the service site:

(i) the service site is a safe and hazard-free environment;

(ii) ~~doors are locked or~~ that toxic substances or dangerous items ~~normally accessible~~ are inaccessible to persons served by the program ~~are stored in locked cabinets, drawers, or containers~~ only to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with a person who is receiving services. If ~~doors are locked or~~ toxic substances or dangerous items ~~normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers~~ are made inaccessible, the license holder must justify and document how this determination was made in consultation with the person or person's legal representative, and how access will otherwise be provided to the person and all other affected persons receiving services; and document an assessment of the physical plant, its environment, and its population identifying the risk factors which require toxic substances or dangerous items to be inaccessible and a statement of specific measures to be taken to minimize the safety risk to persons receiving services;

(iii) doors are locked from the inside to prevent a person from exiting only when necessary to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with the person. If doors are locked from the inside, the license holder must document an assessment of the physical plant, the environment and the population served, identifying the risk factors which require the use of locked doors, and a statement of specific measures to be taken to minimize the safety risk to persons receiving services at the service site; and

(iii) (iv) a staff person is available ~~on~~ at the service site who is trained in basic first aid and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, cardiopulmonary resuscitation, "CPR," whenever persons are present and staff are required to be at the site to provide direct service. The CPR training must include in-person instruction, hands-on practice, and an observed skills assessment under the direct supervision of a CPR instructor;

(2) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition when used to provide services;

(3) follow procedures to ensure safe transportation, handling, and transfers of the person and any equipment used by the person, when the license holder is responsible for transportation of a person or a person's equipment;

(4) be prepared for emergencies and follow emergency response procedures to ensure the person's safety in an emergency; and

(5) follow universal precautions and sanitary practices, including hand washing, for infection prevention and control, and to prevent communicable diseases.

~~Subd. 3. **Compliance with fire and safety codes.** When services are provided at a service site licensed according to chapter 245A or where the license holder is the owner, lessor, or tenant of the service site, the license holder must document compliance with applicable building codes, fire and safety codes, health rules, and zoning ordinances, or document that an appropriate waiver has been granted.~~

Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person with the safekeeping of funds or other property according to section 245A.04, subdivision 13, the license holder must have obtain written authorization to do so from the person or the person's legal representative and the case manager. Authorization must be obtained within five working days of service initiation and renewed annually thereafter. At the time initial authorization is obtained, the license holder must survey, document, and implement the preferences of the person or the person's legal representative and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of funds or other property. The license holder must document changes to these preferences when they are requested.

(b) A license holder or staff person may not accept powers-of-attorney from a person receiving services from the license holder for any purpose, ~~and may not accept an appointment as guardian or conservator of a person receiving services from the license holder.~~ This does not apply to license holders that are Minnesota counties or other units of government or to staff persons employed by license holders who were acting as power-of-attorney, guardian, or conservator attorney-in-fact for specific individuals prior to April 23, 2012 implementation of this chapter. The license holder must maintain documentation of the power-of-attorney, guardianship, or conservatorship in the service recipient record.

(c) Upon the transfer or death of a person, any funds or other property of the person must be surrendered to the person or the person's legal representative, or given to the executor or administrator of the estate in exchange for an itemized receipt.

Subd. 5. **Prohibitions Prohibited procedures.** (a) The license holder is prohibited from using psychotropic medication chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience, or for any reason other than as prescribed.

(b) ~~The license holder is prohibited from using restraints or seclusion under any circumstance, unless the commissioner has approved a variance request from the license holder that allows for the emergency use of restraints and seclusion according to terms and conditions approved in the variance. Applicants and license holders who have reason to believe they may be serving an individual who will need emergency use of restraints or seclusion may request a variance on the application or reapplication, and the commissioner shall automatically review the request for a variance as part of the application or reapplication process. License holders may also request the variance any time after issuance of a license. In the event a license holder uses restraint or seclusion for any reason without first obtaining a variance as required, the license holder must report the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the occurrence and request the required variance.~~

Subd. 6. **Restricted procedures.** The following procedures are allowed when the procedures are implemented in compliance with the standards governing their use as identified in clauses (1) to (3). Allowed but restricted procedures include:

(1) permitted actions and procedures subject to the requirements in subdivision 7;

(2) procedures identified in a positive support transition plan subject to the requirements in subdivision 8; or

(3) emergency use of manual restraint subject to the requirements in section 245D.061.

For purposes of this chapter, this section supersedes the requirements identified in Minnesota Rules, part 9525.2740.

Subd. 7. **Permitted actions and procedures.** (a) Use of the instructional techniques and intervention procedures as identified in paragraphs (b) and (c), is permitted when used on an intermittent or continuous basis. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum as identified in sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

(b) Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:

(1) to calm or comfort a person by holding that person with no resistance from that person;

(2) to protect a person known to be at risk or injury due to frequent falls as a result of a medical condition;

(3) to facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; or

(4) to briefly block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others.

(c) Restraint may be used as an intervention procedure to:

(1) allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition;

(2) assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.

Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in section 245D.061, subdivision 3; or

(3) to position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.

(d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

Subd. 8. **Positive support transition plan.** License holders must develop a positive support transition plan on the forms and in the manner prescribed by the commissioner for a person who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. The positive support transition plan forms and instructions will supersede the requirements in Minnesota Rules, parts 9525.2750; 9525.2760; and 9525.2780. The positive support

transition plan must phase out any existing plans for the emergency or programmatic use of aversive or deprivation procedures prohibited under this chapter within the following timelines:

(1) for persons receiving services from the license holder before January 1, 2014, the plan must be developed and implemented by February 1, 2014, and phased out no later than December 31, 2014; and

(2) for persons admitted to the program on or after January 1, 2014, the plan must be developed and implemented within 30 calendar days of service initiation and phased out no later than 11 months from the date of plan implementation.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 28. **[245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

Subdivision 1. **Standards for emergency use of manual restraints.** The license holder must ensure that emergency use of manual restraints complies with the requirements of this chapter and the license holder's policy and procedures as required under subdivision 10. For the purposes of persons receiving services governed by this chapter, this section supersedes the requirements identified in Minnesota Rules, part 9525.2770.

Subd. 2. **Conditions for emergency use of manual restraint.** Emergency use of manual restraint must meet the following conditions:

(1) immediate intervention must be needed to protect the person or others from imminent risk of physical harm; and

(2) the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

Subd. 3. **Restrictions when implementing emergency use of manual restraint.** (a) Emergency use of manual restraint procedures must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

(2) be implemented with an adult in a manner that constitutes abuse or neglect as defined in section 626.5572, subdivisions 2 and 17;

(3) be implemented in a manner that violates a person's rights and protections identified in section 245D.04;

(4) restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program;

(5) deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;

(6) be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by the program; or

(7) use prone restraint. For the purposes of this section, "prone restraint" means use of manual restraint that places a person in a face-down position. This does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible. Applying back or chest pressure while a person is in the prone or supine position or face-up is prohibited.

Subd. 4. Monitoring emergency use of manual restraint. The license holder shall monitor a person's health and safety during an emergency use of a manual restraint. Staff monitoring the procedure must not be the staff implementing the procedure when possible. The license holder shall complete a monitoring form, approved by the commissioner, for each incident involving the emergency use of a manual restraint.

Subd. 5. Reporting emergency use of manual restraint incident. (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

(1) the staff and persons receiving services who were involved in the incident leading up to the emergency use of manual restraint;

(2) a description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of manual restraint;

(3) a description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented that identifies when, how, and how long the alternative measures were attempted before manual restraint was implemented;

(4) a description of the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident leading up to, during, and following the manual restraint;

(5) whether there was any injury to the person who was restrained or other persons involved in the incident, including staff, before or as a result of the use of manual restraint;

(6) whether there was a debriefing with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident and the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned; and

(7) a copy of the report must be maintained in the person's service recipient record.

(b) Each single incident of emergency use of manual restraint must be reported separately. For the purposes of this subdivision, an incident of emergency use of manual restraint is a single incident when the following conditions have been met:

(1) after implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety;

(2) upon the attempt to release the restraint, the person's behavior immediately re-escalates; and

(3) staff must immediately reimplement the restraint in order to maintain safety.

Subd. 6. Internal review of emergency use of manual restraint. (a) Within five working days of the emergency use of manual restraint, the license holder must complete and document an internal review of each report of emergency use of manual restraint. The review must include an evaluation of whether:

(1) the person's service and support strategies developed according to sections 245D.07 and 245D.071 need to be revised;

(2) related policies and procedures were followed;

(3) the policies and procedures were adequate;

(4) there is a need for additional staff training;

(5) the reported event is similar to past events with the persons, staff, or the services involved; and

(6) there is a need for corrective action by the license holder to protect the health and safety of persons.

(b) Based on the results of the internal review, the license holder must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the license holder, if any. The corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

(c) The license holder must maintain a copy of the internal review and the corrective action plan, if any, in the person's service recipient record.

Subd. 7. **Expanded support team review.** (a) Within five working days after the completion of the internal review required in subdivision 8, the license holder must consult with the expanded support team following the emergency use of manual restraint to:

(1) discuss the incident reported in subdivision 7, to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served; and

(2) determine whether the person's coordinated service and support plan addendum needs to be revised according to sections 245D.07 and 245D.071 to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.

(b) The license holder must maintain a written summary of the expanded support team's discussion and decisions required in paragraph (a) in the person's service recipient record.

Subd. 8. **External review and reporting.** Within five working days of the expanded support team review, the license holder must submit the following to the Department of Human Services, and the Office of the Ombudsman for Mental Health and Developmental Disabilities, as required under section 245.94, subdivision 2a:

(1) the report required under subdivision 7;

(2) the internal review and the corrective action plan required under subdivision 8; and

(3) the summary of the expanded support team review required under subdivision 9.

Subd. 9. **Emergency use of manual restraints policy and procedures.** The license holder must develop, document, and implement a policy and procedures that promote service recipient rights and protect health and safety during the emergency use of manual restraints. The policy and procedures must comply with the requirements of this section and must specify the following:

(1) a description of the positive support strategies and techniques staff must use to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others;

(2) a description of the types of manual restraints the license holder allows staff to use on an emergency basis, if any. If the license holder will not allow the emergency use of manual restraint, the policy and procedure must identify the alternative measures the license holder will require staff to use when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety;

(3) instructions for safe and correct implementation of the allowed manual restraint procedures;

(4) the training that staff must complete and the timelines for completion, before they may implement an emergency use of manual restraint. In addition to the training on this policy and procedure and the orientation and annual training required in section 245D.09, subdivision 4, the training for emergency use of manual restraint must incorporate the following subjects:

(i) alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others;

(ii) de-escalation methods, positive support strategies, and how to avoid power struggles;

(iii) simulated experiences of administering and receiving manual restraint procedures allowed by the license holder on an emergency basis;

(iv) how to properly identify thresholds for implementing and ceasing restrictive procedures;

(v) how to recognize, monitor, and respond to the person's physical signs of distress, including positional asphyxia;

(vi) the physiological and psychological impact on the person and the staff when restrictive procedures are used;

(vii) the communicative intent of behaviors; and

(viii) relationship building;

(5) the procedures and forms to be used to monitor the emergency use of manual restraints, including what must be monitored and the frequency of monitoring per each incident of emergency use of manual restraint, and the person or position who is responsible for monitoring the use;

(6) the instructions, forms, and timelines required for completing and submitting an incident report by the person or persons who implemented the manual restraint; and

(7) the procedures and timelines for conducting the internal review and the expanded support team review, and the person or position responsible for completing the reviews and for ensuring that corrective action is taken or the person's coordinated service and support plan addendum is revised, when determined necessary.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 29. Minnesota Statutes 2012, section 245D.07, is amended to read:

245D.07 SERVICE NEEDS PLANNING AND DELIVERY.

Subdivision 1. **Provision of services.** The license holder must provide services as ~~specified~~ assigned in the coordinated service and support plan ~~and assigned to the license holder~~. The provision of services must comply with the requirements of this chapter and the federal waiver plans.

Subd. 1a. Person-centered planning and service delivery. (a) The license holder must provide services in response to the person's identified needs, interests, preferences, and desired outcomes as specified in the coordinated service and support plan and the coordinated service and support plan addendum, and in compliance with the requirements of this chapter. License holders providing intensive support services must also provide outcome-based services according to the requirements in section 245D.071.

(b) Services must be provided in a manner that supports the person's preferences, daily needs, and activities and accomplishment of the person's personal goals and service outcomes, consistent with the principles of:

(1) person-centered service planning and delivery that:

(i) identifies and supports what is important to the person as well as what is important for the person, including preferences for when, how, and by whom direct support service is provided;

(ii) uses that information to identify outcomes the person desires; and

(iii) respects each person's history, dignity, and cultural background;

(2) self-determination that supports and provides:

(i) opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and

(ii) the affirmation and protection of each person's civil and legal rights; and

(3) providing the most integrated setting and inclusive service delivery that supports, promotes, and allows:

(i) inclusion and participation in the person's community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible and supports the person in developing and maintaining a role as a valued community member;

(ii) opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports; and

(iii) a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety, or rights.

Subd. 2. **Service planning requirements for basic support services.** (a) License holders providing basic support services must meet the requirements of this subdivision.

(b) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(c) Within 60 days of service initiation the license holder must review and revise as needed the preliminary coordinated service and support plan addendum to document the services that will be provided including how, when, and by whom services will be provided, and the person responsible for overseeing the delivery and coordination of services.

(d) The license holder must participate in service planning and support team meetings related to for the person following stated timelines established in the person's coordinated service and support plan or as requested by ~~the support team~~, the person; or the person's legal representative, the support team or the expanded support team.

Subd. 3. **Reports.** The license holder must provide written reports regarding the person's progress or status as requested by the person, the person's legal representative, the case manager, or the team.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 30. **[245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE SUPPORT SERVICES.**

Subdivision 1. Requirements for intensive support services. A license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in section 245D.07, subdivisions 1 and 3, and this section.

Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder must develop, document, and implement an abuse prevention plan according to section 245A.65, subdivision 2.

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(b) Within 45 days of service initiation the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to assess and determine the following based on the person's coordinated service and support plan and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

- (1) the scope of the services to be provided to support the person's daily needs and activities;
- (2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;
- (3) the person's preferences for how services and supports are provided;
- (4) whether the current service setting is the most integrated setting available and appropriate for the person; and
- (5) how services must be coordinated across other providers licensed under this chapter serving the same person to ensure continuity of care for the person.

(c) Within the scope of services, the license holder must, at a minimum, assess the following areas:

- (1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;
- (2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and
- (3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others. The assessments must produce information about the person that is descriptive of the person's overall strengths, functional skills and abilities, and behaviors or symptoms.

Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the 45-day meeting, the license holder must develop and document the service outcomes and supports based on the assessments completed under subdivision 3 and the requirements in section 245D.07, subdivision 1a. The outcomes and supports must be included in the coordinated service and support plan addendum.

(b) The license holder must document the supports and methods to be implemented to support the accomplishment of outcomes related to acquiring, retaining, or improving skills. The documentation must include:

- (1) the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:
 - (i) any changes or modifications to the physical and social environments necessary when the service supports are provided;
 - (ii) any equipment and materials required; and
 - (iii) techniques that are consistent with the person's communication mode and learning style;
- (2) the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;
- (3) the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and

(4) the names of the staff or position responsible for implementing the supports and methods.

(c) Within 20 working days of the 45-day meeting, the license holder must obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and coordinated service and support plan addendum.

Subd. 5. **Progress reviews.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. The license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in progress review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year.

(b) The license holder must summarize the person's progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a written report sent to the person or the person's legal representative and case manager five working days prior to the review meeting, unless the person, the person's legal representative, or the case manager requests to receive the report at the time of the meeting.

(c) Within ten working days of the progress review meeting, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 31. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND OVERSIGHT.**

Subdivision 1. **Program coordination and evaluation.** (a) The license holder is responsible for:

(1) coordination of service delivery and evaluation for each person served by the program as identified in subdivision 2; and

(2) program management and oversight that includes evaluation of the program quality and program improvement for services provided by the license holder as identified in subdivision 3.

(b) The same person may perform the functions in paragraph (a) if the work and education qualifications are met in subdivisions 2 and 3.

Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery and evaluation of services provided by the license holder must be coordinated by a designated staff person. The designated coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities assigned in the person's coordinated service and support plan and the coordinated service and support plan addendum;

(2) taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

(3) instruction and assistance to direct support staff implementing the coordinated service and support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency; and

(4) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.

(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education and training in human services and disability-related fields, and work experience in providing direct care services and supports to persons with disabilities. The designated coordinator must have the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

(1) a baccalaureate degree in a field related to human services, and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(2) an associate degree in a field related to human services, and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(3) a diploma in a field related to human services from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or

(4) a minimum of 50 hours of education and training related to human services and disabilities; and

(5) four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3).

Subd. 3. Program management and oversight. (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph (b);

(2) ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

(3) ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and condition of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 32. Minnesota Statutes 2012, section 245D.09, is amended to read:

245D.09 STAFFING STANDARDS.

Subdivision 1. **Staffing requirements.** The license holder must provide the level of direct service support staff sufficient supervision, assistance, and training necessary:

(1) to ensure the health, safety, and protection of rights of each person; and

(2) to be able to implement the responsibilities assigned to the license holder in each person's coordinated service and support plan or identified in the coordinated service and support plan addendum, according to the requirements of this chapter.

Subd. 2. **Supervision of staff having direct contact.** Except for a license holder who is the sole direct ~~service support~~ staff, the license holder must provide adequate supervision of staff providing direct ~~service support~~ to ensure the health, safety, and protection of rights of each person and implementation of the responsibilities assigned to the license holder in each person's ~~service plan~~ coordinated service and support plan or coordinated service and support plan addendum.

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff is providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education to meet the person's needs and additional requirements as written in the coordinated service and support plan or coordinated service and support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and the needs of the general population of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the coordinated service and support plan or coordinated service and support plan addendum;

(2) ~~completion of required~~ demonstrated competency in the orientation and training areas required under this chapter, including and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing and observed skill assessment conducted by the trainer or instructor; and

(3) except for a license holder who is the sole direct ~~service support~~ staff, periodic performance evaluations completed by the license holder of the direct ~~service support~~ staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties or administer medication.

Subd. 4. **Orientation to program requirements.** ~~(a)~~ Except for a license holder who does not supervise any direct service support staff, within ~~90 days of hiring direct service staff~~ 60 days of hire, unless stated otherwise, the license holder must provide and ensure completion of 30 hours of orientation for direct support staff that combines supervised on-the-job training with review of and instruction ~~on~~ in the following areas:

- (1) the job description and how to complete specific job functions, including:
 - (i) responding to and reporting incidents as required under section 245D.06, subdivision 1; and
 - (ii) following safety practices established by the license holder and as required in section 245D.06, subdivision 2;
- (2) the license holder's current policies and procedures required under this chapter, including their location and access, and staff responsibilities related to implementation of those policies and procedures;
- (3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices;
- (4) the service recipient rights ~~under section 245D.04~~, and staff responsibilities related to ensuring the exercise and protection of those rights according to the requirements in section 245D.04;
- (5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment. This orientation must be provided within 72 hours of first providing direct contact services and annually thereafter according to section 245A.65, subdivision 3;
- (6) ~~what constitutes use of restraints, seclusion, and psychotropic medications, and staff responsibilities related to the prohibitions of their use~~ the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person; and
- (7) other topics as determined necessary in the person's coordinated service and support plan by the case manager or other areas identified by the license holder.

~~(b) License holders who provide direct service themselves must complete the orientation required in paragraph (a), clauses (3) to (7).~~

Subd. 4a. **Orientation to individual service recipient needs.** ~~(c)~~ (a) Before ~~providing~~ having unsupervised direct ~~service to contact with~~ a person served by the program, or for whom the staff person has not previously provided direct service support, or any time the plans or procedures identified in ~~clauses (1) and (2) paragraphs (b) to (f)~~ are revised, the staff person must review and receive instruction on the following as it relates requirements in paragraphs (b) to (f) as they relate to the staff person's job functions for that person:

- (b) Training and competency evaluations must include the following:
 - (1) appropriate and safe techniques in personal hygiene and grooming, including hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of daily living (ADLs) as defined under section 256B.0659, subdivision 1;
 - (2) an understanding of what constitutes a healthy diet according to data from the Centers for Disease Control and Prevention and the skills necessary to prepare that diet;
 - (3) skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) as defined under section 256B.0659, subdivision 1; and

(4) demonstrated competence in providing first aid.

(1) (c) The staff person must review and receive instruction on the person's coordinated service and support plan or coordinated service and support plan addendum as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan according to section 245A.65, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans; and.

(2) (d) The staff person must review and receive instruction on medication administration procedures established for the person when medication administration is assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may administer medications only after successful completion of a medication administration training, from a training curriculum developed by a registered nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or physician incorporating. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:

(i) (1) specialized or intensive medical or nursing supervision; and

(ii) (2) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person; and.

(iii) necessary training in order to meet the health service needs of the person as determined by the person's physician.

(e) The staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life, including but not limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer's instructions.

(f) The staff person must review and receive instruction on what constitutes use of restraints, time out, and seclusion, including chemical restraint, and staff responsibilities related to the prohibitions of their use according to the requirements in section 245D.06, subdivision 5, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior and why they are not safe, and the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061.

(g) In the event of an emergency service initiation, the license holder must ensure the training required in this subdivision occurs within 72 hours of the direct support staff person first having unsupervised contact with the person receiving services. The license holder must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

(h) License holders who provide direct support services themselves must complete the orientation required in subdivision 4, clauses (3) to (7).

Subd. 5. **Annual training.** (a) A license holder must provide annual training to direct service support staff on the topics identified in subdivision 4, paragraph (a), clauses (3) to (6) (7), and subdivision 4a. A license holder must provide a minimum of 24 hours of annual training to direct service staff with fewer than five years of documented experience and 12 hours of annual training to direct service staff with five or more years of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a) to (h).

Training on relevant topics received from sources other than the license holder may count toward training requirements.

~~(b) A license holder providing behavioral programming, specialist services, personal support, 24-hour emergency assistance, night supervision, independent living skills, structured day, prevocational, or supported employment services must provide a minimum of eight hours of annual training to direct service staff that addresses:~~

~~(1) topics related to the general health, safety, and service needs of the population served by the license holder; and~~

~~(2) other areas identified by the license holder or in the person's current service plan.~~

~~Training on relevant topics received from sources other than the license holder may count toward training requirements:~~

~~(c) When the license holder is the owner, lessor, or tenant of the service site and whenever a person receiving services is present at the site, the license holder must have a staff person available on site who is trained in basic first aid and, when required in a person's service plan, cardiopulmonary resuscitation.~~

Subd. 5a. **Alternative sources of training.** Orientation or training received by the staff person from sources other than the license holder in the same subjects as identified in subdivision 4 may count toward the orientation and annual training requirements if received in the 12-month period before the staff person's date of hire. The license holder must maintain documentation of the training received from other sources and of each staff person's competency in the required area according to the requirements in subdivision 3.

Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a subcontractor or temporary staff to perform services licensed under this chapter on the license holder's behalf, the license holder must ensure that the subcontractor or temporary staff meets and maintains compliance with all requirements under this chapter that apply to the services to be provided, including training, orientation, and supervision necessary to fulfill their responsibilities. The license holder must ensure that a background study has been completed according to the requirements in sections 245C.03, subdivision 1, and 245C.04. Subcontractors and temporary staff hired by the license holder must meet the Minnesota licensing requirements applicable to the disciplines in which they are providing services. The license holder must maintain documentation that the applicable requirements have been met.

Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide direct support services to persons served by the program receive the training, orientation, and supervision necessary to fulfill their responsibilities. The license holder must ensure that a background study has been completed according to the requirements in sections 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation that the applicable requirements have been met.

Subd. 8. **Staff orientation and training plan.** The license holder must develop a staff orientation and training plan documenting when and how compliance with subdivisions 4, 4a, and 5 will be met.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 33. **[245D.091] INTERVENTION SERVICES.**

Subdivision 1. **Licensure requirements.** An individual meeting the staff qualification requirements of this section who is an employee of a program licensed according to this chapter and providing behavioral support services, specialist services, or crisis respite services is not required to hold a separate license under this chapter. An individual meeting the staff qualifications of this section who is not providing these services as an employee of a program licensed according to this chapter must obtain a license according to this chapter.

Subd. 2. **Behavior professional qualifications.** A behavior professional, as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans, must have competencies in areas related to:

- (1) ethical considerations;
- (2) functional assessment;
- (3) functional analysis;
- (4) measurement of behavior and interpretation of data;
- (5) selecting intervention outcomes and strategies;
- (6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;
- (7) data collection;
- (8) staff and caregiver training;
- (9) support plan monitoring;
- (10) co-occurring mental disorders or neuro-cognitive disorder;
- (11) demonstrated expertise with populations being served; and
- (12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); or

(vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans, must:

- (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services discipline; or
- (2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision

17.

(b) In addition, a behavior analyst must:

(1) have four years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;

(2) have received ten hours of instruction in functional assessment and functional analysis;

(3) have received 20 hours of instruction in the understanding of the function of behavior;

(4) have received ten hours of instruction on design of positive practices behavior support strategies;

(5) have received 20 hours of instruction on the use of behavior reduction approved strategies used only in combination with behavior positive practices strategies;

(6) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives behavioral support; and

(7) be under the direct supervision of a behavior professional.

Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans, must meet the following qualifications:

(1) have an associate's degree in a social services discipline; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received a minimum of four hours of training in functional assessment;

(2) have received 20 hours of instruction in the understanding of the function of behavior;

(3) have received ten hours of instruction on design of positive practices behavioral support strategies;

(4) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior reduction approved intervention to the person who receives behavioral support; and

(5) be under the direct supervision of a behavior professional.

Subd. 5. **Specialist services qualifications.** An individual providing specialist services, as defined in the developmental disabilities waiver plan or successor plan, must have:

(1) the specific experience and skills required of the specialist to meet the needs of the person identified by the person's service planning team; and

(2) the qualifications of the specialist identified in the person's coordinated service and support plan.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 34. [245D.095] RECORD REQUIREMENTS.

Subdivision 1. **Record-keeping systems.** The license holder must ensure that the content and format of service recipient, personnel, and program records are uniform and legible according to the requirements of this chapter.

Subd. 2. **Admission and discharge register.** The license holder must keep a written or electronic register, listing in chronological order the dates and names of all persons served by the program who have

been admitted, discharged, or transferred, including service terminations initiated by the license holder and deaths.

Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of current services provided to each person on the premises where the services are provided or coordinated. When the services are provided in a licensed facility, the records must be maintained at the facility, otherwise the records must be maintained at the license holder's program office. The license holder must protect service recipient records against loss, tampering, or unauthorized disclosure according to the requirements in sections 13.01 to 13.10 and 13.46.

(b) The license holder must maintain the following information for each person:

(1) an admission form signed by the person or the person's legal representative that includes:

(i) identifying information, including the person's name, date of birth, address, and telephone number;
and

(ii) the name, address, and telephone number of the person's legal representative, if any, and a primary emergency contact, the case manager, and family members or others as identified by the person or case manager;

(2) service information, including service initiation information, verification of the person's eligibility for services, documentation verifying that services have been provided as identified in the coordinated service and support plan or coordinated service and support plan addendum according to paragraph (a), and date of admission or readmission;

(3) health information, including medical history, special dietary needs, and allergies, and when the license holder is assigned responsibility for meeting the person's health service needs according to section 245D.05:

(i) current orders for medication, treatments, or medical equipment and a signed authorization from the person or the person's legal representative to administer or assist in administering the medication or treatments, if applicable;

(ii) a signed statement authorizing the license holder to act in a medical emergency when the person's legal representative, if any, cannot be reached or is delayed in arriving;

(iii) medication administration procedures;

(iv) a medication administration record documenting the implementation of the medication administration procedures, and the medication administration record reviews, including any agreements for administration of injectable medications by the license holder according to the requirements in section 245D.05; and

(v) a medical appointment schedule when the license holder is assigned responsibility for assisting with medical appointments;

(4) the person's current coordinated service and support plan or that portion of the plan assigned to the license holder;

(5) copies of the individual abuse prevention plan and assessments as required under section 245D.071, subdivisions 2 and 3;

(6) a record of other service providers serving the person when the person's coordinated service and support plan or coordinated service and support plan addendum identifies the need for coordination between the service providers, that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds, according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports involving the person, required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3, progress review reports as required under section 245D.071, subdivision 5, progress or daily log notes that are recorded by the program, and reports received from other agencies involved in providing services or care to the person; and

(12) discharge summary, including service termination notice and related documentation, when applicable.

Subd. 4. Access to service recipient records. The license holder must ensure that the following people have access to the information in subdivision 1 in accordance with applicable state and federal laws, regulations, or rules:

(1) the person, the person's legal representative, and anyone properly authorized by the person;

(2) the person's case manager;

(3) staff providing services to the person unless the information is not relevant to carrying out the coordinated service and support plan or coordinated service and support plan addendum; and

(4) the county child or adult foster care licenser, when services are also licensed as child or adult foster care.

Subd. 5. Personnel records. (a) The license holder must maintain a personnel record of each employee to document and verify staff qualifications, orientation, and training. The personnel record must include:

(1) the employee's date of hire, completed application, an acknowledgement signed by the employee that job duties were reviewed with the employee and the employee understands those duties, and documentation that the employee meets the position requirements as determined by the license holder;

(2) documentation of staff qualifications, orientation, training, and performance evaluations as required under section 245D.09, subdivisions 3 to 5, including the date the training was completed, the number of hours per subject area, and the name of the trainer or instructor; and

(3) a completed background study as required under chapter 245C.

(b) For employees hired after January 1, 2014, the license holder must maintain documentation in the personnel record or elsewhere, sufficient to determine the date of the employee's first supervised direct contact with a person served by the program, and the date of first unsupervised direct contact with a person served by the program.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 35. Minnesota Statutes 2012, section 245D.10, is amended to read:

245D.10 POLICIES AND PROCEDURES.

Subdivision 1. **Policy and procedure requirements.** ~~The~~ A license holder providing either basic or intensive supports and services must establish, enforce, and maintain policies and procedures as required in this chapter, chapter 245A, and other applicable state and federal laws and regulations governing the provision of home and community-based services licensed according to this chapter.

Subd. 2. **Grievances.** The license holder must establish policies and procedures that provide promote service recipient rights by providing a simple complaint process for persons served by the program and their authorized representatives to bring a grievance that:

(1) provides staff assistance with the complaint process when requested, and the addresses and telephone numbers of outside agencies to assist the person;

(2) allows the person to bring the complaint to the highest level of authority in the program if the grievance cannot be resolved by other staff members, and that provides the name, address, and telephone number of that person;

(3) requires the license holder to promptly respond to all complaints affecting a person's health and safety. For all other complaints, the license holder must provide an initial response within 14 calendar days of receipt of the complaint. All complaints must be resolved within 30 calendar days of receipt or the license holder must document the reason for the delay and a plan for resolution;

(4) requires a complaint review that includes an evaluation of whether:

(i) related policies and procedures were followed and adequate;

(ii) there is a need for additional staff training;

(iii) the complaint is similar to past complaints with the persons, staff, or services involved; and

(iv) there is a need for corrective action by the license holder to protect the health and safety of persons receiving services;

(5) based on the review in clause (4), requires the license holder to develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any;

(6) provides a written summary of the complaint and a notice of the complaint resolution to the person and case manager that:

(i) identifies the nature of the complaint and the date it was received;

(ii) includes the results of the complaint review;

(iii) identifies the complaint resolution, including any corrective action; and

(7) requires that the complaint summary and resolution notice be maintained in the service recipient record.

Subd. 3. **Service suspension and service termination.** (a) The license holder must establish policies and procedures for temporary service suspension and service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person.

(b) The policy must include the following requirements:

(1) the license holder must notify the person or the person's legal representative and case manager in writing of the intended termination or temporary service suspension, and the person's right to seek a temporary order staying the termination of service according to the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

(2) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective when a license holder is providing ~~independent living skills training, structured day, prevocational or supported employment services to the person~~ intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter;

(3) the license holder must provide information requested by the person or case manager when services are temporarily suspended or upon notice of termination;

(4) prior to giving notice of service termination or temporary service suspension, the license holder must document actions taken to minimize or eliminate the need for service suspension or termination;

(5) during the temporary service suspension or service termination notice period, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the person and others;

(6) the license holder must maintain information about the service suspension or termination, including the written termination notice, in the service recipient record; and

(7) the license holder must restrict temporary service suspension to situations in which the person's ~~behavior causes immediate and serious danger to the health and safety of the person or others~~ conduct poses an imminent risk of physical harm to self or others and less restrictive or positive support strategies would not achieve safety.

Subd. 4. **Availability of current written policies and procedures.** (a) The license holder must review and update, as needed, the written policies and procedures required under this chapter.

(b)(1) The license holder must inform the person and case manager of the policies and procedures affecting a person's rights under section 245D.04, and provide copies of those policies and procedures, within five working days of service initiation.

(2) If a license holder only provides basic services and supports, this includes the:

(i) grievance policy and procedure required under subdivision 2; and

(ii) service suspension and termination policy and procedure required under subdivision 3.

(3) For all other license holders this includes the:

(i) policies and procedures in clause (2);

(ii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 10; and

(iii) data privacy requirements under section 245D.11, subdivision 3.

(c) The license holder must provide a written notice to all persons or their legal representatives and case managers at least 30 days before implementing any revised policies and procedures procedural revisions to policies affecting a person's service-related or protection-related rights under section 245D.04 and maltreatment reporting policies and procedures. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the ~~reason~~ reasonable cause for not providing the notice at least 30 days before implementing the revisions.

(d) Before implementing revisions to required policies and procedures, the license holder must inform all employees of the revisions and provide training on implementation of the revised policies and procedures.

(e) The license holder must annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under this chapter, other than those in paragraph

(c). Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 36. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT SERVICES.**

Subdivision 1. **Policy and procedure requirements.** A license holder providing intensive support services as identified in section 245D.03, subdivision 1, paragraph (c), must establish, enforce, and maintain policies and procedures as required in this section.

Subd. 2. **Health and safety.** The license holder must establish policies and procedures that promote health and safety by ensuring:

(1) use of universal precautions and sanitary practices in compliance with section 245D.06, subdivision 2, clause (5);

(2) if the license holder operates a residential program, health service coordination and care according to the requirements in section 245D.05, subdivision 1;

(3) safe medication assistance and administration according to the requirements in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in consultation with a registered nurse, nurse practitioner, physician's assistant, or medical doctor and require completion of medication administration training according to the requirements in section 245D.09, subdivision 4a, paragraph (d). Medication assistance and administration includes, but is not limited to:

(i) providing medication-related services for a person;

(ii) medication setup;

(iii) medication administration;

(iv) medication storage and security;

(v) medication documentation and charting;

(vi) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;

(vii) coordination of medication refills;

(viii) handling changes to prescriptions and implementation of those changes;

(ix) communicating with the pharmacy; and

(x) coordination and communication with prescriber;

(4) safe transportation, when the license holder is responsible for transportation of persons, with provisions for handling emergency situations according to the requirements in section 245D.06, subdivision 2, clauses (2) to (4);

(5) a plan for ensuring the safety of persons served by the program in emergencies as defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies to the license holder. A license holder with a community residential setting or a day service facility license must ensure the policy and procedures comply with the requirements in section 245D.22, subdivision 4;

(6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11; and reporting all incidents required to be reported according to section 245D.06, subdivision 1. The plan must:

(i) provide the contact information of a source of emergency medical care and transportation; and

(ii) require staff to first call 911 when the staff believes a medical emergency may be life threatening, or to call the mental health crisis intervention team when the person is experiencing a mental health crisis; and

(7) a procedure for the review of incidents and emergencies to identify trends or patterns, and corrective action if needed. The license holder must establish and maintain a record-keeping system for the incident and emergency reports. Each incident and emergency report file must contain a written summary of the incident. The license holder must conduct a review of incident reports for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. Each incident report must include:

(i) the name of the person or persons involved in the incident. It is not necessary to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident;

(ii) the date, time, and location of the incident or emergency;

(iii) a description of the incident or emergency;

(iv) a description of the response to the incident or emergency and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;

(v) the name of the staff person or persons who responded to the incident or emergency; and

(vi) the determination of whether corrective action is necessary based on the results of the review.

Subd. 3. **Data privacy.** The license holder must establish policies and procedures that promote service recipient rights by ensuring data privacy according to the requirements in:

(1) the Minnesota Government Data Practices Act, section 13.46, and all other applicable Minnesota laws and rules in handling all data related to the services provided; and

(2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the extent that the license holder performs a function or activity involving the use of protected health information as defined under Code of Federal Regulations, title 45, section 164.501, including, but not limited to, providing health care services; health care claims processing or administration; data analysis, processing, or administration; utilization review; quality assurance; billing; benefit management; practice management; repricing; or as otherwise provided by Code of Federal Regulations, title 45, section 160.103. The license holder must comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164, and all applicable requirements.

Subd. 4. **Admission criteria.** The license holder must establish policies and procedures that promote continuity of care by ensuring that admission or service initiation criteria:

(1) is consistent with the license holder's registration information identified in the requirements in section 245D.031, subdivision 2, and with the service-related rights identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

(2) identifies the criteria to be applied in determining whether the license holder can develop services to meet the needs specified in the person's coordinated service and support plan;

(3) requires a license holder providing services in a health care facility to comply with the requirements in section 243.166, subdivision 4b, to provide notification to residents when a registered predatory offender is admitted into the program or to a potential admission when the facility was already serving a registered predatory offender. For purposes of this clause, "health care facility" means a facility licensed by the commissioner as a residential facility under chapter 245A to provide adult foster care or residential services to persons with disabilities; and

(4) requires that when a person or the person's legal representative requests services from the license holder, a refusal to admit the person must be based on an evaluation of the person's assessed needs and the license holder's lack of capacity to meet the needs of the person. The license holder must not refuse to admit a person based solely on the type of residential services the person is receiving, or solely on the person's severity of disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of communication skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress. Documentation of the basis for refusal must be provided to the person or the person's legal representative and case manager upon request.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 37. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

Subdivision 1. **Community residential settings and day service facilities.** For purposes of this section, "facility" means both a community residential setting and day service facility and the physical plant.

Subd. 2. **Inspections and code compliance.** (a) Physical plants must comply with applicable state and local fire, health, building, and zoning codes.

(b)(1) The facility must be inspected by a fire marshal or their delegate within 12 months before initial licensure to verify that it meets the applicable occupancy requirements as defined in the State Fire Code and that the facility complies with the fire safety standards for that occupancy code contained in the State Fire Code.

(2) The fire marshal inspection of a community residential setting must verify the residence is a dwelling unit within a residential occupancy as defined in section 9.117 of the State Fire Code. A home safety checklist, approved by the commissioner, must be completed for a community residential setting by the license holder and the commissioner before the satellite license is reissued.

(3) The facility shall be inspected according to the facility capacity specified on the initial application form.

(4) If the commissioner has reasonable cause to believe that a potentially hazardous condition may be present or the licensed capacity is increased, the commissioner shall request a subsequent inspection and written report by a fire marshal to verify the absence of hazard.

(5) Any condition cited by a fire marshal, building official, or health authority as hazardous or creating an immediate danger of fire or threat to health and safety must be corrected before a license is issued by the department, and for community residential settings, before a license is reissued.

(c) The facility must maintain in a permanent file the reports of health, fire, and other safety inspections.

(d) The facility's plumbing, ventilation, heating, cooling, lighting, and other fixtures and equipment, including elevators or food service, if provided, must conform to applicable health, sanitation, and safety codes and regulations.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 38. **[245D.22] FACILITY SANITATION AND HEALTH.**

Subdivision 1. **General maintenance.** The license holder must maintain the interior and exterior of buildings, structures, or enclosures used by the facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a sanitary and safe condition. The facility must be clean

and free from accumulations of dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must correct building and equipment deterioration, safety hazards, and unsanitary conditions.

Subd. 2. **Hazards and toxic substances.** The license holder must ensure that service sites owned or leased by the license holder are free from hazards that would threaten the health or safety of a person receiving services by ensuring the requirements in paragraphs (a) to (g) are met.

(a) Chemicals, detergents, and other hazardous or toxic substances must not be stored with food products or in any way that poses a hazard to persons receiving services.

(b) The license holder must install handrails and nonslip surfaces on interior and exterior runways, stairways, and ramps according to the applicable building code.

(c) If there are elevators in the facility, the license holder must have elevators inspected each year. The date of the inspection, any repairs needed, and the date the necessary repairs were made must be documented.

(d) The license holder must keep stairways, ramps, and corridors free of obstructions.

(e) Outside property must be free from debris and safety hazards. Exterior stairs and walkways must be kept free of ice and snow.

(f) Heating, ventilation, air conditioning units, and other hot surfaces and moving parts of machinery must be shielded or enclosed.

(g) Use of dangerous items or equipment by persons served by the program must be allowed in accordance with the person's coordinated service and support plan addendum or the program abuse prevention plan, if not addressed in the coordinated service and support plan addendum.

Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in the facility that are named in section 152.02, subdivision 3, must be stored in a locked storage area permitting access only by persons and staff authorized to administer the medication. This must be incorporated into the license holder's medication administration policy and procedures required under section 245D.11, subdivision 2, clause (3). Medications must be disposed of according to the Environmental Protection Agency recommendations.

Subd. 4. **First aid must be available on site.** (a) A staff person trained in first aid must be available on site and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, be able to provide cardiopulmonary resuscitation, whenever persons are present and staff are required to be at the site to provide direct service. The CPR training must include in-person instruction, hands-on practice, and an observed skills assessment under the direct supervision of a CPR instructor.

(b) A facility must have first aid kits readily available for use by, and that meet the needs of, persons receiving services and staff. At a minimum, the first aid kit must be equipped with accessible first aid supplies including bandages, sterile compresses, scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, and first aid manual.

Subd. 5. **Emergencies.** (a) The license holder must have a written plan for responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the safety of persons served in the facility. The plan must include:

(1) procedures for emergency evacuation and emergency sheltering, including:

(i) how to report a fire or other emergency;

(ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive procedures or equipment to assist with the safe evacuation of persons with physical or sensory disabilities; and

(iii) instructions on closing off the fire area, using fire extinguishers, and activating and responding to alarm systems;

(2) a floor plan that identifies:

(i) the location of fire extinguishers;

(ii) the location of audible or visual alarm systems, including but not limited to manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and sprinkler systems;

(iii) the location of exits, primary and secondary evacuation routes, and accessible egress routes, if any; and

(iv) the location of emergency shelter within the facility;

(3) a site plan that identifies:

(i) designated assembly points outside the facility;

(ii) the locations of fire hydrants; and

(iii) the routes of fire department access;

(4) the responsibilities each staff person must assume in case of emergency;

(5) procedures for conducting quarterly drills each year and recording the date of each drill in the file of emergency plans;

(6) procedures for relocation or service suspension when services are interrupted for more than 24 hours;

(7) for a community residential setting with three or more dwelling units, a floor plan that identifies the location of enclosed exit stairs; and

(8) an emergency escape plan for each resident.

(b) The license holder must:

(1) maintain a log of quarterly fire drills on file in the facility;

(2) provide an emergency response plan that is readily available to staff and persons receiving services;

(3) inform each person of a designated area within the facility where the person should go for emergency shelter during severe weather and the designated assembly points outside the facility; and

(4) maintain emergency contact information for persons served at the facility that can be readily accessed in an emergency.

Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable radio or television set that do not require electricity and can be used if a power failure occurs.

Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated telephone that is readily accessible. A list of emergency numbers must be posted in a prominent location. When an area has a 911 number or a mental health crisis intervention team number, both numbers must be posted and the emergency number listed must be 911. In areas of the state without a 911 number, the numbers listed must be those of the local fire department, police department, emergency transportation, and poison control center. The names and telephone numbers of each person's representative, physician, and dentist must be readily available.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 39. [245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE LICENSURE REQUIREMENTS AND APPLICATION PROCESS.

Subdivision 1. **Separate satellite license required for separate sites.** (a) A license holder providing residential support services must obtain a separate satellite license for each community residential setting located at separate addresses when the community residential settings are to be operated by the same license holder. For purposes of this chapter, a community residential setting is a satellite of the home and community-based services license.

(b) Community residential settings are permitted single-family use homes. After a license has been issued, the commissioner shall notify the local municipality where the residence is located of the approved license.

Subd. 2. **Notification to local agency.** The license holder must notify the local agency within 24 hours of the onset of changes in a residence resulting from construction, remodeling, or damages requiring repairs that require a building permit or may affect a licensing requirement in this chapter.

Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate overnight supervision technology adult foster care license according to section 245A.11, subdivision 7a, that converts to a community residential setting satellite license according to this chapter, must retain that designation.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 40. [245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL PLANT AND ENVIRONMENT.

Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling unit in a residential occupancy.

Subd. 2. **Common area requirements.** The living area must be provided with an adequate number of furnishings for the usual functions of daily living and social activities. The dining area must be furnished to accommodate meals shared by all persons living in the residence. These furnishings must be in good repair and functional to meet the daily needs of the persons living in the residence.

Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in writing, to sharing a bedroom with one another. No more than two people receiving services may share one bedroom.

(b) A single occupancy bedroom must have at least 80 square feet of floor space with a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and other habitable rooms by floor to ceiling walls containing no openings except doorways and must not serve as a corridor to another room used in daily living.

(c) A person's personal possessions and items for the person's own use are the only items permitted to be stored in a person's bedroom.

(d) Unless otherwise documented through assessment as a safety concern for the person, each person must be provided with the following furnishings:

(1) a separate bed of proper size and height for the convenience and comfort of the person, with a clean mattress in good repair;

(2) clean bedding appropriate for the season for each person;

(3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal possessions and clothing; and

(4) a mirror for grooming.

(e) When possible, a person must be allowed to have items of furniture that the person personally owns in the bedroom, unless doing so would interfere with safety precautions, violate a building or fire code, or interfere with another person's use of the bedroom. A person may choose not to have a cabinet, dresser, shelves, or a mirror in the bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may choose to use a mattress other than an innerspring mattress and may choose not to have the mattress on a mattress frame or support. If a person chooses not to have a piece of required furniture, the license holder must document this choice and is not required to provide the item. If a person chooses to use a mattress other than an innerspring mattress or chooses not to have a mattress frame or support, the license holder must document this choice and allow the alternative desired by the person.

(f) A person must be allowed to bring personal possessions into the bedroom and other designated storage space, if such space is available, in the residence. The person must be allowed to accumulate possessions to the extent the residence is able to accommodate them, unless doing so is contraindicated for the person's physical or mental health, would interfere with safety precautions or another person's use of the bedroom, or would violate a building or fire code. The license holder must allow for locked storage of personal items. Any restriction on the possession or locked storage of personal items, including requiring a person to use a lock provided by the license holder, must comply with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if and when the license holder opens the lock.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 41. [245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND WATER.

Subdivision 1. **Water.** Potable water from privately owned wells must be tested annually by a Department of Health-certified laboratory for coliform bacteria and nitrate nitrogens to verify safety. The health authority may require retesting and corrective measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in the event of flooding or an incident which may put the well at risk of contamination. To prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

Subd. 2. **Food.** Food served must meet any special dietary needs of a person as prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day must be served or made available to persons, and nutritious snacks must be available between meals.

Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to prevent contamination, spoilage, or a threat to the health of a person.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 42. [245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION AND HEALTH.

Subdivision 1. **Goods provided by the license holder.** Individual clean bed linens appropriate for the season and the person's comfort, including towels and wash cloths, must be available for each person. Usual or customary goods for the operation of a residence which are communally used by all persons receiving services living in the residence must be provided by the license holder, including household items for meal preparation, cleaning supplies to maintain the cleanliness of the residence, window coverings on windows for privacy, toilet paper, and hand soap.

Subd. 2. **Personal items.** Personal health and hygiene items must be stored in a safe and sanitary manner.

Subd. 3. **Pets and service animals.** Pets and service animals housed within the residence must be immunized and maintained in good health as required by local ordinances and state law. The license holder must ensure that the person and the person's representative are notified before admission of the presence of pets in the residence.

Subd. 4. **Smoking in the residence.** License holders must comply with the requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when smoking is permitted in the residence.

Subd. 5. **Weapons.** Weapons and ammunition must be stored separately in locked areas that are inaccessible to a person receiving services. For purposes of this subdivision, "weapons" means firearms and other instruments or devices designed for and capable of producing bodily harm.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 43. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

Except for day service facilities on the same or adjoining lot, the license holder providing day services must apply for a separate license for each facility-based service site when the license holder is the owner, lessor, or tenant of the service site at which persons receive day services and the license holder's employees who provide day services are present for a cumulative total of more than 30 days within any 12-month period. For purposes of this chapter, a day services facility license is a satellite license of the day services program. A day services program may operate multiple licensed day service facilities in one or more counties in the state. For the purposes of this section, "adjoining lot" means day services facilities that are next door to or across the street from one another.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 44. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND SPACE REQUIREMENTS.**

Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility capacity of each day service facility must be determined by the amount of primary space available, the scheduling of activities at other service sites, and the space requirements of all persons receiving services at the facility, not just the licensed services. The facility capacity must specify the maximum number of persons that may receive services on site at any one time.

(b) When a facility is located in a multifunctional organization, the facility may share common space with the multifunctional organization if the required available primary space for use by persons receiving day services is maintained while the facility is operating. The license holder must comply at all times with all applicable fire and safety codes under section 245A.04, subdivision 2a, and adequate supervision requirements under section 245D.31 for all persons receiving day services.

(c) A day services facility must have a minimum of 40 square feet of primary space available for each person receiving services who is present at the site at any one time. Primary space does not include:

- (1) common areas, such as hallways, stairways, closets, utility areas, bathrooms, and kitchens;
- (2) floor areas beneath stationary equipment; or

(3) any space occupied by persons associated with the multifunctional organization while persons receiving day services are using common space.

Subd. 2. **Individual personal articles.** Each person must be provided space in a closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own use while receiving services at the

facility, unless doing so would interfere with safety precautions, another person's work space, or violate a building or fire code.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 45. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY REQUIREMENTS.**

Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service sites owned or leased by the license holder for storing perishable foods and perishable portions of bag lunches, whether the foods are supplied by the license holder or the persons receiving services, the refrigeration must have a temperature of 40 degrees Fahrenheit or less.

Subd. 2. **Drinking water.** Drinking water must be available to all persons receiving services. If a person is unable to request or obtain drinking water, it must be provided according to that person's individual needs. Drinking water must be provided in single-service containers or from drinking fountains accessible to all persons.

Subd. 3. **Individuals who become ill during the day.** There must be an area in which a person receiving services can rest if:

(1) the person becomes ill during the day;

(2) the person does not live in a licensed residential site;

(3) the person requires supervision; and

(4) there is not a caretaker immediately available. Supervision must be provided until the caretaker arrives to bring the person home.

Subd. 4. **Safety procedures.** The license holder must establish general written safety procedures that include criteria for selecting, training, and supervising persons who work with hazardous machinery, tools, or substances. Safety procedures specific to each person's activities must be explained and be available in writing to all staff members and persons receiving services.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 46. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND FACILITY COVERAGE.**

Subdivision 1. **Scope.** This section applies only to facility-based day services.

Subd. 2. **Factors.** (a) The number of direct support service staff members that a license holder must have on duty at the facility at a given time to meet the minimum staffing requirements established in this section varies according to:

(1) the number of persons who are enrolled and receiving direct support services at that given time;

(2) the staff ratio requirement established under subdivision 3 for each person who is present; and

(3) whether the conditions described in subdivision 8 exist and warrant additional staffing beyond the number determined to be needed under subdivision 7.

(b) The commissioner must consider the factors in paragraph (a) in determining a license holder's compliance with the staffing requirements and must further consider whether the staff ratio requirement established under subdivision 3 for each person receiving services accurately reflects the person's need for staff time.

Subd. 3. **Staff ratio requirement for each person receiving services.** The case manager, in consultation with the interdisciplinary team, must determine at least once each year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio assigned each person and the documentation of how the ratio was arrived at must be kept in each person's individual service plan. Documentation must include an assessment of the person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard assessment form required by the commissioner.

Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a staff ratio requirement of one to four if:

(1) on a daily basis the person requires total care and monitoring or constant hand-over-hand physical guidance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, ambulating; or is not capable of taking appropriate action for self-preservation under emergency conditions; or

(2) the person engages in conduct that poses an imminent risk of physical harm to self or others at a documented level of frequency, intensity, or duration requiring frequent daily ongoing intervention and monitoring as established in the person's coordinated service and support plan or coordinated service and support plan addendum.

Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a staff ratio requirement of one to eight if:

(1) the person does not meet the requirements in subdivision 4; and

(2) on a daily basis the person requires verbal prompts or spot checks and minimal or no physical assistance to successfully complete at least four of the following activities: toileting, communicating basic needs, eating, ambulating, or taking appropriate action for self-preservation under emergency conditions.

Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio requirement of one to six.

Subd. 7. **Determining number of direct support service staff required.** The minimum number of direct support service staff members required at any one time to meet the combined staff ratio requirements of the persons present at that time can be determined by the following steps:

(1) assign to each person in attendance the three-digit decimal below that corresponds to the staff ratio requirement assigned to that person. A staff ratio requirement of one to four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

(2) add all of the three-digit decimals (one three-digit decimal for every person in attendance) assigned in clause (1);

(3) when the sum in clause (2) falls between two whole numbers, round off the sum to the larger of the two whole numbers; and

(4) the larger of the two whole numbers in clause (3) equals the number of direct support service staff members needed to meet the staff ratio requirements of the persons in attendance.

Subd. 8. **Staff to be included in calculating minimum staffing requirement.** Only staff providing direct support must be counted as staff members in calculating the staff-to-participant ratio. A volunteer may be counted as a direct support staff in calculating the staff-to-participant ratio if the volunteer meets the same standards and requirements as paid staff. No person receiving services must be counted as or be substituted for a staff member in calculating the staff-to-participant ratio.

Subd. 9. **Conditions requiring additional direct support staff.** The license holder must increase the number of direct support staff members present at any one time beyond the number arrived at in subdivision 4 if necessary when any one or combination of the following circumstances can be documented by the commissioner as existing:

(1) the health and safety needs of the persons receiving services cannot be met by the number of staff members available under the staffing pattern in effect even though the number has been accurately calculated under subdivision 7; or

(2) the person's conduct frequently presents an imminent risk of physical harm to self or others.

Subd. 10. **Supervision requirements.** (a) At no time must one direct support staff member be assigned responsibility for supervision and training of more than ten persons receiving supervision and training, except as otherwise stated in each person's risk management plan.

(b) In the temporary absence of the director or a supervisor, a direct support staff member must be designated to supervise the center.

Subd. 11. **Multifunctional programs.** A multifunctional program may count other employees of the organization besides direct support staff of the day service facility in calculating the staff-to-participant ratio if the employee is assigned to the day services facility for a specified amount of time, during which the employee is not assigned to another organization or program.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 47. **[245D.32] ALTERNATIVE LICENSING INSPECTIONS.**

Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license holder providing services licensed under this chapter, with a qualifying accreditation and meeting the eligibility criteria in paragraphs (b) and (c), may request approval for an alternative licensing inspection when all services provided under the license holder's license are accredited. A license holder with a qualifying accreditation and meeting the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative licensing inspection for individual community residential settings or day services facilities licensed under this chapter.

(b) In order to be eligible for an alternative licensing inspection, the program must have had at least one inspection by the commissioner following issuance of the initial license. For programs operating a day services facility, each facility must have had at least one on-site inspection by the commissioner following issuance of the initial license.

(c) In order to be eligible for an alternative licensing inspection, the program must have been in substantial and consistent compliance at the time of the last licensing inspection and during the current licensing period. For purposes of this section, "substantial and consistent compliance" means:

(1) the license holder's license was not made conditional, suspended, or revoked;

(2) there have been no substantiated allegations of maltreatment against the license holder;

(3) there were no program deficiencies identified that would jeopardize the health, safety, or rights of persons being served; and

(4) the license holder maintained substantial compliance with the other requirements of chapters 245A and 245C and other applicable laws and rules.

(d) For the purposes of this section, the license holder's license includes services licensed under this chapter that were previously licensed under chapter 245B until December 31, 2013.

Subd. 2. **Qualifying accreditation.** The commissioner must accept a three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) as a qualifying accreditation.

Subd. 3. **Request for approval of an alternative inspection status.** (a) A request for an alternative inspection must be made on the forms and in the manner prescribed by the commissioner. When submitting the request, the license holder must submit all documentation issued by the accrediting body verifying that the license holder has obtained and maintained the qualifying accreditation and has complied with recommendations or requirements from the accrediting body during the period of accreditation. Based on the request and the additional required materials, the commissioner may approve an alternative inspection status.

(b) The commissioner must notify the license holder in writing that the request for an alternative inspection status has been approved. Approval must be granted until the end of the qualifying accreditation period.

(c) The license holder must submit a written request for approval to be renewed one month before the end of the current approval period according to the requirements in paragraph (a). If the license holder does not submit a request to renew approval as required, the commissioner must conduct a licensing inspection.

Subd. 4. **Programs approved for alternative licensing inspection; deemed compliance licensing requirements.** (a) A license holder approved for alternative licensing inspection under this section is required to maintain compliance with all licensing standards according to this chapter.

(b) A license holder approved for alternative licensing inspection under this section must be deemed to be in compliance with all the requirements of this chapter, and the commissioner must not perform routine licensing inspections.

(c) Upon receipt of a complaint regarding the services of a license holder approved for alternative licensing inspection under this section, the commissioner must investigate the complaint and may take any action as provided under section 245A.06 or 245A.07.

Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this section changes the commissioner's responsibilities to investigate alleged or suspected maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

Subd. 6. **Termination or denial of subsequent approval.** Following approval of an alternative licensing inspection, the commissioner may terminate or deny subsequent approval of an alternative licensing inspection if the commissioner determines that:

- (1) the license holder has not maintained the qualifying accreditation;
- (2) the commissioner has substantiated maltreatment for which the license holder or facility is determined to be responsible during the qualifying accreditation period; or
- (3) during the qualifying accreditation period, the license holder has been issued an order for conditional license, fine, suspension, or license revocation that has not been reversed upon appeal.

Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for an alternative licensing inspection have not been met is final and not subject to appeal under the provisions of chapter 14.

Subd. 8. **Commissioner's programs.** Home and community-based services licensed under this chapter for which the commissioner is the license holder with a qualifying accreditation are excluded from being approved for an alternative licensing inspection.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 48. **[245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.**

(a) The commissioner of human services shall issue a mental health certification for services licensed under this chapter when a license holder is determined to have met the requirements under paragraph (b). This certification is voluntary for license holders. The certification shall be printed on the license and identified on the commissioner's public Web site.

(b) The requirements for certification are:

(1) all staff have received at least seven hours of annual training covering all of the following topics:

(i) mental health diagnoses;

(ii) mental health crisis response and de-escalation techniques;

(iii) recovery from mental illness;

(iv) treatment options, including evidence-based practices;

(v) medications and their side effects;

(vi) co-occurring substance abuse and health conditions; and

(vii) community resources;

(2) a mental health professional, as defined in section 245.462, subdivision 18, or a mental health practitioner as defined in section 245.462, subdivision 17, is available for consultation and assistance;

(3) there is a plan and protocol in place to address a mental health crisis; and

(4) each person's individual service and support plan identifies who is providing clinical services and their contact information, and includes an individual crisis prevention and management plan developed with the person.

(c) License holders seeking certification under this section must request this certification on forms and in the manner prescribed by the commissioner.

(d) If the commissioner finds that the license holder has failed to comply with the certification requirements under paragraph (b), the commissioner may issue a correction order and an order of conditional license in accordance with section 245A.06 or may issue a sanction in accordance with section 245A.07, including and up to removal of the certification.

(e) A denial of the certification or the removal of the certification based on a determination that the requirements under paragraph (b) have not been met is not subject to appeal. A license holder that has been denied a certification or that has had a certification removed may again request certification when the license holder is in compliance with the requirements of paragraph (b).

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 49. Minnesota Statutes 2012, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the coordinated service and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

- (3) consulting with relevant medical experts or service providers;
- (4) assisting the person in the identification of potential providers;
- (5) assisting the person to access services and assisting in appeals under section 256.045;
- (6) coordination of services, if coordination is not provided by another service provider;
- (7) evaluation and monitoring of the services identified in the coordinated service and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and
- (8) reviewing coordinated service and support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated service and support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the coordinated service and support plan and habilitation plan.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

- (1) phasing out the use of prohibited procedures;
- (2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and
- (3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

~~(e)~~ (f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 50. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and brain injury waivers. Existing waiver

service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8, a foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

(b) Residential support services must meet the following criteria:

~~(1) providers of residential support services must own or control the residential site;~~

~~(2) the residential site must not be the primary residence of the license holder;~~

~~(3)~~ (1) the residential site must have a designated ~~program supervisor~~ person responsible for program management, oversight, development, and implementation of policies and procedures;

~~(4)~~ (2) the provider of residential support services must provide supervision, training, and assistance as described in the person's coordinated service and support plan; and

~~(5)~~ (3) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~ must be licensed according to chapter 245D. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

Sec. 51. Minnesota Statutes 2012, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the written coordinated service and support plan within ten working days after the case manager receives the plan from the certified assessor;

(2) informing the recipient or the recipient's legal guardian or conservator of service options;

(3) assisting the recipient in the identification of potential service providers and available options for case management service and providers;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved

federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

- (1) phasing out the use of prohibited procedures;
- (2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and
- (3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 52. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

- (1) agreements with enrolled waiver service providers to ensure providers meet Minnesota health care program requirements;
- (2) regular reviews of provider qualifications, and including requests of proof of documentation; and
- (3) processes to gather the necessary information to determine provider qualifications.

(b) Beginning July 1, 2012, staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

(c) Beginning January 1, 2014, service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or, for new providers, prior to initial enrollment if they have not already done so as a part of service licensure requirements.

Sec. 53. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:

Subd. 7. **Applicant and license holder training.** An applicant or license holder for the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is not enrolled as a Minnesota health care program home and community-based services waiver provider at the time of application must ensure that at least one controlling individual completes a onetime training on the requirements for providing home and community-based services ~~from a qualified source~~ as determined by the commissioner, before a provider is enrolled or license is issued. Within six months of enrollment, a newly enrolled home and community-based

waiver service provider must ensure that at least one controlling individual has completed training on waiver and related program billing. Exemptions to new waiver provider training requirements may be granted, as determined by the commissioner.

Sec. 54. Minnesota Statutes 2012, section 256B.4912, is amended by adding a subdivision to read:

Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1, 2013, facilities and services to be licensed under chapter 245D shall submit data regarding the use of emergency use of manual restraint as identified in section 245D.061 in a format and at a frequency identified by the commissioner.

Sec. 55. Minnesota Statutes 2012, section 256B.4912, is amended by adding a subdivision to read:

Subd. 9. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them.

(b) "Controlling individual" means a public body, governmental agency, business entity, officer, owner, or managerial official whose responsibilities include the direction of the management or policies of a program.

(c) "Managerial official" means an individual who has decision-making authority related to the operation of the program and responsibility for the ongoing management of or direction of the policies, services, or employees of the program.

(d) "Owner" means an individual who has direct or indirect ownership interest in a corporation or partnership, or business association enrolling with the Department of Human Services as a provider of waiver services.

Sec. 56. Minnesota Statutes 2012, section 256B.4912, is amended by adding a subdivision to read:

Subd. 10. **Enrollment requirements.** All home and community-based waiver providers must provide, at the time of enrollment and within 30 days of a request, in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) proof of surety bond coverage in the amount of \$50,000 or ten percent of the provider's payments from Medicaid in the previous calendar year, whichever is greater;

(2) proof of fidelity bond coverage in the amount of \$20,000; and

(3) proof of liability insurance.

Sec. 57. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:

Subd. 9a. **Evaluation and referral of reports made to common entry point unit.** The common entry point must screen the reports of alleged or suspected maltreatment for immediate risk and make all necessary referrals as follows:

(1) if the common entry point determines that there is an immediate need for adult protective services, the common entry point agency shall immediately notify the appropriate county agency;

(2) if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;

(3) the common entry point shall refer all reports of alleged or suspected maltreatment to the appropriate lead investigative agency as soon as possible, but in any event no longer than two working days; and

~~(4) if the report involves services licensed by the Department of Human Services and subject to chapter 245D, the common entry point shall refer the report to the county as the lead agency according to clause (3), but shall also notify the Department of Human Services of the report; and~~

~~(5)~~ (4) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman for mental health and developmental disabilities established under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law.

Sec. 58. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home, whether a private home or a housing with services establishment registered under chapter 144D, including those that offer assisted living services under chapter 144G.

~~(b) Except as provided under paragraph (c), for services licensed according to chapter 245D,~~ The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with developmental disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs, the Minnesota sex offender program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including, but not limited to, reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659, ~~or receiving home and community-based services licensed by the Department of Human Services and subject to chapter 245D.~~

Sec. 59. **REPORT ON TRANSFER OF VULNERABLE ADULT MALTREATMENT INVESTIGATION DUTIES.**

(a) The commissioner of human services shall provide a follow-up report on the collection of fees and actual licensing and maltreatment investigation costs resulting from the reform of the standards and oversight for home and community-based services as adopted and funded by the 2013 legislature.

(b) The report must identify actual fees collected based on provider revenue, distinguish the amount of fees collected based on non-medical assistance revenue, and determine the impact of the non-medical assistance revenue on future licensing fees.

(c) The report must recommend how maltreatment investigations, when conducted by the commissioner of human services, should be funded and at what amount. The recommendation must identify whether maltreatment investigation costs should be recovered through licensure fees, an appropriation from the general fund, provider fines for substantiated maltreatment, licensing fee surcharges related to substantiated maltreatment, or a combination of these sources.

(d) The report must contain a cost comparison between similar maltreatment investigations completed by the Minnesota Department of Health and the Department of Human Services, and describe the method of funding for the investigations conducted by the Department of Health.

(e) The report must make recommendations for changes that the commissioner determines are appropriate to reduce the costs of maltreatment investigations.

(f) The commissioner must submit the report with draft legislation proposing alternative fees, if necessary, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by July 1, 2015.

Sec. 60. INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME AND COMMUNITY-BASED SERVICES.

(a) The Department of Health Compliance Monitoring Division and the Department of Human Services Licensing Division shall jointly develop an integrated licensing system for providers of both home care services subject to licensure under Minnesota Statutes, chapter 144A, and for home and community-based services subject to licensure under Minnesota Statutes, chapter 245D. The integrated licensing system shall:

(1) require only one license of any provider of services under Minnesota Statutes, sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

(2) promote quality services that recognize a person's individual needs and protect the person's health, safety, rights, and well-being;

(3) promote provider accountability through application requirements, compliance inspections, investigations, and enforcement actions;

(4) reference other applicable requirements in existing state and federal laws, including the federal Affordable Care Act;

(5) establish internal procedures to facilitate ongoing communications between the agencies and with providers and services recipients about the regulatory activities;

(6) create a link between the agency Web sites so that providers and the public can access the same information regardless of which Web site is accessed initially; and

(7) collect data on identified outcome measures as necessary for the agencies to report to the Centers for Medicare and Medicaid Services.

(b) The joint recommendations for legislative changes to implement the integrated licensing system are due to the legislature by February 15, 2014.

(c) Before implementation of the integrated licensing system, providers licensed as home care providers under Minnesota Statutes, chapter 144A, may also provide home and community-based services subject to licensure under Minnesota Statutes, chapter 245D, without obtaining a home and community-based services license under Minnesota Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall apply to these providers:

(1) the provider must comply with all requirements under Minnesota Statutes, chapter 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

(2) a violation of requirements under Minnesota Statutes, chapter 245D, may be enforced by the Department of Health under the enforcement authority set forth in Minnesota Statutes, section 144A.475; and

(3) the Department of Health will provide information to the Department of Human Services about each provider licensed under this section, including the provider's license application, licensing documents, inspections, information about complaints received, and investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

Sec. 61. **REPEALER.**

(a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and 245B.08, are repealed effective January 1, 2014.

(b) Minnesota Statutes 2012, section 245D.08, is repealed.

ARTICLE 9

WAIVER PROVIDER STANDARDS TECHNICAL CHANGES

Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:

Subd. 5. **Specific purchases.** The solicitation process described in this chapter is not required for acquisition of the following:

- (1) merchandise for resale purchased under policies determined by the commissioner;
- (2) farm and garden products which, as determined by the commissioner, may be purchased at the prevailing market price on the date of sale;
- (3) goods and services from the Minnesota correctional facilities;
- (4) goods and services from rehabilitation facilities and extended employment providers that are certified by the commissioner of employment and economic development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D;
- (5) goods and services for use by a community-based facility operated by the commissioner of human services;
- (6) goods purchased at auction or when submitting a sealed bid at auction provided that before authorizing such an action, the commissioner consult with the requesting agency to determine a fair and reasonable value for the goods considering factors including, but not limited to, costs associated with submitting a bid, travel, transportation, and storage. This fair and reasonable value must represent the limit of the state's bid;
- (7) utility services where no competition exists or where rates are fixed by law or ordinance; and
- (8) goods and services from Minnesota sex offender program facilities.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:

Subdivision 1. **Service contracts.** The commissioner of administration shall ensure that a portion of all contracts for janitorial services; document imaging; document shredding; and mailing, collating, and sorting services be awarded by the state to rehabilitation programs and extended employment providers that are certified by the commissioner of employment and economic development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D. The amount of each contract

awarded under this section may exceed the estimated fair market price as determined by the commissioner for the same goods and services by up to six percent. The aggregate value of the contracts awarded to eligible providers under this section in any given year must exceed 19 percent of the total value of all contracts for janitorial services; document imaging; document shredding; and mailing, collating, and sorting services entered into in the same year. For the 19 percent requirement to be applicable in any given year, the contract amounts proposed by eligible providers must be within six percent of the estimated fair market price for at least 19 percent of the contracts awarded for the corresponding service area.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660, or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable successor rules or laws;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units; or

(10) services for persons with developmental disabilities that are provided under a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until January 1, 1998, or under chapter ~~245B~~ 245D.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The operating standards for special transportation service adopted under this section do not apply to special transportation provided by:

- (1) a common carrier operating on fixed routes and schedules;
- (2) a volunteer driver using a private automobile;
- (3) a school bus as defined in section 169.011, subdivision 71; or
- (4) an emergency ambulance regulated under chapter 144.

(b) The operating standards adopted under this section only apply to providers of special transportation service who receive grants or other financial assistance from either the state or the federal government, or both, to provide or assist in providing that service; except that the operating standards adopted under this section do not apply to any nursing home licensed under section 144A.02, to any board and care facility licensed under section 144.50, or to any day training and habilitation services, day care, or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or program provides transportation to nonresidents on a regular basis and the facility receives reimbursement, other than per diem payments, for that service under rules promulgated by the commissioner of human services.

(c) Notwithstanding paragraph (b), the operating standards adopted under this section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that provides transportation services to consumers or residents of other vendors licensed under chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents and the driver.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:

Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the meanings given them in this section.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:

Subd. 9. **License holder.** "License holder" means an individual, corporation, partnership, voluntary association, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

Subd. 9. **Permitted services by an individual who is related.** Notwithstanding subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a person receiving supported living services may provide licensed services to that person if:

- (1) the person who receives supported living services received these services in a residential site on July 1, 2005;

(2) the services under clause (1) were provided in a corporate foster care setting for adults and were funded by the developmental disabilities home and community-based services waiver defined in section 256B.092;

(3) the individual who is related obtains and maintains both a license under chapter ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105 to 9555.6265; and

(4) the individual who is related is not the guardian of the person receiving supported living services.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:

Subd. 13. **Funds and property; other requirements.** (a) A license holder must ensure that persons served by the program retain the use and availability of personal funds or property unless restrictions are justified in the person's individual plan. ~~This subdivision does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~

(b) The license holder must ensure separation of funds of persons served by the program from funds of the license holder, the program, or program staff.

(c) Whenever the license holder assists a person served by the program with the safekeeping of funds or other property, the license holder must:

(1) immediately document receipt and disbursement of the person's funds or other property at the time of receipt or disbursement, including the person's signature, or the signature of the conservator or payee; and

(2) return to the person upon the person's request, funds and property in the license holder's possession subject to restrictions in the person's treatment plan, as soon as possible, but no later than three working days after the date of request.

(d) License holders and program staff must not:

(1) borrow money from a person served by the program;

(2) purchase personal items from a person served by the program;

(3) sell merchandise or personal services to a person served by the program;

(4) require a person served by the program to purchase items for which the license holder is eligible for reimbursement; or

(5) use funds of persons served by the program to purchase items for which the facility is already receiving public or private payments.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has a disqualification which has not been set aside under section 245C.22;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; or

(4) after July 1, 2012, and upon request by the commissioner, a license holder fails to submit the information required of an applicant under section 245A.04, subdivision 1, paragraph (f) or (g).

A license holder who has had a license suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and (h), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit \$200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and the license holder shall forfeit \$100 for

each occurrence of a violation of law or rule other than those subject to a \$1,000 or \$200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide ~~the residential-based habilitation home and community-based services, as defined under identified in section 245B.02, subdivision 20 245D.03, subdivision 1, and a community residential setting or day services facility license to provide foster care under chapter 245D where the services are provided,~~ may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); ~~or~~ a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified ~~developmental disabilities specialist under section 245B.07, subdivision 4 designated coordinator under section 245D.081, subdivision 2.~~ The qualified professional shall perform the duties required in section 256B.0659.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

Subd. 2. **Contract provisions.** (a) The service contract with each intermediate care facility must include provisions for:

- (1) modifying payments when significant changes occur in the needs of the consumers;
- (2) appropriate and necessary statistical information required by the commissioner;
- (3) annual aggregate facility financial information; and

(4) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

(b) The commissioner of human services and the commissioner of health, in consultation with representatives from counties, advocacy organizations, and the provider community, shall review ~~the~~

~~consolidated standards under chapter 245B and the home and community-based services standards under chapter 245D and the supervised living facility rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for intermediate care facilities in order to enable facilities to implement the performance measures in their contract and provide quality services to residents without a duplication of or increase in regulatory requirements.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:

Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered into through action of their governing bodies, may jointly or cooperatively exercise any power common to the contracting parties or any similar powers, including those which are the same except for the territorial limits within which they may be exercised. The agreement may provide for the exercise of such powers by one or more of the participating governmental units on behalf of the other participating units. The term "governmental unit" as used in this section includes every city, county, town, school district, independent nonprofit firefighting corporation, other political subdivision of this or another state, another state, federally recognized Indian tribe, the University of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under sections 144.50 to 144.56, rehabilitation facilities and extended employment providers that are certified by the commissioner of employment and economic development, ~~day training and habilitation services licensed under sections 245B.01 to 245B.08;~~ day and supported employment services licensed under chapter 245D, and any agency of the state of Minnesota or the United States, and includes any instrumentality of a governmental unit. For the purpose of this section, an instrumentality of a governmental unit means an instrumentality having independent policy-making and appropriating authority.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(b) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve substantial child endangerment, and for reports of maltreatment in facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10; or in a nonlicensed personal care provider association as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

(c) "Substantial child endangerment" means a person responsible for a child's care, and in the case of sexual abuse includes a person who has a significant relationship to the child as defined in section 609.341, or a person in a position of authority as defined in section 609.341, who by act or omission commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

- (2) sexual abuse as defined in paragraph (d);
- (3) abandonment under section 260C.301, subdivision 2;
- (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
- (5) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;
- (6) manslaughter in the first or second degree under section 609.20 or 609.205;
- (7) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;
- (8) solicitation, inducement, and promotion of prostitution under section 609.322;
- (9) criminal sexual conduct under sections 609.342 to 609.3451;
- (10) solicitation of children to engage in sexual conduct under section 609.352;
- (11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;
- (12) use of a minor in sexual performance under section 617.246; or
- (13) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.301, subdivision 3, paragraph (a).

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(e) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(f) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment,

when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 121A.67 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following that are done in anger or without regard to the safety of the child:

- (1) throwing, kicking, burning, biting, or cutting a child;
- (2) striking a child with a closed fist;
- (3) shaking a child under age three;
- (4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;
- (5) unreasonable interference with a child's breathing;
- (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
- (7) striking a child under age one on the face or head;

(8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(9) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(10) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(h) "Report" means any report received by the local welfare agency, police department, county sheriff, or agency responsible for assessing or investigating maltreatment pursuant to this section.

(i) "Facility" means:

(1) a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;

(2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or

(3) a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

(j) "Operator" means an operator or agency as defined in section 245A.02.

(k) "Commissioner" means the commissioner of human services.

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(n) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (e), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (o) from the Department of Human Services.

(o) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (n), the

Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.301, subdivision 3.

(p) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

(q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

(r) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency, or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing. The county sheriff and the head of every local welfare agency, agency responsible for assessing or investigating reports, and police department shall each designate a person within their agency, department, or office who is responsible for ensuring that the notification duties of this paragraph and paragraph (b) are carried out. Nothing in this subdivision shall be construed to require more than one report from any institution, facility, school, or agency.

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter ~~245B~~ 245D; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Any person mandated to report shall receive a summary of the disposition of any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be

licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ 245D, or a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed personal care provider organization as defined in section 256B.04, subdivision 16, and 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 16. **REPEALER.**

Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective January 1, 2014.

ARTICLE 10**HEALTH-RELATED LICENSING BOARDS**

Section 1. Minnesota Statutes 2012, section 148B.17, subdivision 2, is amended to read:

Subd. 2. **Licensure and application fees.** ~~Nonrefundable licensure and application fees charged established by the board are as follows~~ shall not exceed the following amounts:

- (1) application fee for national examination is ~~\$220~~ \$110;
- (2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination is \$110;
- (3) initial LMFT license fee is prorated, but cannot exceed \$125;
- (4) annual renewal fee for LMFT license is \$125;
- (5) late fee for ~~initial Licensed Associate Marriage and Family Therapist LAMFT~~ LMFT license renewal is \$50;
- (6) application fee for LMFT licensure by reciprocity is ~~\$340~~ \$220;
- (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license is \$75;
- (8) annual renewal fee for LAMFT license is \$75;
- (9) late fee for LAMFT renewal is ~~\$50~~ \$25;
- (10) fee for reinstatement of license is \$150; and
- (11) fee for emeritus status is \$125.

Sec. 2. Minnesota Statutes 2012, section 151.19, subdivision 1, is amended to read:

Subdivision 1. **Pharmacy registration licensure requirements.** ~~The board shall require and provide for the annual registration of every pharmacy now or hereafter doing business within this state. Upon the 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 persons as may be qualified by law to conduct a pharmacy. Such certificate shall be displayed in a conspicuous place in the pharmacy for which it is issued and expire on the 30th day of June following the date of issue. It shall be unlawful for any person to conduct a pharmacy unless such certificate has been issued to the person by the board.~~ (a) No person shall operate a pharmacy without first obtaining a license from the board and paying any applicable fee specified in section 151.065. The license shall be displayed in a conspicuous place in the pharmacy for which it is issued and expires on June 30 following the date of issue. It is unlawful for any person to operate a pharmacy unless the license has been issued to the person by the board.

(b) Application for a pharmacy license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a pharmacy located within the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and state law and according to rules adopted by the board. No license shall be issued for a pharmacy located outside of the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal law and, when dispensing medications for residents of this state, the laws of this state, and Minnesota Rules.

(d) No license shall be issued or renewed for a pharmacy that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration.

(e) The board shall require a separate license for each pharmacy located within the state and for each pharmacy located outside of the state at which any portion of the dispensing process occurs for drugs dispensed to residents of this state.

(f) The board shall not issue an initial or renewed license for a pharmacy unless the pharmacy passes an inspection conducted by an authorized representative of the board. In the case of a pharmacy located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) The board shall not issue an initial or renewed license for a pharmacy located outside of the state unless the applicant discloses and certifies:

(1) the location, names, and titles of all principal corporate officers and all pharmacists who are involved in dispensing drugs to residents of this state;

(2) 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;

(3) that it agrees to cooperate with, and provide information to, the board concerning matters related to dispensing drugs to residents of this state;

(4) that, during its regular hours of operation, but no 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

(5) that, upon request of a resident of a long-term care facility located in this state, 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 section 151.415, subdivision 5.

Sec. 3. Minnesota Statutes 2012, section 151.19, subdivision 3, is amended to read:

Subd. 3. Sale of federally restricted medical gases. ~~The board shall require and provide for the annual registration of every person or establishment not licensed as a pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted medical gases. Upon the 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 those persons or places that may be qualified to sell or distribute federally restricted medical gases. The certificate shall be displayed in a conspicuous place in the business for which it is issued and expire on the date set by the board. It is unlawful for a person to sell or distribute federally restricted medical gases unless a certificate has been issued to that person by the board.~~ (a) A person or establishment not licensed as a pharmacy or a practitioner shall not engage in the retail sale or distribution of federally restricted medical gases without first obtaining a registration from the board and paying the applicable fee specified in section 151.065. The registration shall be displayed in a conspicuous place in the business for which it is issued and expires on the date set by the board. It is unlawful for a person to sell or distribute federally restricted medical gases unless a certificate has been issued to that person by the board.

(b) Application for a medical gas distributor registration under this section shall be made in a manner specified by the board.

(c) No registration shall be issued or renewed for a medical gas distributor located within the state unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board. No license shall be issued for a medical gas distributor located outside of the state unless the applicant agrees to operate in a manner prescribed by federal law and, when distributing medical gases for residents of this state, the laws of this state and Minnesota Rules.

(d) No registration shall be issued or renewed for a medical gas distributor that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of the licensure or registration. The board may, by rule, establish standards for the registration of a medical gas distributor that is not required to be licensed or registered by the state in which it is physically located.

(e) The board shall require a separate registration for each medical gas distributor located within the state and for each facility located outside of the state from which medical gases are distributed to residents of this state.

(f) The board shall not issue an initial or renewed registration for a medical gas distributor unless the medical gas distributor passes an inspection conducted by an authorized representative of the board. In the case of a medical gas distributor located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 4. **[151.252] LICENSING OF DRUG MANUFACTURERS; FEES; PROHIBITIONS.**

Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for a drug manufacturer license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a drug manufacturer unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

(d) No license shall be issued or renewed for a drug manufacturer that is required to be registered pursuant to United State Code, title 21, section 360, unless the applicant supplies the board with proof of registration. The board may establish by rule the standards for licensure of drug manufacturers that are not required to be registered under United States Code, title 21, section 360.

(e) No license shall be issued or renewed for a drug manufacturer that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule, standards for the licensure of a drug manufacturer that is not required to be licensed or registered by the state in which it is physically located.

(f) The board shall require a separate license for each facility located within the state at which drug manufacturing occurs and for each facility located outside of the state at which drugs that are shipped into the state are manufactured.

(g) The board shall not issue an initial or renewed license for a drug manufacturing facility unless the facility passes an inspection conducted by an authorized representative of the board. In the case of a drug manufacturing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by

the United States Food and Drug Administration, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Subd. 2. **Prohibition.** It is unlawful for any person engaged in drug manufacturing to sell legend drugs to anyone located in this state except as provided in this chapter.

Subd. 3. **Payment to practitioner; reporting.** Unless prohibited by United States Code, title 42, section 1320a-7h, a drug manufacturer shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement, or other compensation authorized under section 151.461, clauses (4) and (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling \$100 or more to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this subdivision are public data.

Sec. 5. Minnesota Statutes 2012, section 151.37, subdivision 4, is amended to read:

Subd. 4. **Research.** (a) Any qualified person may use legend drugs in the course of a bona fide research project, but cannot administer or dispense such drugs to human beings unless such drugs are prescribed, dispensed, and administered by a person lawfully authorized to do so.

(b) Drugs may be dispensed or distributed by a pharmacy licensed by the board for use by, or administration to, patients enrolled in a bona fide research study that is being conducted pursuant to either an investigational new drug application approved by the United States Food and Drug Administration or that has been approved by an institutional review board. For the purposes of this subdivision only:

(1) a prescription drug order is not required for a pharmacy to dispense a research drug, unless the study protocol requires the pharmacy to receive such an order;

(2) notwithstanding the prescription labeling requirements found in this chapter or the rules promulgated by the board, a research drug may be labeled as required by the study protocol; and

(3) dispensing and distribution of research drugs by pharmacies shall not be considered compounding, manufacturing, or wholesaling under this chapter.

(c) An entity that is under contract to a federal agency for the purpose of distributing drugs for bona fide research studies is exempt from the drug wholesaler licensing requirements of this chapter. Any other entity is exempt from the drug wholesaler licensing requirements of this chapter if the board finds that the entity is licensed or registered according to the laws of the state in which it is physically located and it is distributing drugs for use by, or administration to, patients enrolled in a bona fide research study that is being conducted pursuant to either an investigational new drug application approved by the United States Food and Drug Administration or that has been approved by an institutional review board.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 6. Minnesota Statutes 2012, section 151.47, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) All wholesale drug distributors are subject to the requirements in paragraphs (a) to (f) of this subdivision.

(a) (b) No person or distribution outlet shall act as a wholesale drug distributor without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(c) Application for a wholesale drug distributor license under this section shall be made in a manner specified by the board.

~~(b)~~ (d) No license shall be issued or renewed for a wholesale drug distributor to operate unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

~~(c) The board may require a separate license for each facility directly or indirectly owned or operated by the same business entity within the state, or for a parent entity with divisions, subsidiaries, or affiliate companies within the state, when operations are conducted at more than one location and joint ownership and control exists among all the entities.~~

(e) No license may be issued or renewed for a drug wholesale distributor that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule, standards for the licensure of a drug wholesale distributor that is not required to be licensed or registered by the state in which it is physically located.

(f) The board shall require a separate license for each drug wholesale distributor facility located within the state and for each drug wholesale distributor facility located outside of the state from which drugs are shipped into the state or to which drugs are reverse distributed.

(g) The board shall not issue an initial or renewed license for a drug wholesale distributor facility unless the facility passes an inspection conducted by an authorized representative of the board, or is accredited by an accreditation program approved by the board. In the case of a drug wholesale distributor facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board, or furnishes the board with proof of current accreditation. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

~~(d)~~ (h) As a condition for receiving and retaining a wholesale drug distributor license issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has and will continuously maintain:

- (1) adequate storage conditions and facilities;
- (2) minimum liability and other insurance as may be required under any applicable federal or state law;
- (3) a viable security system that includes an after hours central alarm, or comparable entry detection capability; restricted access to the premises; comprehensive employment applicant screening; and safeguards against all forms of employee theft;
- (4) a system of records describing all wholesale drug distributor activities set forth in section 151.44 for at least the most recent two-year period, which shall be reasonably accessible as defined by board regulations in any inspection authorized by the board;
- (5) principals and persons, including officers, directors, primary shareholders, and key management executives, who must at all times demonstrate and maintain their capability of conducting business in conformity with sound financial practices as well as state and federal law;
- (6) complete, updated information, to be provided to the board as a condition for obtaining and retaining a license, about each wholesale drug distributor to be licensed, including all pertinent corporate licensee information, if applicable, or other ownership, principal, key personnel, and facilities information found to be necessary by the board;
- (7) written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including, but not limited

to, those caused by natural disaster or government emergency, inventory inaccuracies or product shipping and receiving, outdated product or other unauthorized product control, appropriate disposition of returned goods, and product recalls;

(8) sufficient inspection procedures for all incoming and outgoing product shipments; and

(9) operations in compliance with all federal requirements applicable to wholesale drug distribution.

~~(e)~~ (i) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section.

~~(f) A wholesale drug distributor shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement or other compensation authorized under section 151.461, clauses (3) to (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling \$100 or more, to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this provision are public data.~~

Sec. 7. Minnesota Statutes 2012, section 151.47, is amended by adding a subdivision to read:

Subd. 3. **Prohibition.** It is unlawful for any person engaged in wholesale drug distribution to sell drugs to a person located within the state or to receive drugs in reverse distribution from a person located within the state except as provided in this chapter.

Sec. 8. Minnesota Statutes 2012, section 151.49, is amended to read:

151.49 LICENSE RENEWAL APPLICATION PROCEDURES.

Application blanks or notices for renewal of a license required by sections 151.42 to 151.51 shall be mailed or otherwise provided to each licensee on or before the first day of the month prior to the month in which the license expires and, if application for renewal of the license with the required fee and supporting documents is not made before the expiration date, the existing license or renewal shall lapse and become null and void upon the date of expiration.

Sec. 9. [214.075] HEALTH-RELATED LICENSING BOARDS; CRIMINAL BACKGROUND CHECKS.

Subdivision 1. **Applications.** (a) By January 1, 2018, each health-related licensing board, as defined in section 214.01, subdivision 2, shall require applicants for initial licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse in licensure, as defined by the individual health-related licensing boards, to submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI).

(b) An applicant must complete a criminal background check if more than one year has elapsed since the applicant last submitted a background check to the board.

Subd. 2. **Investigations.** If a health-related licensing board has reasonable cause to believe a licensee has been charged with or convicted of a crime in this or any other jurisdiction, the health-related licensing board may require the licensee to submit to a criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI.

Subd. 3. **Consent form; fees; fingerprints.** (a) In order to effectuate the federal and state level, fingerprint-based criminal background check, the applicant or licensee must submit a completed criminal history records check consent form and a full set of fingerprints to the respective health-related licensing board or a designee in the manner and form specified by the board.

(b) The applicant or licensee is responsible for all fees associated with preparation of the fingerprints, the criminal records check consent form, and the criminal background check. The fees for the criminal records background check shall be set by the BCA and the FBI and are not refundable. The fees shall be submitted to the respective health-related licensing board by the applicant or licensee as prescribed by the respective board.

(c) All fees received by the health-related licensing boards under this subdivision shall be deposited in a dedicated account in the special revenue fund and are appropriated to the Board of Nursing Home Administrators for the administrative services unit to pay for the criminal background checks conducted by the Bureau of Criminal Apprehension and Federal Bureau of Investigation.

Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue a license to any applicant who refuses to consent to a criminal background check or fails to submit fingerprints within 90 days after submission of an application for licensure. Any fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent to the criminal background check or fails to submit the required fingerprints.

(b) The failure of a licensee to submit to a criminal background check as provided in subdivision 3 is grounds for disciplinary action by the respective health licensing board.

Subd. 5. **Submission of fingerprints to the Bureau of Criminal Apprehension.** The health-related licensing board or designee shall submit applicant or licensee fingerprints to the BCA. The BCA shall perform a check for state criminal justice information and shall forward the applicant's or licensee's fingerprints to the FBI to perform a check for national criminal justice information regarding the applicant or licensee. The BCA shall report to the board the results of the state and national criminal justice information checks.

Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The health-related licensing board may require an alternative method of criminal history checks for an applicant or licensee who has submitted at least three sets of fingerprints in accordance with this section that have been unreadable by the BCA or the FBI.

Subd. 7. **Opportunity to challenge accuracy of report.** Prior to taking disciplinary action against an applicant or a licensee based on a criminal conviction, the health-related licensing board shall provide the applicant or the licensee an opportunity to complete or challenge the accuracy of the criminal history information reported to the board. The applicant or licensee shall have 30 calendar days following notice from the board of the intent to deny licensure or to take disciplinary action to request an opportunity to correct or complete the record prior to the board taking disciplinary action based on the information reported to the board. The board shall provide the applicant up to 180 days to challenge the accuracy or completeness of the report with the agency responsible for the record. This subdivision does not affect the right of the subject of the data to contest the accuracy or completeness under section 13.04, subdivision 4.

Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in collaboration with the commissioner of human services and the BCA, shall establish a plan for completing criminal background checks of all licensees who were licensed before the effective date requirement under subdivision 1. The plan must seek to minimize duplication of requirements for background checks of licensed health professionals. The plan for background checks of current licensees shall be developed no later than January 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI in which any new crimes that an applicant or licensee commits after an initial background check are flagged in the BCA's or FBI's database and reported back to the board. The plan shall include recommendations for any necessary statutory changes.

Sec. 10. Minnesota Statutes 2012, section 214.12, is amended by adding a subdivision to read:

Subd. 4. **Parental depression.** The health-related licensing boards that regulate professions that serve caregivers at risk of depression, or their children, including behavioral health and therapy, chiropractic, marriage and family therapy, medical practice, nursing, psychology, and social work, shall provide educational materials to licensees on the subject of parental depression and its potential effects on children if unaddressed, including how to:

- (1) screen mothers for depression;
- (2) identify children who are affected by their mother's depression; and
- (3) provide treatment or referral information on needed services.

Sec. 11. Minnesota Statutes 2012, section 214.40, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Administrative services unit" means the administrative services unit for the health-related licensing boards.

(c) "Charitable organization" means a charitable organization within the meaning of section 501(c)(3) of the Internal Revenue Code that has as a purpose the sponsorship or support of programs designed to improve the quality, awareness, and availability of health care services and that serves as a funding mechanism for providing those services.

(d) "Health care facility or organization" means a health care facility licensed under chapter 144 or 144A, or a charitable organization.

(e) "Health care provider" means a physician licensed under chapter 147, physician assistant ~~registered~~ licensed and practicing under chapter 147A, nurse licensed and registered to practice under chapter 148, ~~or dentist or~~ dental hygienist, ~~or dental therapist~~ licensed under chapter 150A, or an advanced dental therapist licensed and certified under chapter 150A.

(f) "Health care services" means health promotion, health monitoring, health education, diagnosis, treatment, minor surgical procedures, the administration of local anesthesia for the stitching of wounds, and primary dental services, including preventive, diagnostic, restorative, and emergency treatment. Health care services do not include the administration of general anesthesia or surgical procedures other than minor surgical procedures.

(g) "Medical professional liability insurance" means medical malpractice insurance as defined in section 62F.03.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 12. **INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO CRIMINAL BACKGROUND CHECKS.**

(a) If the Department of Health is not reviewed by the Sunset Advisory Commission according to the schedule in Minnesota Statutes, section 3D.21, the commissioner of health, as the regulator for occupational therapy practitioners, speech-language pathologists, audiologists, and hearing instrument dispensers, shall require applicants for licensure or renewal to submit to a criminal history records check as required under Minnesota Statutes, section 214.075, for other health-related licensed occupations regulated by the health-related licensing boards.

(b) Any statutory changes necessary to include the commissioner of health to Minnesota Statutes, section 214.075, shall be included in the plan required in Minnesota Statutes, section 214.075, subdivision 8.

Sec. 13. **REPEALER.**

Minnesota Statutes 2012, sections 151.19, subdivision 2; 151.25; 151.45; 151.47, subdivision 2; and 151.48, are repealed.

ARTICLE 11**HOME CARE PROVIDERS**

Section 1. Minnesota Statutes 2012, section 13.381, subdivision 2, is amended to read:

Subd. 2. **Health occupations data.** (a) **Health-related licensees and registrants.** The collection, analysis, reporting, and use of data on individuals licensed or registered by the commissioner of health or health-related licensing boards are governed by sections 144.051, ~~subdivision 2~~ subdivisions 2 to 6, and 144.052.

(b) **Health services personnel.** Data collected by the commissioner of health for the database on health services personnel are classified under section 144.1485.

Sec. 2. Minnesota Statutes 2012, section 13.381, subdivision 10, is amended to read:

Subd. 10. **Home care and hospice provider.** Data regarding a home care provider under sections 144A.43 to 144A.47 are governed by section 144A.45. Data regarding home care provider background studies are governed by section 144A.476, subdivision 1. Data regarding a hospice provider under sections 144A.75 to 144A.755 are governed by sections 144A.752 and 144A.754.

Sec. 3. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 3. **Data classification; private data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the following data collected, created, or maintained by the commissioner are classified as private data on individuals as defined in section 13.02, subdivision 12:

- (1) data submitted by or on behalf of applicants for licenses prior to issuance of the license;
- (2) the identity of complainants who have made reports concerning licensees or applicants unless the complainant consents to the disclosure;
- (3) the identity of individuals who provide information as part of surveys and investigations;
- (4) Social Security numbers; and
- (5) health record data.

Sec. 4. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 4. **Data classification; public data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the following data collected, created, or maintained by the commissioner are classified as public data as defined in section 13.02, subdivision 15:

- (1) all application data on licensees, license numbers, license status;
- (2) licensing information about licenses previously held under this chapter;
- (3) correction orders, including information about compliance with the order and whether the fine was paid;
- (4) final enforcement actions pursuant to chapter 14;

(5) orders for hearing, findings of fact and conclusions of law; and

(6) when the licensee and department agree to resolve the matter without a hearing, the agreement and specific reasons for the agreement are public data.

Sec. 5. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the following data collected, created, or maintained by the Department of Health are classified as confidential data on individuals as defined in section 13.02, subdivision 3: active investigative data relating to the investigation of potential violations of law by a licensee including data from the survey process before the correction order is issued by the department.

Sec. 6. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 6. **Release of private or confidential data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the department may release private or confidential data, except Social Security numbers, to the appropriate state, federal, or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, Office of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health and Developmental Disabilities, the health licensing boards, Department of Human Services, county or city attorney's offices, police, and local or county public health offices.

Sec. 7. Minnesota Statutes 2012, section 144A.43, is amended to read:

144A.43 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.

Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall be served and who is authorized to accept service of notices and orders on behalf of the home care provider.

Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association, corporation, unit of government, or other entity that applies for a temporary license, license, or renewal of the applicant's home care provider license under section 144A.472.

Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

Subd. 1d. **Client record.** "Client record" means all records that document information about the home care services provided to the client by the home care provider.

Subd. 1e. **Client representative.** "Client representative" means a person who, because of the client's needs, makes decisions about the client's care on behalf of the client. A client representative may be a guardian, health care agent, family member, or other agent of the client. Nothing in this section expands or diminishes the rights of persons to act on behalf of clients under other law.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given in section 152.01, subdivision 4.

Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken by mouth that contains a dietary ingredient intended to supplement the diet. Dietary ingredients may include vitamins,

minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissue, glandulars, or metabolites.

Subd. 2d. **Dietitian.** "Dietitian" is a person licensed under sections 148.621 to 148.633.

Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is performed by a licensed dietitian or licensed nutritionist and includes the activities of assessment, setting priorities and objectives, providing nutrition counseling, developing and implementing nutrition care services, and evaluating and maintaining appropriate standards of quality of nutrition care under sections 148.621 to 148.633.

Subd. 3. **Home care service.** "Home care service" means any of the following services ~~when delivered in a place of residence to~~ the home of a person whose illness, disability, or physical condition creates a need for the service:

~~(1) nursing services, including the services of a home health aide;~~

~~(2) personal care services not included under sections 148.171 to 148.285;~~

~~(3) physical therapy;~~

~~(4) speech therapy;~~

~~(5) respiratory therapy;~~

~~(6) occupational therapy;~~

~~(7) nutritional services;~~

~~(8) home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home management services include at least two of the following services: housekeeping, meal preparation, and shopping;~~

~~(9) medical social services;~~

~~(10) the provision of medical supplies and equipment when accompanied by the provision of a home care service; and~~

~~(11) other similar medical services and health-related support services identified by the commissioner in rule.~~

~~"Home care service" does not include the following activities conducted by the commissioner of health or a board of health as defined in section 145A.02, subdivision 2: communicable disease investigations or testing; administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease; or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.~~

~~(1) assistive tasks provided by unlicensed personnel;~~

~~(2) services provided by a registered nurse or licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;~~

~~(3) medication and treatment management services; or~~

~~(4) the provision of durable medical equipment services when provided with any of the home care services listed in clauses (1) to (3).~~

Subd. 3a. **Hands-on assistance.** "Hands-on assistance" means physical help by another person without which the client is not able to perform the activity.

Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of residence.

Subd. 4. **Home care provider.** "Home care provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery of at least one home care service, directly or by contractual arrangement, of home care services in a client's home for a fee and who has a valid current temporary license or license issued under sections 144A.43 to 144A.482. At least one home care service must be provided directly, although additional home care services may be provided by contractual arrangements. "Home care provider" does not include:

(1) any home care or nursing services conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing;

(2) an individual who only provides services to a relative;

(3) an individual not connected with a home care provider who provides assistance with home management services or personal care needs if the assistance is provided primarily as a contribution and not as a business;

(4) an individual not connected with a home care provider who shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;

(5) an individual or agency providing home-delivered meal services;

(6) an agency providing senior companion services and other older American volunteer programs established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(7) an employee of a nursing home licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 who responds to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home or boarding care home;

(8) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in subdivision 3;

(9) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;

(10) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service;

(11) an individual licensed under chapter 147; or

(12) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver.

Subd. 5. **Medication reminder.** "Medication reminder" means providing a verbal or visual reminder to a client to take medication. This includes bringing the medication to the client and providing liquids or nutrition to accompany medication that a client is self-administering.

Subd. 6. **License.** "License" means a basic or comprehensive home care license issued by the commissioner to a home care provider.

Subd. 7. **Licensed health professional.** "Licensed health professional" means a person, other than a registered nurse or licensed practical nurse, who provides home care services within the scope of practice of the person's health occupation license, registration, or certification as regulated and who is licensed by the appropriate Minnesota state board or agency.

Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under this chapter.

Subd. 9. **Managerial official.** "Managerial official" means an administrator, director, officer, trustee, or employee of a home care provider, however designated, who has the authority to establish or control business policy.

Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug. For purposes of this chapter only, medication includes dietary supplements.

Subd. 11. **Medication administration.** "Medication administration" means performing a set of tasks to ensure a client takes medications, and includes the following:

- (1) checking the client's medication record;
- (2) preparing the medication as necessary;
- (3) administering the medication to the client;
- (4) documenting the administration or reason for not administering the medication; and
- (5) reporting to a nurse any concerns about the medication, the client, or the client's refusal to take the medication.

Subd. 12. **Medication management.** "Medication management" means the provision of any of the following medication-related services to a client:

- (1) performing medication setup;
- (2) administering medication;
- (3) storing and securing medications;
- (4) documenting medication activities;
- (5) verifying and monitoring effectiveness of systems to ensure safe handling and administration;
- (6) coordinating refills;
- (7) handling and implementing changes to prescriptions;
- (8) communicating with the pharmacy about the client's medications; and
- (9) coordinating and communicating with the prescriber.

Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the client or by comprehensive home care staff.

Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to 148.285.

Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is licensed under sections 148.6401 to 148.6450.

Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the symbol "Rx only."

Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who has five percent or more equity interest in a limited partnership, a person who owns or controls voting stock in a corporation in an amount equal to or greater than five percent of the shares issued and outstanding, or a corporation that owns equity interest in a licensee or applicant for a license.

Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01, subdivision 3.

Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed under sections 148.65 to 148.78.

Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.

Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections 148.235; 151.01, subdivision 23; and 151.37 to prescribe prescription drugs.

Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine.

Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder to a client.

Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who is licensed under chapter 147C.

Subd. 26. **Revenues.** "Revenues" means all money received by a licensee derived from the provision of home care services, including fees for services and appropriations of public money for home care services.

Subd. 27. **Service plan.** "Service plan" means the written plan between the client or client's representative and the temporary licensee or licensee about the services that will be provided to the client.

Subd. 28. **Social worker.** "Social worker" means a person who is licensed under chapter 148D or 148E.

Subd. 29. **Speech-language pathologist.** "Speech-language pathologist" has the meaning given in section 148.512.

Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another person within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cuing.

Subd. 31. **Substantial compliance.** "Substantial compliance" means complying with the requirements in this chapter sufficiently to prevent unacceptable health or safety risks to the home care client.

Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure for compliance with this chapter.

Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized to conduct surveys of home care providers and applicants.

Subd. 34. **Temporary license.** "Temporary license" means the initial basic or comprehensive home care license the department issues after approval of a complete written application and before the department completes the temporary license survey and determines that the temporary licensee is in substantial compliance.

Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision of care, other than medications, ordered or prescribed by a licensed health professional provided to a client to cure, rehabilitate, or ease symptoms.

Subd. 36. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, or agency of the state or federal government, which includes any instrumentality of a unit of government.

Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not otherwise licensed or certified by a governmental health board or agency who provide home care services in the client's home.

Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

Sec. 8. Minnesota Statutes 2012, section 144A.44, is amended to read:

144A.44 HOME CARE BILL OF RIGHTS.

Subdivision 1. **Statement of rights.** A person who receives home care services has these rights:

(1) the right to receive written information about rights ~~in advance of~~ before receiving care ~~or during the initial evaluation visit before the initiation of treatment services~~, including what to do if rights are violated;

(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in ~~creating and changing the plan~~ developing, modifying, and evaluating care the plan and services;

(3) the right to be told ~~in advance of~~ before receiving care ~~about the services that will be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and ~~the consequences of these choices including the potential~~ consequences of refusing these services;

(4) the right to be told in advance of any ~~change~~ recommended changes by the provider in the service plan of care and to take an active part in any ~~change~~ decisions about changes to the service plan;

(5) the right to refuse services or treatment;

(6) the right to know, ~~in advance~~ before receiving services or during the initial visit, any limits to the services available from a home care provider, and ~~the provider's grounds for a termination of services~~;

(7) ~~the right to know in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay~~;

(8) ~~(7)~~ the right to ~~know~~ be told before services are initiated what the provider charges are for the services, no matter who will be paying the bill; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying;

(9) ~~(8)~~ the right to know that there may be other services available in the community, including other home care services and providers, and to know where to ~~go for~~ find information about these services;

(10) ~~(9)~~ the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, or other health programs;

(11) ~~(10)~~ the right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

(12) ~~(11)~~ the right to ~~be allowed~~ access to the client's own records and written information from those records in accordance with sections 144.291 to 144.298;

(13) ~~(12)~~ the right to be served by people who are properly trained and competent to perform their duties;

(14) ~~(13)~~ the right to be treated with courtesy and respect, and to have the ~~patient's~~ client's property treated with respect;

(15) ~~(14)~~ the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

- ~~(16)~~ (15) the right to reasonable, advance notice of changes in services or charges, ~~including;~~
- (16) the right to know the provider's reason for termination of services;
- (17) the right to at least ten days' advance notice of the termination of a service by a provider, except in cases where:
- (i) ~~the recipient of services~~ client engages in conduct that significantly alters the ~~conditions of employment as specified in the employment contract between terms of the service plan with the home care provider and the individual providing home care services, or creates;~~
- (ii) ~~the client, person who lives with the client, or others create~~ an abusive or unsafe work environment for the ~~individual person~~ person providing home care services; or
- (ii) (iii) an emergency for ~~the informal caregiver~~ or a significant change in the ~~recipient's~~ client's condition has resulted in service needs that exceed the current service ~~provider agreement plan~~ and that cannot be safely met by the home care provider;
- ~~(17)~~ (18) the right to a coordinated transfer when there will be a change in the provider of services;
- ~~(18)~~ (19) the right to ~~voice grievances regarding treatment or care that is complain about services that are provided, or fails to be, furnished, or regarding fail to be provided, and~~ the lack of courtesy or respect to the ~~patient~~ client or the ~~patient's~~ client's property;
- ~~(19)~~ (20) the right to know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint;
- ~~(20)~~ (21) the right to know the name and address of the state or county agency to contact for additional information or assistance; and
- ~~(21)~~ (22) the right to assert these rights personally, or have them asserted by the ~~patient's family or guardian when the patient has been judged incompetent,~~ client's representative or by anyone on behalf of the client, without retaliation.

Subd. 2. **Interpretation and enforcement of rights.** These rights are established for the benefit of persons clients who receive home care services. "Home care services" means home care services as defined in section 144A.43, subdivision 3, and unlicensed personal care assistance services, including services covered by medical assistance under section 256B.0625, subdivision 19a. All home care providers, including those exempted under section 144A.471, must comply with this section. The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a person client to surrender any of these rights as a condition of receiving services. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons clients receiving home care services, persons providing home care services, or providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services, including personal care assistance services, are initiated. The copy shall also contain the address and phone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long-Term Care shall be included in notices of change in client fees and in notices where home care providers initiate transfer or discontinuation of services sections 144A.43 to 144A.482.

Sec. 9. Minnesota Statutes 2012, section 144A.45, is amended to read:

144A.45 REGULATION OF HOME CARE SERVICES.

Subdivision 1. **Rules Regulations.** The commissioner shall ~~adopt rules for the regulation of regulate~~ home care providers pursuant to sections 144A.43 to ~~144A.47~~ 144A.482. The ~~rules regulations~~ shall include the following:

(1) provisions to assure, to the extent possible, the health, safety ~~and~~, well-being, and appropriate treatment of persons who receive home care services while respecting a client's autonomy and choice;

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

(3) standards of training of home care provider personnel, ~~which may vary according to the nature of the services provided or the health status of the consumer~~;

(4) standards for provision of home care services;

~~(4) (5) standards for medication management which may vary according to the nature of the services provided, the setting in which the services are provided, or the status of the consumer. Medication management includes the central storage, handling, distribution, and administration of medications;~~

~~(5) (6) standards for supervision of home care services requiring supervision by a registered nurse or other appropriate health care professional which must occur on site at least every 62 days, or more frequently if indicated by a clinical assessment, and in accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a person performing home care aide tasks for a class B licensee providing paraprofessional services does not require nursing supervision;~~

~~(6) (7) standards for client evaluation or assessment which may vary according to the nature of the services provided or the status of the consumer;~~

~~(7) (8) requirements for the involvement of a consumer's physician client's health care provider, the documentation of physicians' health care providers' orders, if required, and the consumer's treatment client's service plan; and;~~

~~(9) the maintenance of accurate, current clinical client records;~~

~~(8) (10) the establishment of different classes basic and comprehensive levels of licenses for different types of providers and different standards and requirements for different kinds of home care based on services provided; and~~

~~(9) operating procedures required to implement (11) provisions to enforce these regulations and the home care bill of rights.~~

Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting toileting, transfers, and ambulation if the client is ambulatory and if the client has no serious acute illness or infectious disease.

Subd. 1b. **Home health aide qualifications.** Notwithstanding the provisions of Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks if the person maintains current registration as a nursing assistant on the Minnesota nursing assistant registry. Maintaining current registration on the Minnesota nursing assistant registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110, subpart 3.

Subd. 2. **Regulatory functions.** (a) The commissioner shall:

(1) ~~evaluate, monitor, and license, survey, and monitor without advance notice,~~ home care providers in accordance with sections ~~144A.45 to 144A.47~~ 144A.43 to 144A.482;

~~(2) inspect the office and records of a provider during regular business hours without advance notice to the home care provider;~~

(2) survey every temporary licensee within one year of the temporary license issuance date subject to the temporary licensee providing home care services to a client or clients;

(3) survey all licensed home care providers on an interval that will promote the health and safety of clients;

~~(3)~~ (4) with the consent of the consumer client, visit the home where services are being provided;

~~(4)~~ (5) issue correction orders and assess civil penalties in accordance with section 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to 144A.47 or the rules adopted under those sections 144A.482;

~~(5)~~ (6) take action as authorized in section 144A.46, subdivision 3 144A.475; and

~~(6)~~ (7) take other action reasonably required to accomplish the purposes of sections 144A.43 to 144A.47 144A.482.

~~(b) In the exercise of the authority granted in sections 144A.43 to 144A.47, the commissioner shall comply with the applicable requirements of section 144.122, the Government Data Practices Act, and the Administrative Procedure Act.~~

~~Subd. 4. **Medicaid reimbursement.** Notwithstanding the provisions of section 256B.37 or state plan requirements to the contrary, certification by the federal Medicare program must not be a requirement of Medicaid payment for services delivered under section 144A.4605.~~

~~Subd. 5. **Home care providers; services for Alzheimer's disease or related disorder.** (a) If a home care provider licensed under section 144A.46 or 144A.4605 markets or otherwise promotes services for persons with Alzheimer's disease or related disorders, the facility's direct care staff and their supervisors must be trained in dementia care.~~

~~(b) Areas of required training include:~~

~~(1) an explanation of Alzheimer's disease and related disorders;~~

~~(2) assistance with activities of daily living;~~

~~(3) problem solving with challenging behaviors; and~~

~~(4) communication skills.~~

~~(c) The licensee shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.~~

Sec. 10. [144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.

Subdivision 1. **License required.** A home care provider may not open, operate, manage, conduct, maintain, or advertise itself as a home care provider or provide home care services in Minnesota without a temporary or current home care provider license issued by the commissioner of health.

Subd. 2. **Determination of direct home care service.** (a) "Direct home care service" means a home care service provided to a client by the home care provider or its employees, and not by contract. Factors that must be considered in determining whether an individual or a business entity provides at least one home care service directly include, but are not limited to, whether the individual or business entity:

(1) has the right to control, and does control, the types of services provided;

(2) has the right to control, and does control, when and how the services are provided;

(3) establishes the charges;

(4) collects fees from the clients or receives payment from third-party payers on the clients' behalf;

(5) pays individuals providing services compensation on an hourly, weekly, or similar basis;

(6) treats the individuals providing services as employees for the purposes of payroll taxes and workers' compensation insurance; and

(7) holds itself out as a provider of home care services or acts in a manner that leads clients or potential clients to believe that it is a home care provider providing home care services.

(b) None of the factors listed in this subdivision is solely determinative.

Subd. 3. Determination of regularly engaged. (a) "Regularly engaged" means providing, or offering to provide, home care services as a regular part of a business. The following factors must be considered by the commissioner in determining whether an individual or a business entity is regularly engaged in providing home care services:

(1) whether the individual or business entity states or otherwise promotes that the individual or business entity provides home care services;

(2) whether persons receiving home care services constitute a substantial part of the individual's or the business entity's clientele; and

(3) whether the home care services provided are other than occasional or incidental to the provision of services other than home care services.

(b) None of the factors listed in this subdivision is solely determinative.

Subd. 4. Penalties for operating without license. A person involved in the management, operation, or control of a home care provider that operates without an appropriate license is guilty of a misdemeanor. This section does not apply to a person who has no legal authority to affect or change decisions related to the management, operation, or control of a home care provider.

Subd. 5. Basic and comprehensive levels of licensure. An applicant seeking to become a home care provider must apply for either a basic or comprehensive home care license.

Subd. 6. Basic home care license provider. Home care services that can be provided with a basic home care license are assistive tasks provided by licensed or unlicensed personnel that include:

(1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing;

(2) providing standby assistance;

(3) providing verbal or visual reminders to the client to take regularly scheduled medication, which includes bringing the client previously set-up medication, medication in original containers, or liquid or food to accompany the medication;

(4) providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises;

(5) preparing modified diets ordered by a licensed health professional; and

(6) assisting with laundry, housekeeping, meal preparation, shopping, or other household chores and services if the provider is also providing at least one of the activities in clauses (1) to (5).

Subd. 7. Comprehensive home care license provider. Home care services that may be provided with a comprehensive home care license include any of the basic home care services listed in subdivision 6, and one or more of the following:

(1) services of an advanced practice nurse, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;

(2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;

(3) medication management services;

(4) hands-on assistance with transfers and mobility;

(5) assisting clients with eating when the clients have complicating eating problems as identified in the client record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed; or

(6) providing other complex or specialty health care services.

Subd. 8. Exemptions from home care services licensure. (a) Except as otherwise provided in this chapter, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

(b) An exemption under this subdivision does not excuse the exempted individual or organization from complying with applicable provisions of the home care bill of rights in section 144A.44. The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) an individual or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;

(2) a provider that is licensed by the commissioner of human services to provide semi-independent living services for persons with developmental disabilities under section 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

(3) a provider that is licensed by the commissioner of human services to provide home and community-based services for persons with developmental disabilities under section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

(4) an individual or organization that provides only home management services, if the individual or organization is registered under section 144A.482; or

(5) an individual who is licensed in this state as a nurse, dietitian, social worker, occupational therapist, physical therapist, or speech-language pathologist who provides health care services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

Subd. 9. Exclusions from home care licensure. The following are excluded from home care licensure and are not required to provide the home care bill of rights:

(1) an individual or business entity providing only coordination of home care that includes one or more of the following:

(i) determination of whether a client needs home care services, or assisting a client in determining what services are needed;

(ii) referral of clients to a home care provider;

(iii) administration of payments for home care services; or

(iv) administration of a health care home established under section 256B.0751;

- (2) an individual who is not an employee of a licensed home care provider if the individual:
- (i) only provides services as an independent contractor to one or more licensed home care providers;
 - (ii) provides no services under direct agreements or contracts with clients; and
 - (iii) is contractually bound to perform services in compliance with the contracting home care provider's policies and service plans;
- (3) a business that provides staff to home care providers, such as a temporary employment agency, if the business:
- (i) only provides staff under contract to licensed or exempt providers;
 - (ii) provides no services under direct agreements with clients; and
 - (iii) is contractually bound to perform services under the contracting home care provider's direction and supervision;
- (4) any home care services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means, or by prayer for healing;
- (5) an individual who only provides home care services to a relative;
- (6) an individual not connected with a home care provider that provides assistance with basic home care needs if the assistance is provided primarily as a contribution and not as a business;
- (7) an individual not connected with a home care provider that shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;
- (8) an individual or provider providing home-delivered meal services;
- (9) an individual providing senior companion services and other older American volunteer programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United States Code, title 42, chapter 66;
- (10) an employee of a nursing home licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 who responds to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home or boarding care home;
- (11) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in section 144A.43, subdivision 3;
- (12) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in section 144A.43, subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;
- (13) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service;
- (14) a physician licensed under chapter 147;
- (15) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver;
- (16) a business that only provides services that are primarily instructional and not medical services or health-related support services;

(17) an individual who performs basic home care services for no more than 14 hours each calendar week to no more than one client;

(18) an individual or business licensed as hospice as defined in sections 144A.75 to 144A.755 who is not providing home care services independent of hospice service;

(19) activities conducted by the commissioner of health or a board of health as defined in section 145A.02, subdivision 2, including communicable disease investigations or testing; or

(20) administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease, or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.

Sec. 11. **[144A.472] HOME CARE PROVIDER LICENSE; APPLICATION AND RENEWAL.**

Subdivision 1. **License applications.** Each application for a home care provider license must include information sufficient to show that the applicant meets the requirements of licensure, including:

(1) the applicant's name, e-mail address, physical address, and mailing address, including the name of the county in which the applicant resides and has a principal place of business;

(2) the initial license fee in the amount specified in subdivision 7;

(3) the e-mail address, physical address, mailing address, and telephone number of the principal administrative office;

(4) the e-mail address, physical address, mailing address, and telephone number of each branch office, if any;

(5) the names, e-mail and mailing addresses, and telephone numbers of all owners and managerial officials;

(6) documentation of compliance with the background study requirements of section 144A.476 for all persons involved in the management, operation, or control of the home care provider;

(7) documentation of a background study as required by section 144.057 for any individual seeking employment, paid or volunteer, with the home care provider;

(8) evidence of workers' compensation coverage as required by sections 176.181 and 176.182;

(9) documentation of liability coverage, if the provider has it;

(10) identification of the license level the provider is seeking;

(11) documentation that identifies the managerial official who is in charge of day-to-day operations and attestation that the person has reviewed and understands the home care provider regulations;

(12) documentation that the applicant has designated one or more owners, managerial officials, or employees as an agent or agents, which shall not affect the legal responsibility of any other owner or managerial official under this chapter;

(13) the signature of the officer or managing agent on behalf of an entity, corporation, association, or unit of government;

(14) verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures and keep them current:

(i) requirements in sections 626.556, reporting of maltreatment of minors, and 626.557, reporting of maltreatment of vulnerable adults;

- (ii) conducting and handling background studies on employees;
- (iii) orientation, training, and competency evaluations of home care staff, and a process for evaluating staff performance;
- (iv) handling complaints from clients, family members, or client representatives regarding staff or services provided by staff;
- (v) conducting initial evaluation of clients' needs and the providers' ability to provide those services;
- (vi) conducting initial and ongoing client evaluations and assessments and how changes in a client's condition are identified, managed, and communicated to staff and other health care providers as appropriate;
- (vii) orientation to and implementation of the home care client bill of rights;
- (viii) infection control practices;
- (ix) reminders for medications, treatments, or exercises, if provided; and
- (x) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and
- (15) other information required by the department.

Subd. 2. **Comprehensive home care license applications.** In addition to the information and fee required in subdivision 1, applicants applying for a comprehensive home care license must also provide verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures in this subdivision and keep them current:

- (1) conducting initial and ongoing assessments of the client's needs by a registered nurse or appropriate licensed health professional, including how changes in the client's conditions are identified, managed, and communicated to staff and other health care providers, as appropriate;
- (2) ensuring that nurses and licensed health professionals have current and valid licenses to practice;
- (3) medication and treatment management;
- (4) delegation of home care tasks by registered nurses or licensed health professionals;
- (5) supervision of registered nurses and licensed health professionals; and
- (6) supervision of unlicensed personnel performing delegated home care tasks.

Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license may be renewed for a period of one year if the licensee satisfies the following:

- (1) submits an application for renewal in the format provided by the commissioner at least 30 days before expiration of the license;
- (2) submits the renewal fee in the amount specified in subdivision 7;
- (3) has provided home care services within the past 12 months;
- (4) complies with sections 144A.43 to 144A.4798;
- (5) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under subdivision 1;
- (6) provides verification that all policies under subdivision 1 are current; and
- (7) provides any other information deemed necessary by the commissioner.

(b) A renewal applicant who holds a comprehensive home care license must also provide verification that policies listed under subdivision 2 are current.

Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services from the main office.

Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license issued by the commissioner may not be transferred to another party. Before acquiring ownership of a home care provider business, a prospective applicant must apply for a new temporary license. A change of ownership is a transfer of operational control to a different business entity and includes:

- (1) transfer of the business to a different or new corporation;
- (2) in the case of a partnership, the dissolution or termination of the partnership under chapter 323A, with the business continuing by a successor partnership or other entity;
- (3) relinquishment of control of the provider to another party, including to a contract management firm that is not under the control of the owner of the business' assets;
- (4) transfer of the business by a sole proprietor to another party or entity; or
- (5) in the case of a privately held corporation, the change in ownership or control of 50 percent or more of the outstanding voting stock.

Subd. 6. **Notification of changes of information.** The temporary licensee or licensee shall notify the commissioner in writing within ten working days after any change in the information required in subdivision 1, except the information required in subdivision 1, clause (5), is required at the time of license renewal.

Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant seeking a temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

- (1) for a basic home care provider, \$2,100; or
- (2) for a comprehensive home care provider, \$4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

- (1) for a basic home care provider, \$2,100; or
- (2) for a comprehensive home care provider, \$4,200.

(c) A home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

<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 \$1,500,000</u>	<u>\$5,797</u>
<u>greater than \$1,100,000 and no more than \$1,275,000</u>	<u>\$4,969</u>
<u>greater than \$950,000 and no more than \$1,100,000</u>	<u>\$4,141</u>

<u>greater than \$850,000 and no more than \$950,000</u>	<u>\$3,727</u>
<u>greater than \$750,000 and no more than \$850,000</u>	<u>\$3,313</u>
<u>greater than \$650,000 and no more than \$750,000</u>	<u>\$2,898</u>
<u>greater than \$550,000 and no more than \$650,000</u>	<u>\$2,485</u>
<u>greater than \$450,000 and no more than \$550,000</u>	<u>\$2,070</u>
<u>greater than \$350,000 and no more than \$450,000</u>	<u>\$1,656</u>
<u>greater than \$250,000 and no more than \$350,000</u>	<u>\$1,242</u>
<u>greater than \$100,000 and no more than \$250,000</u>	<u>\$828</u>
<u>greater than \$50,000 and no more than \$100,000</u>	<u>\$500</u>
<u>greater than \$25,000 and no more than \$50,000</u>	<u>\$400</u>
<u>no more than \$25,000</u>	<u>\$200</u>

(d) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(e) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(f) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(g) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the special state government revenue fund.

(h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

Sec. 12. [144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.

Subdivision 1. Temporary license and renewal of license. (a) The department shall review each application to determine the applicant's knowledge of and compliance with Minnesota home care regulations. Before granting a temporary license or renewing a license, the commissioner may further evaluate the applicant or licensee by requesting additional information or documentation or by conducting an on-site survey of the applicant to determine compliance with sections 144A.43 to 144A.482.

(b) Within 14 calendar days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete.

(c) Within 90 days after receiving a complete application, the commissioner shall issue a temporary license, renew the license, or deny the license.

(d) The commissioner shall issue a license that contains the home care provider's name, address, license level, expiration date of the license, and unique license number. All licenses are valid for one year from the date of issuance.

Subd. 2. Temporary license. (a) For new license applicants, the commissioner shall issue a temporary license for either the basic or comprehensive home care level. A temporary license is effective

for one year from the date of issuance. Temporary licensees must comply with sections 144A.43 to 144A.482.

(b) During the temporary license year, the commissioner shall survey the temporary licensee after the commissioner is notified or has evidence that the temporary licensee is providing home care services.

(c) Within five days of beginning the provision of services, the temporary licensee must notify the commissioner that it is serving clients. The notification to the commissioner may be mailed or e-mailed to the commissioner at the address provided by the commissioner. If the temporary licensee does not provide home care services during the temporary license year, then the temporary license expires at the end of the year and the applicant must reapply for a temporary home care license.

(d) A temporary licensee may request a change in the level of licensure prior to being surveyed and granted a license by notifying the commissioner in writing and providing additional documentation or materials required to update or complete the changed temporary license application. The applicant must pay the difference between the application fees when changing from the basic level to the comprehensive level of licensure. No refund will be made if the provider chooses to change the license application to the basic level.

(e) If the temporary licensee notifies the commissioner that the licensee has clients within 45 days prior to the temporary license expiration, the commissioner may extend the temporary license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial compliance with the survey, the commissioner shall issue either a basic or comprehensive home care license. If the temporary licensee is not in substantial compliance with the survey, the commissioner shall not issue a basic or comprehensive license and there will be no contested hearing right under chapter 14.

(b) If the temporary licensee whose basic or comprehensive license has been denied disagrees with the conclusions of the commissioner, then the licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration request process must be conducted internally by the commissioner or commissioner's designee, and chapter 14 does not apply.

(c) The temporary licensee requesting reconsideration must make the request in writing and must list and describe the reasons why the licensee disagrees with the decision to deny the basic or comprehensive home care license.

(d) A temporary licensee whose license is denied must comply with the requirements for notification and transfer of clients in section 144A.475, subdivision 5.

Sec. 13. **[144A.474] SURVEYS AND INVESTIGATIONS.**

Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home care provider. By June 30, 2016, the commissioner shall conduct a survey of home care providers on a frequency of at least once every three years. Survey frequency may be based on the license level, the provider's compliance history, number of clients served, or other factors as determined by the department deemed necessary to ensure the health, safety, and welfare of clients and compliance with the law.

Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a new temporary licensee conducted after the department is notified or has evidence that the temporary licensee is providing home care services to determine if the provider is in compliance with home care requirements. Initial full surveys must be completed within 14 months after the department's issuance of a temporary basic or comprehensive license.

(b) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and safety requirements. Core surveys are available to licensed home care providers who have been licensed for three years and surveyed at least once in the past three years with the latest survey having no widespread violations beyond Level 1 as provided in subdivision 11. Providers must also not have had any substantiated licensing complaints, substantiated complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors Act, or an enforcement action as authorized in section 144A.475 in the past three years.

(1) The core survey for basic home care providers must review compliance in the following areas:

(i) reporting of maltreatment;

(ii) orientation to and implementation of Home Care Client Bill of Rights;

(iii) statement of home care services;

(iv) initial evaluation of clients and initiation of services;

(v) client review and monitoring;

(vi) service plan implementation and changes to the service plan;

(vii) client complaint and investigative process;

(viii) competency of unlicensed personnel; and

(ix) infection control.

(2) For comprehensive home care providers, the core survey must include everything in the basic core survey plus these areas:

(i) delegation to unlicensed personnel;

(ii) assessment, monitoring, and reassessment of clients; and

(iii) medication, treatment, and therapy management.

(c) "Full survey" means the periodic inspection of home care providers to determine ongoing compliance with the home care requirements that cover the core survey areas and all the legal requirements for home care providers. A full survey is conducted for all temporary licensees and for providers who do not meet the requirements needed for a core survey, and when a surveyor identifies unacceptable client health or safety risks during a core survey. A full survey must include all the tasks identified as part of the core survey and any additional review deemed necessary by the department, including additional observation, interviewing, or records review of additional clients and staff.

(d) "Follow-up surveys" means surveys conducted to determine if a home care provider has corrected deficient issues and systems identified during a core survey, full survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be concluded with an exit conference and written information provided on the process for requesting a reconsideration of the survey results.

(e) Upon receiving information alleging that a home care provider has violated or is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall investigate the complaint according to sections 144A.51 to 144A.54.

Subd. 3. **Survey process.** (a) The survey process for core surveys shall include the following as applicable to the particular licensee and setting surveyed:

(1) presurvey review of pertinent documents and notification to the ombudsman for long-term care;

- (2) an entrance conference with available staff;
- (3) communication with managerial officials or the registered nurse in charge, if available, and ongoing communication with key staff throughout the survey regarding information needed by the surveyor, clarifications regarding home care requirements, and applicable standards of practice;
- (4) presentation of written contact information to the provider about the survey staff conducting the survey, the supervisor, and the process for requesting a reconsideration of the survey results;
- (5) a brief tour of a sample of the housing with services establishments in which the provider is providing home care services;
- (6) a sample selection of home care clients;
- (7) information-gathering through client and staff observations, client and staff interviews, and reviews of records, policies, procedures, practices, and other agency information;
- (8) interviews of clients' family members, if available, with clients' consent when the client can legally give consent;
- (9) except for complaint surveys conducted by the Office of Health Facilities Complaints, an on-site exit conference, with preliminary findings shared and discussed with the provider, documentation that an exit conference occurred, and written information provided on the process for requesting a reconsideration of the survey results; and
- (10) postsurvey analysis of findings and formulation of survey results, including correction orders when applicable.

Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted without advance notice to home care providers. Surveyors may contact the home care provider on the day of a survey to arrange for someone to be available at the survey site. The contact does not constitute advance notice.

Subd. 5. **Information provided by home care provider.** The home care provider shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.

Subd. 6. **Providing client records.** Upon request of a surveyor, home care providers shall provide a list of current and past clients or client representatives that includes addresses and telephone numbers and any other information requested about the services to clients within a reasonable period of time.

Subd. 7. **Contacting and visiting clients.** Surveyors may contact or visit a home care provider's clients to gather information without notice to the home care provider. Before visiting a client, a surveyor shall obtain the client's or client's representative's permission by telephone, mail, or in person. Surveyors shall inform all clients or client's representatives of their right to decline permission for a visit.

Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a home care provider, a managerial official, or an employee of the provider is not in compliance with sections 144A.43 to 144A.482. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail copies of any correction order within 30 calendar days after an exit survey to the last known address of the home care provider. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the home care provider, and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this

documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations, under subdivision 11, or any violations determined to be widespread, the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made. If a new violation is identified on a follow-up survey, no fine will be imposed unless it is not corrected on the next follow-up survey.

Subd. 10. **Performance incentive.** A licensee is eligible for a performance incentive if there are no violations identified in a core or full survey. The performance incentive is a ten percent discount on the licensee's next home care renewal license fee.

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (c) as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475; and

(4) Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) Level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death.

(2) Scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider required to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner may impose a fine.

A notice of noncompliance with a correction order must be mailed to the applicant's or provider's last known address. The noncompliance notice must list the violations not corrected.

(d) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(e) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(f) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

(g) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(h) In addition to any fine imposed under this section, the commissioner may assess costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(i) Fines collected under this subdivision shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected may be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care providers a correction order reconsideration process. This process may be used to challenge the correction order issued, including the level and scope described in subdivision 11, and any fine assessed. During the correction order reconsideration request, the issuance for the correction orders under reconsideration are not stayed, but the department shall post information on the Web site with the correction order that the licensee has requested a reconsideration and that the review is pending.

(b) A licensed home care provider may request from the commissioner, in writing, a correction order reconsideration regarding any correction order issued to the provider. The correction order reconsideration shall not be reviewed by any surveyor, investigator, or supervisor that participated in the writing or reviewing of the correction order being disputed. The correction order reconsiderations may be conducted in person, by telephone, by another electronic form, or in writing, as determined by the commissioner. The commissioner shall respond in writing to the request from a home care provider for a correction order reconsideration within 60 days of the date the provider requests a reconsideration. The commissioner's response shall identify the commissioner's decision regarding each citation challenged by the home care provider.

(c) The findings of a correction order reconsideration process shall be one or more of the following:

(1) supported in full, the correction order is supported in full, with no deletion of findings to the citation;

(2) supported in substance, the correction order is supported, but one or more findings are deleted or modified without any change in the citation;

(3) correction order cited an incorrect home care licensing requirement, the correction order is amended by changing the correction order to the appropriate statutory reference;

(4) correction order was issued under an incorrect citation, the correction order is amended to be issued under the more appropriate correction order citation;

(5) the correction order is rescinded;

(6) fine is amended, it is determined that the fine assigned to the correction order was applied incorrectly; or

(7) the level or scope of the citation is modified based on the reconsideration.

(d) If the correction order findings are changed by the commissioner, the commissioner shall update the correction order Web site.

Subd. 13. **Home care surveyor training.** (a) Before conducting a home care survey, each home care surveyor must receive training on the following topics:

(1) Minnesota home care licensure requirements;

(2) Minnesota Home Care Client Bill of Rights;

(3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

(4) principles of documentation;

(5) survey protocol and processes;

(6) Offices of the Ombudsman roles;

(7) Office of Health Facility Complaints;

(8) Minnesota landlord-tenant and housing with services laws;

(9) types of payors for home care services; and

(10) Minnesota Nurse Practice Act for nurse surveyors.

(b) Materials used for the training in paragraph (a) shall be posted on the department Web site. Requisite understanding of these topics will be reviewed as part of the quality improvement plan in section 144A.483.

Sec. 14. **[144A.475] ENFORCEMENT.**

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary license, renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:

(1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482;

(2) permits, aids, or abets the commission of any illegal act in the provision of home care;

(3) performs any act detrimental to the health, safety, and welfare of a client;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the home care provider's clients;

(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;

(9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter;

(10) refuses to initiate a background study under section 144.057 or 245A.04;

(11) fails to timely pay any fines assessed by the department;

(12) violates any local, city, or township ordinance relating to home care services;

(13) has repeated incidents of personnel performing services beyond their competency level; or

(14) has operated beyond the scope of the home care provider's license level.

(b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.

Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the provider. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the home care provider's practices and submit reports to the commissioner at the cost of the home care provider;

(2) requiring supervision of the home care provider or staff practices at the cost of the home care provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the home care provider or employees to obtain training at the cost of the home care provider;

(4) requiring the home care provider to submit reports to the commissioner;

(5) prohibiting the home care provider from taking any new clients for a period of time; or

(6) any other action reasonably required to accomplish the purpose of this subdivision and section 144A.45, subdivision 2.

Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 90 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided:

(1) advance notice is given to the home care provider;

(2) after notice, the home care provider fails to correct the problem;

(3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and

(4) there is an opportunity for a contested case hearing within the 90 days.

Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144A.45, subdivision 2, clause (5), and an action against a license under this section, a provider must request a hearing no later than 15 days after the provider receives notice of the action.

Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the home care provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation or suspension notice issued by the commissioner.

Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The owner and managerial officials of a home care provider whose Minnesota license has not been renewed or that has been revoked because of noncompliance with applicable laws or rules shall not be eligible to apply for nor will be granted a home care license, including other licenses under this chapter, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659 for five years following the effective date of the nonrenewal or revocation. If the owner and managerial officials already have enrollment status, their enrollment will be terminated by the Department of Human Services.

(b) The commissioner shall not issue a license to a home care provider for five years following the effective date of license nonrenewal or revocation if the owner or managerial official, including any individual who was an owner or managerial official of another home care provider, had a Minnesota license that was not renewed or was revoked as described in paragraph (a).

(c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend or revoke, the license of any home care provider that includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.

(d) The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of the notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any

limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well-being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials with the home care provider poses to client health, safety, and well-being;

(2) the compliance history of the home care provider; and

(3) the appropriateness of any limits suggested by the home care provider.

If the commissioner grants the stay, the order shall include any restrictions or limitation on the provider's license. The failure of the provider to comply with any restrictions or limitations shall result in the immediate removal of the stay and the commissioner shall take immediate action to suspend, revoke, or not renew the license.

Subd. 7. **Request for hearing.** A request for a hearing must be in writing and must:

(1) be mailed or delivered to the department or the commissioner's designee;

(2) contain a brief and plain statement describing every matter or issue contested; and

(3) contain a brief and plain statement of any new matter that the applicant or home care provider believes constitutes a defense or mitigating factor.

Subd. 8. **Informal conference.** At any time, the applicant or home care provider and the commissioner may hold an informal conference to exchange information, clarify issues, or resolve issues.

Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a home care provider or an employee of the home care provider from illegally engaging in activities regulated by sections 144A.43 to 144A.482. The commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which a home care provider is providing services. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a home care provider, or by an employee of the home care provider, would create an imminent risk of harm to a recipient of home care services.

Subd. 10. **Subpoena.** In matters pending before the commissioner under sections 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district, and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner of health may administer oaths to witnesses or take their affirmation. Depositions may be taken in or outside the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served on a named person anywhere in the state by an officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for a process issued out of a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

Sec. 15. **[144A.476] BACKGROUND STUDIES.**

Subdivision 1. Prior criminal convictions; owner and managerial officials. (a) Before the commissioner issues a temporary license or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to 144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

Subd. 2. Employees, contractors, and volunteers. (a) Employees, contractors, and volunteers of a home care provider are subject to the background study required by section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

(b) Termination of an employee in good faith reliance on information or records obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not subject the home care provider to civil liability or liability for unemployment benefits.

Sec. 16. **[144A.477] COMPLIANCE.**

Subdivision 1. Medicare-certified providers; coordination of surveys. If feasible, the commissioner shall survey licensees to determine compliance with this chapter at the same time as surveys for certification for Medicare if Medicare certification is based on compliance with the federal conditions of participation and on survey and enforcement by the Department of Health as agent for the United States Department of Health and Human Services.

Subd. 2. Medicare-certified providers; equivalent requirements. For home care providers licensed to provide comprehensive home care services that are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, the following state licensure regulations are considered equivalent to the federal requirements:

- (1) quality management, section 144A.479, subdivision 3;
- (2) personnel records, section 144A.479, subdivision 7;
- (3) acceptance of clients, section 144A.4791, subdivision 4;
- (4) referrals, section 144A.4791, subdivision 5;
- (5) client assessment, sections 144A.4791, subdivision 8, and 144A.4792, subdivisions 2 and 3;
- (6) individualized monitoring and reassessment, sections 144A.4791, subdivision 8, and 144A.4792, subdivisions 2 and 3;
- (7) individualized service plan, sections 144A.4791, subdivision 9, 144A.4792, subdivision 5, and 144A.4793, subdivision 3;
- (8) client complaint and investigation process, section 144A.4791, subdivision 11;
- (9) prescription orders, section 144A.4792, subdivisions 13 to 16;
- (10) client records, section 144A.4794, subdivisions 1 to 3;
- (11) qualifications for unlicensed personnel performing delegated tasks, section 144A.4795;
- (12) training and competency staff, section 144A.4795;
- (13) training and competency for unlicensed personnel, section 144A.4795, subdivision 7;
- (14) delegation of home care services, section 144A.4795, subdivision 4;
- (15) availability of contact person, section 144A.4797, subdivision 1; and
- (16) supervision of staff, section 144A.4797, subdivisions 2 and 3.

Violations of requirements in clauses (1) to (16) may lead to enforcement actions under section 144A.474.

Sec. 17. **[144A.478] INNOVATION VARIANCE.**

Subdivision 1. **Definition.** For purposes of this section, "innovation variance" means a specified alternative to a requirement of this chapter. An innovation variance may be granted to allow a home care provider to offer home care services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the clients, and is likely to improve the services provided. The innovative variance cannot change any of the client's rights under section 144A.44, home care bill of rights.

Subd. 2. **Conditions.** The commissioner may impose conditions on the granting of an innovation variance that the commissioner considers necessary.

Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any innovation variance and may renew a limited innovation variance.

Subd. 4. **Applications; innovation variance.** An application for innovation variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following:

- (1) the statute or law from which the innovation variance is requested;
- (2) the time period for which the innovation variance is requested;
- (3) the specific alternative action that the licensee proposes;

(4) the reasons for the request; and

(5) justification that an innovation variance will not impair the services provided, will not adversely affect the health, safety, or welfare of clients, and is likely to improve the services provided.

The commissioner may require additional information from the home care provider before acting on the request.

Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request for an innovation variance in writing within 45 days of receipt of a complete request. Notice of a denial shall contain the reasons for the denial. The terms of a requested innovation variance may be modified upon agreement between the commissioner and the home care provider.

Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of an innovation variance shall be deemed to be a violation of this chapter.

Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or deny renewal of an innovation variance if:

(1) it is determined that the innovation variance is adversely affecting the health, safety, or welfare of the licensee's clients;

(2) the home care provider has failed to comply with the terms of the innovation variance;

(3) the home care provider notifies the commissioner in writing that it wishes to relinquish the innovation variance and be subject to the statute previously varied; or

(4) the revocation or denial is required by a change in law.

Sec. 18. [144A.479] HOME CARE PROVIDER RESPONSIBILITIES; BUSINESS OPERATION.

Subdivision 1. **Display of license.** The original current license must be displayed in the home care providers' principal business office and copies must be displayed in any branch office. The home care provider must provide a copy of the license to any person who requests it.

Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this section, advertising includes any verbal, written, or electronic means of communicating to potential clients about the availability, nature, or terms of home care services.

Subd. 3. **Quality management.** The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government.

(b) A home care provider or staff cannot accept powers-of-attorney from clients for any purpose, and may not accept appointments as guardians or conservators of clients.

(c) A home care provider cannot serve as a client's representative.

Subd. 5. Handling of client's finances and property. (a) A home care provider may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A home care provider must provide a client with receipts for all transactions and purchases paid with the client's funds. When receipts are not available, the transaction or purchase must be documented. A home care provider must maintain records of all such transactions.

(b) A home care provider or staff may not borrow a client's funds or personal or real property, nor in any way convert a client's property to the home care provider's or staff's possession.

(c) Nothing in this section precludes a home care provider or staff from accepting gifts of minimal value, or precludes the acceptance of donations or bequests made to a home care provider that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

Subd. 6. Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.

(b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.

Subd. 7. Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute, or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;

(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;

(5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.

Sec. 19. [144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH RESPECT TO CLIENTS.

Subdivision 1. Home care bill of rights; notification to client. (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 before

the initiation of services to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

(b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices.

"If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

The statement should include the telephone number, Web site address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint.

(c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record.

Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related disorders.** The home care provider that provides services to clients with dementia shall provide in written or electronic form, to clients and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements in section 325F.72, subdivision 2, clause (4).

Subd. 3. **Statement of home care services.** Prior to the initiation of services, a home care provider must provide to the client or the client's representative a written statement which identifies if the provider has a basic or comprehensive home care license, the services the provider is authorized to provide, and which services the provider cannot provide under the scope of the provider's license. The home care provider shall obtain written acknowledgment from the clients that the provider has provided the statement or must document why the provider could not obtain the acknowledgment.

Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice.

Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in need of another medical or health service, including a licensed health professional, or social service provider, the home care provider shall:

- (1) determine the client's preferences with respect to obtaining the service; and
- (2) inform the client of resources available, if known, to assist the client in obtaining services.

Subd. 6. **Initiation of services.** When a provider initiates services and the individualized review or assessment required in subdivisions 7 and 8 has not been completed, the provider must complete a temporary plan and agreement with the client for services.

Subd. 7. **Basic individualized client review and monitoring.** (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the initiation of the home care services.

(b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in-person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services.

(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services.

(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service plan.

(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff;
and

(5) a contingency plan that includes:

(i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

(ii) information and method for a client or client's representative to contact the home care provider;

(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a list of known licensed home care providers in the client's immediate geographic area;

(4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

(5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

(6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and the ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Subd. 11. **Client complaint and investigative process.** (a) The home care provider must have a written policy and system for receiving, investigating, reporting, and attempting to resolve complaints from its clients or clients' representatives. The policy should clearly identify the process by which clients may file a complaint or concern about home care services and an explicit statement that the home care provider will not discriminate or retaliate against a client for expressing concerns or complaints. A home care provider must have a process in place to conduct investigations of complaints made by the client or the client's representative about the services in the client's plan that are or are not being provided or other items covered in the client's home care bill of rights. This complaint system must provide reasonable accommodations for any special needs of the client or client's representative if requested.

(b) The home care provider must document the complaint, name of the client, investigation, and resolution of each complaint filed. The home care provider must maintain a record of all activities regarding complaints received, including the date the complaint was received, and the home care provider's investigation and resolution of the complaint. This complaint record must be kept for each event for at least two years after the date of entry and must be available to the commissioner for review.

(c) The required complaint system must provide for written notice to each client or client's representative that includes:

(1) the client's right to complain to the home care provider about the services received;

(2) the name or title of the person or persons with the home care provider to contact with complaints;

(3) the method of submitting a complaint to the home care provider; and

(4) a statement that the provider is prohibited against retaliation according to paragraph (d).

(d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative.

Subd. 12. **Disaster planning and emergency preparedness plan.** The home care provider must have a written plan of action to facilitate the management of the client's care and services in response to a natural disaster, such as flood and storms, or other emergencies that may disrupt the home care provider's ability to provide care or services. The licensee must provide adequate orientation and training of staff on emergency preparedness.

Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a client, family member, or other caregiver of the client requests that an employee or other agent of the home care provider discontinue a life-sustaining treatment, the employee or agent receiving the request:

(1) shall take no action to discontinue the treatment; and

(2) shall promptly inform the supervisor or other agent of the home care provider of the client's request.

(b) Upon being informed of a request for termination of treatment, the home care provider shall promptly:

(1) inform the client that the request will be made known to the physician who ordered the client's treatment;

(2) inform the physician of the client's request; and

(3) work with the client and the client's physician to comply with the provisions of the Health Care Directive Act in chapter 145C.

(c) This section does not require the home care provider to discontinue treatment, except as may be required by law or court order.

(d) This section does not diminish the rights of clients to control their treatments, refuse services, or terminate their relationships with the home care provider.

(e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by clients under those chapters.

Sec. 20. [144A.4792] MEDICATION MANAGEMENT.

Subdivision 1. **Medication management services; comprehensive home care license.** (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license.

(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for

the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22.

Subd. 2. **Provision of medication management services.** (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications. "Diversion of medications" means the misuse, theft, or illegal or improper disposition of medications.

Subd. 3. **Individualized medication monitoring and reassessment.** The comprehensive home care provider must monitor and reassess the client's medication management services as needed under subdivision 14 when the client presents with symptoms or other issues that may be medication-related and, at a minimum, annually.

Subd. 4. **Client refusal.** The home care provider must document in the client's record any refusal for an assessment for medication management by the client. The provider must discuss with the client the possible consequences of the client's refusal and document the discussion in the client's record.

Subd. 5. **Individualized medication management plan.** (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following:

- (1) a statement describing the medication management services that will be provided;
- (2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;
- (3) documentation of specific client instructions relating to the administration of medications;
- (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
- (5) identification of medication management tasks that may be delegated to unlicensed personnel;
- (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
- (7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

Subd. 6. **Administration of medication.** Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse.

Subd. 7. **Delegation of medication administration.** When administration of medications is delegated to unlicensed personnel, the comprehensive home care provider must ensure that the registered nurse has:

(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated ability to competently follow the procedures;

(2) specified, in writing, specific instructions for each client and documented those instructions in the client's records; and

(3) communicated with the unlicensed personnel about the individual needs of the client.

Subd. 8. **Documentation of administration of medications.** Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan.

Subd. 9. **Documentation of medication setup.** Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at time of setup.

Subd. 10. **Medication management for clients who will be away from home.** (a) A home care provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that:

(1) for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse according to appropriate state and federal laws and nursing standards of practice;

(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed 120 hours;

(3) the client, or the client's representative, must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances;

(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and

(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.

(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:

(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients;

(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:

(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;

(ii) how the container or containers must be labeled;

(iii) the written information about the medications to be given to the client or client's representative;

(iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the client, the number of medications that were given to the client, and other required information;

(v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative; and

(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel.

Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home care provider must determine whether the comprehensive home care provider shall require a prescription for all medications the provider manages. The comprehensive home care provider must inform the client or the client's representative whether the comprehensive home care provider requires a prescription for all over-the-counter and dietary supplements before the comprehensive home care provider agrees to manage those medications.

Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.** A comprehensive home care provider providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The provider must verify that the medications are up-to-date and stored as appropriate.

Subd. 13. **Prescriptions.** There must be a current written or electronically recorded prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed medications that the comprehensive home care provider is managing for the client.

Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.

Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an authorized prescriber must be received by a nurse or pharmacist. The order must be handled according to Minnesota Rules, part 6800.6200.

Subd. 16. **Written or electronic prescription.** When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the client's record.

Subd. 17. **Records confidential.** A prescription or order received verbally, in writing, or electronically must be kept confidential according to sections 144.291 to 144.298 and 144A.44.

Subd. 18. **Medications provided by client or family members.** When the comprehensive home care provider is aware of any medications or dietary supplements that are being used by the client and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the client's record.

Subd. 19. **Storage of medications.** A comprehensive home care provider providing storage of medications outside of the client's private living space must store all prescription medications in securely

locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.

Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.

Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or saved for use by anyone other than the client.

Subd. 22. **Disposition of medications.** (a) Any current medications being managed by the comprehensive home care provider must be given to the client or the client's representative when the client's service plan ends or medication management services are no longer part of the service plan. Medications that have been stored in the client's private living space for a client who is deceased or that have been discontinued or that have expired may be given to the client or the client's representative for disposal.

(b) The comprehensive home care provider will dispose of any medications remaining with the comprehensive home care provider that are discontinued or expired or upon the termination of the service contract or the client's death according to state and federal regulations for disposition of medications and controlled substances.

(c) Upon disposition, the comprehensive home care provider must document in the client's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the client's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations.

(b) The procedures must require the comprehensive home care provider of medication management to investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records.

Sec. 21. [144A.4793] TREATMENT AND THERAPY MANAGEMENT SERVICES.

Subdivision 1. **Providers with a comprehensive home care license.** This section applies only to home care providers with a comprehensive home care license that provide treatment or therapy management services to clients. Treatment or therapy management services cannot be provided by a home care provider that has a basic home care license.

Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.

(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting of treatment or therapy activities, educating and communicating with clients about treatments or therapy they are receiving, monitoring and evaluating the treatment and therapy, and communicating with the prescriber.

Subd. 3. **Individualized treatment or therapy management plan.** For each client receiving management of ordered or prescribed treatments or therapy services, the comprehensive home care provider must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the client. The provider must also develop and maintain a current individualized treatment and therapy management record for each client which must contain at least the following:

- (1) a statement of the type of services that will be provided;
- (2) documentation of specific client instructions relating to the treatments or therapy administration;
- (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
- (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
- (5) any client-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has:

- (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
- (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and
- (3) communicated with the unlicensed personnel about the individual needs of the client.

Subd. 5. **Documentation of administration of treatments and therapies.** Each treatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs.

Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or electronically recorded order or prescription for all treatments and therapies. The order must contain the name of the client, description of the treatment or therapy to be provided, and the frequency and other information needed to administer the treatment or therapy.

Sec. 22. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

Subdivision 1. **Client record.** (a) The home care provider must maintain records for each client for whom it is providing services. Entries in the client records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

(b) Client records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The home care provider shall establish and implement written procedures to control use, storage, and security of client's records and establish criteria for release of client information.

(c) The home care provider may not disclose to any other person any personal, financial, medical, or other information about the client, except:

(1) as may be required by law;

(2) to employees or contractors of the home care provider, another home care provider, other health care practitioner or provider, or inpatient facility needing information in order to provide services to the client, but only such information that is necessary for the provision of services;

(3) to persons authorized in writing by the client or the client's representative to receive the information, including third-party payers; and

(4) to representatives of the commissioner authorized to survey or investigate home care providers under this chapter or federal laws.

Subd. 2. **Access to records.** The home care provider must ensure that the appropriate records are readily available to employees or contractors authorized to access the records. Client records must be maintained in a manner that allows for timely access, printing, or transmission of the records.

Subd. 3. **Contents of client record.** Contents of a client record include the following for each client:

(1) identifying information, including the client's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified;

(3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known;

(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;

(5) client's advance directives, if any;

(6) the home care provider's current and previous assessments and service plans;

(7) all records of communications pertinent to the client's home care services;

(8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(10) documentation that services have been provided as identified in the service plan;

(11) documentation that the client has received and reviewed the home care bill of rights;

(12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3;

(13) documentation of complaints received and resolution;

(14) discharge summary, including service termination notice and related documentation, when applicable; and

(15) other documentation required under this chapter and relevant to the client's services or status.

Subd. 4. **Transfer of client records.** If a client transfers to another home care provider or other health care practitioner or provider, or is admitted to an inpatient facility, the home care provider, upon request of

the client or the client's representative, shall take steps to ensure a coordinated transfer including sending a copy or summary of the client's record to the new home care provider, facility, or the client, as appropriate.

Subd. 5. **Record retention.** Following the client's discharge or termination of services, a home care provider must retain a client's record for at least five years, or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of client records if the home care provider ceases business.

Sec. 23. **[144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**

Subdivision 1. **Qualifications, training, and competency.** All staff providing home care services must: (1) be trained and competent in the provision of home care services consistent with current practice standards appropriate to the client's needs; and (2) be informed of the home care bill of rights under section 144A.44.

Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health professionals and nurses providing home care services as an employee of a licensed home care provider must possess current Minnesota license or registration to practice.

(b) Licensed health professionals and registered nurses must be competent in assessing client needs, planning appropriate home care services to meet client needs, implementing services, and supervising staff if assigned.

(c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law.

Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home care services must have:

(1) successfully completed a training and competency evaluation appropriate to the services provided by the home care provider and the topics listed in subdivision 7, paragraph (b); or

(2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and in the topics listed in subdivision 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7, paragraph (b), clauses (5), (7), and (8), by a practical skills test.

Unlicensed personnel providing home care services for a basic home care provider may not perform delegated nursing or therapy tasks.

(b) Unlicensed personnel performing delegated nursing tasks for a comprehensive home care provider must:

(1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or section 484.36; or

(3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.

(c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks in subdivision 4 and any other training

or competency requirements within the licensed health professional scope of practice relating to delegation or assignment of tasks to unlicensed personnel.

Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health professional may delegate tasks only to staff that are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota Practice Act. The comprehensive home care provider must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual client needs and preferences.

Subd. 5. **Individual contractors.** When a home care provider contracts with an individual contractor excluded from licensure under section 144A.471 to provide home care services, the contractor must meet the same requirements required by this section for personnel employed by the home care provider.

Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary staffing agency excluded from licensure under section 144A.471, those individuals must meet the same requirements required by this section for personnel employed by the home care provider and shall be treated as if they are staff of the home care provider.

Subd. 7. **Requirements for instructors, training content, and competency evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must meet the following requirements:

(1) training and competency evaluations of unlicensed personnel providing basic home care services must be conducted by individuals with work experience and training in providing home care services listed in section 144A.471, subdivisions 6 and 7; and

(2) training and competency evaluations of unlicensed personnel providing comprehensive home care services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. If the home care provider is providing services by licensed health professionals only, then that specific training and competency evaluation may be conducted by the licensed health professionals as appropriate.

(b) Training and competency evaluations for all unlicensed personnel must include the following:

(1) documentation requirements for all services provided;

(2) reports of changes in the client's condition to the supervisor designated by the home care provider;

(3) basic infection control, including blood-borne pathogens;

(4) maintenance of a clean and safe environment;

(5) appropriate and safe techniques in personal hygiene and grooming, including:

(i) hair care and bathing;

(ii) care of teeth, gums, and oral prosthetic devices;

(iii) care and use of hearing aids; and

(iv) dressing and assisting with toileting;

(6) training on the prevention of falls for providers working with the elderly or individuals at risk of falls;

(7) standby assistance techniques and how to perform them;

(8) medication, exercise, and treatment reminders;

- (9) basic nutrition, meal preparation, food safety, and assistance with eating;
- (10) preparation of modified diets as ordered by a licensed health professional;
- (11) communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family;
- (12) awareness of confidentiality and privacy;
- (13) understanding appropriate boundaries between staff and clients and the client's family;
- (14) procedures to utilize in handling various emergency situations; and
- (15) awareness of commonly used health technology equipment and assistive devices.

(c) In addition to paragraph (b), training and competency evaluation for unlicensed personnel providing comprehensive home care services must include:

- (1) observation, reporting, and documenting of client status;
- (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
- (3) reading and recording temperature, pulse, and respirations of the client;
- (4) recognizing physical, emotional, cognitive, and developmental needs of the client;
- (5) safe transfer techniques and ambulation;
- (6) range of motioning and positioning; and
- (7) administering medications or treatments as required.

(d) When the registered nurse or licensed health professional delegates tasks, they must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated home care task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the client's record.

Sec. 24. **[144A.4796] ORIENTATION AND ANNUAL TRAINING REQUIREMENTS.**

Subdivision 1. **Orientation of staff and supervisors to home care.** All staff providing and supervising direct home care services must complete an orientation to home care licensing requirements and regulations before providing home care services to clients. The orientation may be incorporated into the training required under subdivision 6. The orientation need only be completed once for each staff person and is not transferable to another home care provider.

Subd. 2. **Content.** The orientation must contain the following topics:

- (1) an overview of sections 144A.43 to 144A.4798;
- (2) introduction and review of all the provider's policies and procedures related to the provision of home care services;
- (3) handling of emergencies and use of emergency services;
- (4) compliance with and reporting of the maltreatment of minors or vulnerable adults under sections 626.556 and 626.557;

(5) home care bill of rights, under section 144A.44;

(6) handling of clients' complaints; reporting of complaints and where to report complaints including information on the Office of Health Facility Complaints and the Common Entry Point;

(7) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and

(8) review of the types of home care services the employee will be providing and the provider's scope of licensure.

Subd. 3. **Verification and documentation of orientation.** Each home care provider shall retain evidence in the employee record of each staff person having completed the orientation required by this section.

Subd. 4. **Orientation to client.** Staff providing home care services must be oriented specifically to each individual client and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically.

Subd. 5. **Training required relating to Alzheimer's disease and related disorders.** For home care providers that provide services for persons with Alzheimer's or related disorders, all direct care staff and supervisors working with those clients must receive training that includes a current explanation of Alzheimer's disease and related disorders, effective approaches to use to problem solve when working with a client's challenging behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

Subd. 6. **Required annual training.** All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include:

(1) training on reporting of maltreatment of minors under section 626.556 and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided;

(2) review of the home care bill of rights in section 144A.44;

(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of communicable diseases; and

(4) review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures.

Subd. 7. **Documentation.** A home care provider must retain documentation in the employee records of the staff that have satisfied the orientation and training requirements of this section.

Sec. 25. **[144A.4797] PROVISION OF SERVICES.**

Subdivision 1. **Availability of contact person to staff.** (a) A home care provider with a basic home care license must have a person available to staff for consultation on items relating to the provision of services or about the client.

(b) A home care provider with a comprehensive home care license must have a registered nurse available for consultation to staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.

(c) The appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services.

Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform basic home care services must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the home care provider having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff.

(b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the client. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance.

(c) For an individual who is licensed as a home care provider, this section does not apply.

Subd. 3. **Supervision of staff providing delegated nursing or therapy home care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Subd. 4. **Documentation.** A home care provider must retain documentation of supervision activities in the personnel records.

Subd. 5. **Exemption.** This section does not apply to an individual licensed under sections 144A.43 to 144A.4798.

Sec. 26. [144A.4798] EMPLOYEE HEALTH STATUS.

Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider must establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's Web site.

Subd. 2. **Communicable diseases.** A home care provider must follow current federal or state guidelines for prevention, control, and reporting of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other communicable diseases as defined in Minnesota Rules, part 4605.7040.

Sec. 27. [144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE PROVIDER ADVISORY COUNCIL.

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care provider advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be either persons who are currently receiving home care services or have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; and

(4) one member representing the ombudsman for long-term care.

Subd. 2. **Organizations and meetings.** The advisory council shall be organized and administered under section 15.059 with per diems and costs paid within the limits of available appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees may be developed as necessary by the commissioner. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter such as:

(1) advice to the commissioner regarding community standards for home care practices;

(2) advice to the commissioner on enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) advice to the commissioner about ways of distributing information to licensees and consumers of home care;

(4) advice to the commissioner about training standards;

(5) identify emerging issues and opportunities in the home care field, including the use of technology in home and telehealth capabilities; and

(6) perform other duties as directed by the commissioner.

Sec. 28. [144A.481] HOME CARE LICENSING IMPLEMENTATION FOR NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.

Subdivision 1. **Temporary home care licenses and changes of ownership.** (a) Beginning January 1, 2014, all temporary license applicants must apply for either a temporary basic or comprehensive home care license.

(b) Temporary home care licenses issued beginning January 1, 2014, shall be issued according to sections 144A.43 to 144A.4798, and the fees in section 144A.472. Temporary licensees must comply with the requirements of this chapter.

(c) No temporary license applications will be accepted nor temporary licenses issued between December 1, 2013, and December 31, 2013.

(d) Beginning October 1, 2013, changes in ownership applications will require payment of the new fees listed in section 144A.472. Providers who are providing nursing, delegated nursing, or professional health care services, must submit the fee for comprehensive home care providers, and all other providers must submit the fee for basic home care providers as provided in section 144A.472. Change of ownership applicants will be issued a new home care license based on the licensure law in effect on June 30, 2013.

Subd. 2. Current home care licensees with licenses prior to July 1, 2013. (a) Beginning July 1, 2014, department licensed home care providers must apply for either the basic or comprehensive home care license on their regularly scheduled renewal date.

(b) By June 30, 2015, all home care providers must either have a basic or comprehensive home care license or temporary license.

Subd. 3. Renewal application of home care licensure during transition period. (a) Renewal and change of ownership applications of home care licenses issued beginning July 1, 2014, will be issued according to sections 144A.43 to 144A.4798 and, upon license renewal or issuance of a new license for a change of ownership, providers must comply with sections 144A.43 to 144A.4798. Prior to renewal, providers must comply with the home care licensure law in effect on June 30, 2013.

(b) The fees charged for licenses renewed between July 1, 2014, and June 30, 2016, shall be the lesser of 200 percent or \$1,000, except where the 200 percent or \$1,000 increase exceeds the actual renewal fee charged, with a maximum renewal fee of \$6,625.

(c) For fiscal year 2014 only, the fees for providers with revenues greater than \$25,000 and no more than \$100,000 will be \$313 and for providers with revenues no more than \$25,000 the fee will be \$125.

Sec. 29. [144A.482] REGISTRATION OF HOME MANAGEMENT PROVIDERS.

(a) For purposes of this section, a home management provider is a person or organization that provides at least two of the following services: housekeeping, meal preparation, and shopping to a person who is unable to perform these activities due to illness, disability, or physical condition.

(b) A person or organization that provides only home management services may not operate in the state without a current certificate of registration issued by the commissioner of health. To obtain a certificate of registration, the person or organization must annually submit to the commissioner the name, mailing and physical addresses, e-mail address, and telephone number of the person or organization and a signed statement declaring that the person or organization is aware that the home care bill of rights applies to their clients and that the person or organization will comply with the home care bill of rights provisions contained in section 144A.44. A person or organization applying for a certificate must also provide the name, business address, and telephone number of each of the persons responsible for the management or direction of the organization.

(c) The commissioner shall charge an annual registration fee of \$20 for persons and \$50 for organizations. The registration fee shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) A home care provider that provides home management services and other home care services must be licensed, but licensure requirements other than the home care bill of rights do not apply to those employees or volunteers who provide only home management services to clients who do not receive any other home care services from the provider. A licensed home care provider need not be registered as a home management service provider but must provide an orientation on the home care bill of rights to its employees or volunteers who provide home management services.

(e) An individual who provides home management services under this section must, within 120 days after beginning to provide services, attend an orientation session approved by the commissioner that provides training on the home care bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons.

(f) The commissioner may suspend or revoke a provider's certificate of registration or assess fines for violation of the home care bill of rights. Any fine assessed for a violation of the home care bill of rights by a provider registered under this section shall be in the amount established in the licensure rules for home care

providers. As a condition of registration, a provider must cooperate fully with any investigation conducted by the commissioner, including providing specific information requested by the commissioner on clients served and the employees and volunteers who provide services. Fines collected under this paragraph shall be deposited in the state treasury and credited to the fund specified in the statute or rule in which the penalty was established.

(g) The commissioner may use any of the powers granted in sections 144A.43 to 144A.4798 to administer the registration system and enforce the home care bill of rights under this section.

Sec. 30. [144A.483] AGENCY QUALITY IMPROVEMENT PROGRAM.

Subdivision 1. **Annual legislative report on home care licensing.** The commissioner shall establish a quality improvement program for the home care survey and home care complaint investigation processes. The commissioner shall submit to the legislature an annual report, beginning October 1, 2015, and each October 1 thereafter. Each report will review the previous state fiscal year of home care licensing and regulatory activities. The report must include, but is not limited to, an analysis of:

(1) the number of FTE's in the Division of Compliance Monitoring, including the Office of Health Facility Complaints units assigned to home care licensing, survey, investigation and enforcement process;

(2) numbers of and descriptive information about licenses issued, complaints received and investigated, including allegations made and correction orders issued, surveys completed and timelines, and correction order reconsiderations and results;

(3) descriptions of emerging trends in home care provision and areas of concern identified by the department in its regulation of home care providers;

(4) information and data regarding performance improvement projects underway and planned by the commissioner in the area of home care surveys; and

(5) work of the Department of Health Home Care Advisory Council.

Subd. 2. **Study of correction order appeal process.** Starting July 1, 2015, the commissioner shall study whether to add a correction order appeal process conducted by an independent reviewer such as an administrative law judge or other office and submit a report to the legislature by February 1, 2016. The commissioner shall review home care regulatory systems in other states as part of that study. The commissioner shall consult with the home care providers and representatives.

Sec. 31. INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME AND COMMUNITY-BASED SERVICES.

(a) The Department of Health Compliance Monitoring Division and the Department of Human Services Licensing Division shall jointly develop an integrated licensing system for providers of both home care services subject to licensure under Minnesota Statutes, chapter 144A, and for home and community-based services subject to licensure under Minnesota Statutes, chapter 245D. The integrated licensing system shall:

(1) require only one license of any provider of services under Minnesota Statutes, sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

(2) promote quality services that recognize a person's individual needs and protect the person's health, safety, rights, and well-being;

(3) promote provider accountability through application requirements, compliance inspections, investigations, and enforcement actions;

(4) reference other applicable requirements in existing state and federal laws, including the federal Affordable Care Act;

(5) establish internal procedures to facilitate ongoing communications between the agencies, and with providers and services recipients about the regulatory activities;

(6) create a link between the agency Web sites so that providers and the public can access the same information regardless of which Web site is accessed initially; and

(7) collect data on identified outcome measures as necessary for the agencies to report to the Centers for Medicare and Medicaid Services.

(b) The joint recommendations for legislative changes to implement the integrated licensing system are due to the legislature by February 15, 2014.

(c) Before implementation of the integrated licensing system, providers licensed as home care providers under Minnesota Statutes, chapter 144A, may also provide home and community-based services subject to licensure under Minnesota Statutes, chapter 245D, without obtaining a home and community-based services license under Minnesota Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall apply to these providers:

(1) the provider must comply with all requirements under Minnesota Statutes, chapter 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

(2) a violation of requirements under Minnesota Statutes, chapter 245D, may be enforced by the Department of Health under the enforcement authority set forth in Minnesota Statutes, section 144A.475; and

(3) the Department of Health will provide information to the Department of Human Services about each provider licensed under this section, including the provider's license application, licensing documents, inspections, information about complaints received, and investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

Sec. 32. STUDY OF CORRECTION ORDER APPEAL PROCESS.

Beginning July 1, 2015, the commissioner of health shall study whether to use a correction order appeal process conducted by an independent reviewer, such as an administrative law judge or other office. The commissioner shall review home care regulatory systems in other states and consult with the home care providers and representatives. By February 1, 2016, the commissioner shall submit a report to the chairs and ranking minority members of the committees of the legislature with jurisdiction over health and human services and judiciary issues with any recommendations regarding an independent appeal process.

Sec. 33. REPEALER.

(a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

(b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040; 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100; 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

Sec. 34. EFFECTIVE DATE.

This article is effective the day following final enactment.

ARTICLE 12

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in any fiscal biennium shall not exceed \$96,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

(c) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund after the transfer required in paragraph (a), effective for the biennium beginning July 1, 2013, the commissioner of management and budget shall transfer \$1,000,000 each fiscal year from the health access fund to the medical education and research costs fund established under section 62J.692, for distribution under section 62J.692, subdivision 4, paragraph (c).

Sec. 2. Minnesota Statutes 2012, section 43A.23, is amended by adding a subdivision to read:

Subd. 4. **Coverage for autism spectrum disorders.** For participants in the state employee group insurance program, the commissioner of management and budget must administer the identical benefit as is required under section 62A.3094.

EFFECTIVE DATE. This section is effective January 1, 2016, or the date a collective bargaining agreement or compensation plan that includes changes to this section is approved under Minnesota Statutes, section 3.855, whichever is earlier.

Sec. 3. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional as defined in section 245.4871, subdivision 27, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Subd. 2. Coverage required. (a) A health plan issued to a large employer, as defined in section 62Q.18, subdivision 1, must provide coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders, including but not limited to the following:

(1) early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;

(2) neurodevelopmental and behavioral health treatments and management;

(3) speech therapy;

(4) occupational therapy;

(5) physical therapy; and

(6) medications.

(b) The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities.

(c) The coverage required under this subdivision must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional.

(d) A health carrier may not refuse to renew or reissue, or otherwise terminate or restrict, coverage of an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) A health carrier may request an updated treatment plan only once every six months, unless the health carrier and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

(g) An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Subd. 3. No effect on other law. Nothing in this section limits the coverage required under section 62Q.47.

Subd. 4. State health care programs. This section does not affect benefits available under the medical assistance and MinnesotaCare programs and does not limit, restrict, or otherwise reduce coverage under these programs.

EFFECTIVE DATE. This section is effective for health plans offered, sold, issued, or renewed on or after January 1, 2014.

Sec. 4. Minnesota Statutes 2012, section 62J.692, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health ~~in consultation with the Medical Education and Research Advisory Committee.~~

(b) "Commissioner" means the commissioner of health.

(c) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(d) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(e) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(f) "Trainee" means a student or resident involved in a clinical medical education program.

(g) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs in either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues. Training that occurs in nursing facility settings is not eligible for funding under this section.

Sec. 5. Minnesota Statutes 2012, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, ~~or physician assistants is,~~ dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, or community health workers are eligible for funds under subdivision 4 if the program:

- (1) is funded, in part, by patient care revenues;
- (2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and
- (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

- (1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;
- (2) the name, title, and business address of those persons responsible for administering the funds;
- (3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Sec. 6. Minnesota Statutes 2012, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the available medical education funds to all qualifying applicants based on ~~a distribution formula that reflects a summation of two factors:~~

~~(1) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and~~

~~(2) a supplemental public program volume factor, which is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.~~

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under ~~paragraph (a) this paragraph~~, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students. Training sites whose training site level grant is less than \$1,000 \$5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph.

(b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be

equal to ten percent of each training sites grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).

(c) Of available medical education funds, \$1,000,000 shall be distributed each year for grants to family medicine residency programs located outside of the seven-county metropolitan area, as defined in section 473.121, subdivision 4, focused on education and training of family medicine physicians to serve communities outside the metropolitan area. To be eligible for a grant under this paragraph, a family medicine residency program must demonstrate that over the most recent three calendar years, at least 25 percent of its residents practice in Minnesota communities outside of the metropolitan area. Grant funds must be allocated proportionally based on the number of residents per eligible residency program.

~~(b)~~ (d) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

~~(e)~~ (e) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under ~~paragraph~~ paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

~~(d)~~ (f) Use of funds is limited to expenses related to clinical training program costs for eligible programs.

(g) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

~~(e)~~ (h) A maximum of \$150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 7. Minnesota Statutes 2012, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) The reports must provide verification of the distribution of the funds and must include:

- (1) the total number of eligible trainee FTEs in each clinical medical education program;
- (2) the name of each funded program and, for each program, the dollar amount distributed to each training site and a training site expenditure report;
- (3) documentation of any discrepancies between the initial grant distribution notice included in the commissioner's approval letter and the actual distribution;
- (4) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and
- (5) other information the commissioner, ~~with advice from the advisory committee~~, deems appropriate to evaluate the effectiveness of the use of funds for medical education.

(c) ~~By February 15 of~~ Each year, the commissioner, ~~with advice from the advisory committee~~, shall provide an annual summary report to the legislature on the implementation of this section.

Sec. 8. Minnesota Statutes 2012, section 62J.692, subdivision 9, is amended to read:

Subd. 9. **Review of eligible providers.** ~~The commissioner and the Medical Education and Research Costs Advisory Committee~~ may review provider groups included in the definition of a clinical medical education program to assure that the distribution of the funds continue to be consistent with the purpose of this section. The results of any such reviews must be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

Sec. 9. Minnesota Statutes 2012, section 62J.692, is amended by adding a subdivision to read:

Subd. 4a. **Distribution of funds.** If federal approval is not received for the formula described in subdivision 4, paragraphs (a) and (b), 100 percent of available medical education and research funds shall be distributed based on a distribution formula that reflects as summation of two factors:

(1) a public program volume factor, that is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and

(2) a supplemental public program volume factor, that is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for a least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.

Sec. 10. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

- (i) has nonprofit status in accordance with chapter 317A;

- (ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);
- (iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and
- (iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions;

(5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds; ~~or~~

(6) a birth center licensed under section 144.615; or

(7) a hospital and affiliated specialty clinics that predominantly serve patients who are under 21 years of age and meet the following criteria:

(i) provide intensive specialty pediatric services that are routinely provided in fewer than five hospitals in the state; and

(ii) serve children from at least half of the counties in the state.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. Minnesota Statutes 2012, section 103I.005, is amended by adding a subdivision to read:

Subd. 1a. **Bored geothermal heat exchanger.** "Bored geothermal heat exchanger" means an earth-coupled heating or cooling device consisting of a sealed closed-loop piping system installed in a boring in the ground to transfer heat to or from the surrounding earth with no discharge.

Sec. 12. Minnesota Statutes 2012, section 103I.521, is amended to read:

~~103I.521 FEES DEPOSITED WITH COMMISSIONER OF MANAGEMENT AND BUDGET.~~

Unless otherwise specified, fees collected for licenses or registration by the commissioner under this chapter shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 13. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

Subdivision 1. **Who must pay.** Except for the limitation contained in this section, the commissioner of health ~~shall charge a handling fee~~ may enter into a contractual agreement to recover costs incurred for analysis for diagnostic purposes for each specimen submitted to the Department of Health for analysis for diagnostic purposes by any hospital, private laboratory, private clinic, or physician. No fee shall be charged to any entity which receives direct or indirect financial assistance from state or federal funds administered by the Department of Health, including any public health department, nonprofit community clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged The commissioner shall not charge for any biological materials submitted to the Department of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological materials requested by the department to gather information for disease prevention or control purposes. The commissioner of health may establish other exceptions to the handling fee as may be necessary to protect the public's health. All fees collected pursuant to this section shall be deposited in the state treasury and credited to the state government special revenue fund. Funds generated in a contractual agreement made pursuant to this section shall be deposited in a special account and are appropriated to the commissioner for purposes of providing the services specified in the contracts. All such contractual agreements shall be processed in accordance with the provisions of chapter 16C.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 14. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing and the, recording and of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders, including hearing loss detected through the early hearing detection and intervention program under section 144.966.

(c) The fee is \$101 per specimen. Effective July 1, 2010, the fee shall be increased to \$106 to support the newborn screening program, including tests administered under this section and section 144.966, shall be \$135 per specimen. The increased fee amount shall be deposited in the general fund. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be \$15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 15. **[144.1251] NEWBORN SCREENING FOR CRITICAL CONGENITAL HEART DISEASE (CCHD).**

Subdivision 1. **Required testing and reporting.** (a) Each licensed hospital or state-licensed birthing center or facility that provides maternity and newborn care services shall provide screening for congenital heart disease to all newborns prior to discharge using pulse oximetry screening. The screening must occur after the infant is 24 hours old, before discharge from the nursery. If discharge occurs before the infant is 24 hours old, the screening must occur as close as possible to the time of discharge.

(b) For premature infants (less than 36 weeks of gestation) and infants admitted to a higher-level nursery (special care or intensive care), pulse oximetry must be performed when medically appropriate prior to discharge.

(c) Results of the screening must be reported to the Department of Health.

Subd. 2. **Implementation.** The Department of Health shall:

(1) communicate the screening protocol requirements;

(2) make information and forms available to the hospitals, birthing centers, and other facilities that are required to provide the screening, health care providers who provide prenatal care and care to newborns, and expectant parents and parents of newborns. The information and forms must include screening protocol and reporting requirements and parental options;

(3) provide training to ensure compliance with and appropriate implementation of the screening;

(4) establish the mechanism for the required data collection and reporting of screening and follow-up diagnostic results to the Department of Health according to the Department of Health's recommendations;

(5) coordinate the implementation of universal standardized screening;

(6) act as a resource for providers as the screening program is implemented, and in consultation with the Advisory Committee on Heritable and Congenital Disorders, develop and implement policies for early medical and developmental intervention services and long-term follow-up services for children and their families identified with a CCHD; and

(7) comply with sections 144.125 to 144.128.

Sec. 16. Minnesota Statutes 2012, section 144.212, is amended to read:

144.212 DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 144.211 to 144.227, the following terms have the meanings given.

Subd. 1a. **Amendment.** "Amendment" means completion or correction of made to certification items on a vital record: after a certification has been issued or more than one year after the event, whichever occurs first, that does not result in a sealed or replaced record.

Subd. 1b. **Authorized representative.** "Authorized representative" means an agent designated in a written and witnessed statement signed by the subject of the record or other qualified applicant.

Subd. 1c. **Certification item.** "Certification item" means all individual items appearing on a certificate of birth and the demographic and legal items on a certificate of death.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 2a. **Correction.** "Correction" means a change made to a noncertification item, including information collected for medical and statistical purposes. A correction also means a change to a certification item within one year of the event provided that no certification, whether paper or electronic, has been issued.

Subd. 2b. **Court of competent jurisdiction.** "Court of competent jurisdiction" means a court within the United States with jurisdiction over the individual and such other individuals that the court deems necessary.

Subd. 2a 2c. **Delayed registration.** "Delayed registration" means registration of a record of birth or death filed one or more years after the date of birth or death.

Subd. 2d. **Disclosure.** "Disclosure" means to make available or make known personally identifiable information contained in a vital record, by any means of communication.

Subd. 3. **File.** "File" means to present a vital record or report for registration to the Office of ~~the State Registrar~~ Vital Records and to have the vital record or report accepted for registration by the Office of ~~the State Registrar~~ Vital Records.

Subd. 4. **Final disposition.** "Final disposition" means the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or dead fetus.

Subd. 4a. **Institution.** "Institution" means a public or private establishment that:

- (1) provides inpatient or outpatient medical, surgical, or diagnostic care or treatment; or
- (2) provides nursing, custodial, or domiciliary care, or to which persons are committed by law.

Subd. 4b. **Legal representative.** "Legal representative" means a licensed attorney representing an individual.

Subd. 4c. **Local issuance office.** "Local issuance office" means a county governmental office authorized by the state registrar to issue certified birth and death records.

Subd. 4d. **Record.** "Record" means a report of a vital event that has been registered by the state registrar.

Subd. 5. **Registration.** "Registration" means the process by which vital records are completed, filed, and incorporated into the official records of the Office of ~~the State~~ Vital Records Registrar.

Subd. 6. **State registrar.** "State registrar" means the commissioner of health or a designee.

Subd. 7. **System of vital statistics.** "System of vital statistics" includes the registration, collection, preservation, amendment, verification, maintenance of the security and integrity of, and certification of vital records, the collection of other reports required by sections 144.211 to 144.227, and related activities including the tabulation, analysis, publication, and dissemination of vital statistics.

Subd. 7a. **Verification.** "Verification" means a confirmation of the information on a vital record based on the facts contained in a certification.

Subd. 8. **Vital record.** "Vital record" means a record or report of birth, stillbirth, death, marriage, dissolution and annulment, and data related thereto. The birth record is not a medical record of the mother or the child.

Subd. 9. **Vital statistics.** "Vital statistics" means the data derived from records and reports of birth, death, fetal death, induced abortion, marriage, dissolution and annulment, and related reports.

Subd. 10. **Local registrar.** ~~"Local registrar" means an individual designated under section 144.214, subdivision 1, to perform the duties of a local registrar.~~

Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed with the state registrar which sets forth the following information:

- (1) the current name and address of the affiant;

- (2) any previous name by which the affiant was known;
- (3) the original and adopted names, if known, of the adopted child whose original birth record is to be disclosed;
- (4) the place and date of birth of the adopted child;
- (5) the biological relationship of the affiant to the adopted child; and
- (6) the affiant's consent to disclosure of information from the original birth record of the adopted child.

Sec. 17. Minnesota Statutes 2012, section 144.213, is amended to read:

144.213 OFFICE OF THE STATE REGISTRAR VITAL RECORDS.

Subdivision 1. **Creation; state registrar; Office of Vital Records.** The commissioner shall establish an Office of the State Registrar Vital Records under the supervision of the state registrar. ~~The commissioner shall furnish to local registrars the forms necessary for correct reporting of vital statistics, and shall instruct the local registrars in the collection and compilation of the data.~~ The commissioner shall promulgate rules for the collection, filing, and registering of vital statistics information by the state and local registrars registrar, physicians, morticians, and others. Except as otherwise provided in sections 144.211 to 144.227, rules previously promulgated by the commissioner relating to the collection, filing and registering of vital statistics shall remain in effect until repealed, modified or superseded by a rule promulgated by the commissioner.

Subd. 2. **General duties.** (a) The state registrar shall coordinate the work of local registrars to maintain a statewide system of vital statistics. The state registrar is responsible for the administration and enforcement of sections 144.211 to 144.227; and shall supervise local registrars in the enforcement of sections 144.211 to 144.227 and the rules promulgated thereunder. Local issuance offices that fail to comply with the statutes or rules or to properly train employees may have their issuance privileges and access to the vital records system revoked.

(b) To preserve vital records the state registrar is authorized to prepare typewritten, photographic, electronic or other reproductions of original records and files in the Office of Vital Records. The reproductions when certified by the state registrar shall be accepted as the original records.

(c) The state registrar shall also:

- (1) establish, designate, and eliminate offices in the state to aid in the efficient issuance of vital records;
- (2) direct the activities of all persons engaged in activities pertaining to the operation of the system of vital statistics;
- (3) develop and conduct training programs to promote uniformity of policy and procedures throughout the state in matters pertaining to the system of vital statistics; and
- (4) prescribe, furnish, and distribute all forms required by sections 144.211 to 144.227 and any rules adopted under these sections, and prescribe other means for the transmission of data, including electronic submission, that will accomplish the purpose of complete, accurate, and timely reporting and registration.

~~Subd. 3. **Record keeping.** To preserve vital records the state registrar is authorized to prepare typewritten, photographic, electronic or other reproductions of original records and files in the Office of the State Registrar. The reproductions when certified by the state or local registrar shall be accepted as the original records.~~

Sec. 18. **[144.2131] SECURITY OF VITAL RECORDS SYSTEM.**

The state registrar shall:

(1) authenticate all users of the system of vital statistics and document that all users require access based on their official duties;

(2) authorize authenticated users of the system of vital statistics to access specific components of the vital statistics systems necessary for their official roles and duties;

(3) establish separation of duties between staff roles that may be susceptible to fraud or misuse and routinely perform audits of staff work for the purposes of identifying fraud or misuse within the vital statistics system;

(4) require that authenticated and authorized users of the system of vital statistics maintain a specified level of training related to security and provide written acknowledgment of security procedures and penalties;

(5) validate data submitted for registration through site visits or with independent sources outside the registration system at a frequency specified by the state registrar to maximize the integrity of the data collected;

(6) protect personally identifiable information and maintain systems pursuant to applicable state and federal laws;

(7) accept a report of death if the decedent was born in Minnesota or if the decedent was a resident of Minnesota from the United States Department of Defense or the United States Department of State when the death of a United States citizen occurs outside the United States;

(8) match death records registered in Minnesota and death records provided from other jurisdictions to live birth records in Minnesota;

(9) match death records received from the United States Department of Defense or the United States Department of State for deaths of United States citizens occurring outside the United States to live birth records in Minnesota;

(10) work with law enforcement to initiate and provide evidence for active fraud investigations;

(11) provide secure workplace, storage, and technology environments that have limited role-based access;

(12) maintain overt, covert, and forensic security measures for certifications, verifications, and automated systems that are part of the vital statistics system; and

(13) comply with applicable state and federal laws and rules associated with information technology systems and related information security requirements.

Sec. 19. Minnesota Statutes 2012, section 144.215, subdivision 3, is amended to read:

Subd. 3. **Father's name; child's name.** In any case in which paternity of a child is determined by a court of competent jurisdiction, ~~a declaration of parentage is executed under section 257.34,~~ or a recognition of parentage is executed under section 257.75, the name of the father shall be entered on the birth record. If the order of the court declares the name of the child, it shall also be entered on the birth record. If the order of the court does not declare the name of the child, or there is no court order, then upon the request of both parents in writing, the surname of the child shall be defined by both parents.

Sec. 20. Minnesota Statutes 2012, section 144.215, subdivision 4, is amended to read:

Subd. 4. **Social Security number registration.** (a) Parents of a child born within this state shall give the parents' Social Security numbers to the Office of ~~the State Registrar~~ Vital Records at the time of filing the birth record, but the numbers shall not appear on the certified record.

(b) The Social Security numbers are classified as private data, ~~as defined in section 13.02, subdivision 12, on individuals,~~ but the Office of the State Registrar Vital Records shall provide a Social Security number to the public authority responsible for child support services upon request by the public authority for use in the establishment of parentage and the enforcement of child support obligations.

Sec. 21. Minnesota Statutes 2012, section 144.216, subdivision 1, is amended to read:

Subdivision 1. **Reporting a foundling.** Whoever finds a live born infant of unknown parentage shall report within five days to the Office of the State Registrar Vital Records such information as the commissioner may by rule require to identify the foundling.

Sec. 22. Minnesota Statutes 2012, section 144.217, subdivision 2, is amended to read:

Subd. 2. **Court petition.** If a delayed record of birth is rejected under subdivision 1, a person may petition the appropriate court in the county in which the birth allegedly occurred for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered. The petition shall state:

- (1) that the person for whom a delayed record of birth is sought was born in this state;
- (2) that no record of birth can be found in the Office of the State Registrar Vital Records;
- (3) that diligent efforts by the petitioner have failed to obtain the evidence required in subdivision 1;
- (4) that the state registrar has refused to register a delayed record of birth; and
- (5) other information as may be required by the court.

Sec. 23. Minnesota Statutes 2012, section 144.218, subdivision 5, is amended to read:

Subd. 5. **Replacement of vital records.** Upon the order of a court of this state, upon the request of a court of another state, ~~upon the filing of a declaration of parentage under section 257.34,~~ or upon the filing of a recognition of parentage with a the state registrar, a replacement birth record must be registered consistent with the findings of the court, ~~the declaration of parentage,~~ or the recognition of parentage.

Sec. 24. **[144.2181] AMENDMENT AND CORRECTION OF VITAL RECORDS.**

(a) A vital record registered under sections 144.212 to 144.227 may be amended or corrected only according to sections 144.212 to 144.227 and rules adopted by the commissioner of health to protect the integrity and accuracy of vital records.

(b)(1) A vital record that is amended under this section shall indicate that it has been amended, except as otherwise provided in this section or by rule.

(2) Electronic documentation shall be maintained by the state registrar that identifies the evidence upon which the amendment or correction was based, the date of the amendment or correction, and the identity of the authorized person making the amendment or correction.

(c) Upon receipt of a certified copy of an order of a court of competent jurisdiction changing the name of a person whose birth is registered in Minnesota and upon request of such person if 18 years of age or older or having the status of emancipated minor, the state registrar shall amend the birth record to show the new name. If the person is a minor or an incapacitated person then a parent, guardian, or legal representative of the minor or incapacitated person may make the request.

(d) When an applicant does not submit the minimum documentation required for amending a vital record or when the state registrar has cause to question the validity or completeness of the applicant's statements or the documentary evidence, and the deficiencies are not corrected, the state registrar shall

not amend the vital record. The state registrar shall advise the applicant of the reason for this action and shall further advise the applicant of the right of appeal to a court with competent jurisdiction over the Department of Health.

Sec. 25. Minnesota Statutes 2012, section 144.225, subdivision 1, is amended to read:

Subdivision 1. **Public information; access to vital records.** Except as otherwise provided for in this section and section 144.2252, information contained in vital records shall be public information. Physical access to vital records shall be subject to the supervision and regulation of the state and local registrars registrar and their employees pursuant to rules promulgated by the commissioner in order to protect vital records from loss, mutilation or destruction and to prevent improper disclosure of vital records which are confidential or private data on individuals, as defined in section 13.02, subdivisions 3 and 12.

Sec. 26. Minnesota Statutes 2012, section 144.225, subdivision 4, is amended to read:

Subd. 4. **Access to records for research purposes.** The state registrar may permit persons performing medical research access to the information restricted in subdivision 2 or 2a if those persons agree in writing not to disclose private or confidential data on individuals.

Sec. 27. Minnesota Statutes 2012, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) ~~The state or local registrar~~ or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and payment of the required fee:

(1) to a person who has a tangible interest in the requested vital record. A person who has a tangible interest is:

- (i) the subject of the vital record;
- (ii) a child of the subject;
- (iii) the spouse of the subject;
- (iv) a parent of the subject;
- (v) the grandparent or grandchild of the subject;
- (vi) if the requested record is a death record, a sibling of the subject;
- (vii) the party responsible for filing the vital record;
- (viii) the legal custodian, guardian or conservator, or health care agent of the subject;
- (ix) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;
- (x) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;
- (xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;
- (xii) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or
- (xiii) adoption agencies in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties. ~~An authorized governmental agency includes the Department of Human Services, the Department of Revenue, and the United States Citizenship and Immigration Services;~~

(3) to an attorney upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state ~~or local~~ registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to (viii), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 28. Minnesota Statutes 2012, section 144.225, subdivision 8, is amended to read:

Subd. 8. **Standardized format for certified birth and death records.** ~~No later than July 1, 2000,~~ The commissioner shall ~~develop~~ maintain a standardized format for certified birth records and death records issued by ~~the state and local registrars~~ registrar and local issuance offices. The format shall incorporate security features in accordance with this section. ~~The standardized format must be implemented on a statewide basis by July 1, 2001.~~

Sec. 29. Minnesota Statutes 2012, section 144.226, is amended to read:

144.226 FEES.

Subdivision 1. **Which services are for fee.** The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(a) The fee for the ~~issuance of~~ administrative review and processing of a request for a certified vital record or a certification that the vital record cannot be found is \$9. ~~No fee shall be charged for a certified birth, stillbirth, or death record that is reissued within one year of the original issue, if an amendment is made to the vital record and if the previously issued vital record is surrendered.~~ The fee is payable at the time of application and is nonrefundable.

(b) The fee for processing a request for the replacement of a birth record for all events, except when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is \$40. The fee is payable at the time of application and is nonrefundable.

(c) The fee for administrative review and processing of a request for the filing of a delayed registration of birth, stillbirth, or death is \$40. The fee is payable at the time of application and is nonrefundable. ~~This fee includes one subsequent review of the request if the request is not acceptable upon the initial receipt.~~

(d) The fee for administrative review and processing of a request for the amendment of any vital record ~~when requested more than 45 days after the filing of the vital record~~ is \$40. ~~No fee shall be charged for an amendment requested within 45 days after the filing of the vital record.~~ The fee is payable at the time of application and is nonrefundable. ~~This fee includes one subsequent review of the request if the request is not acceptable upon the initial receipt.~~

(e) The fee for administrative review and processing of a request for the verification of information from vital records is \$9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is \$20 per hour for staff time expended.

Specific information includes the correct date of the event and the correct name of the registrant subject of the record. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee is payable at the time of application and is nonrefundable.

(f) The fee for administrative review and processing of a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is \$9. The fee is payable at the time of application and is nonrefundable.

Subd. 2. **Fees to state government special revenue fund.** Fees collected under this section by the state registrar shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record and for a certification that the vital record cannot be found. ~~The local or state registrar or local issuance office~~ shall forward this amount to the commissioner of management and budget for deposit into the account for the children's trust fund for the prevention of child abuse established under section 256E.22. This surcharge shall not be charged under those circumstances in which no fee for a certified birth or stillbirth record is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of management and budget that the assets in that fund exceed \$20,000,000, this surcharge shall be discontinued.

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of \$10 for each certified birth record. ~~The local or state registrar or local issuance office~~ shall forward this amount to the commissioner of management and budget for deposit in the general fund. ~~This surcharge shall not be charged under those circumstances in which no fee for a certified birth record is permitted under subdivision 1, paragraph (a).~~

Subd. 4. **Vital records surcharge.** ~~(a)~~ In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of ~~\$2~~ \$4 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. ~~The local issuance office or state registrar~~ shall forward this amount to the commissioner of management and budget to be deposited into the state government special revenue fund. ~~This surcharge shall not be charged under those circumstances in which no fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).~~

~~(b) Effective August 1, 2005, the surcharge in paragraph (a) is \$4.~~

Subd. 5. **Electronic verification.** A fee for the electronic verification or electronic certification of a vital event, when the information being verified or certified is obtained from a certified birth or death record, shall be established through contractual or interagency agreements ~~with interested local, state, or federal government agencies.~~

Subd. 6. **Alternative payment methods.** Notwithstanding subdivision 1, alternative payment methods may be approved and implemented by the state registrar or a local ~~registrar~~ issuance office.

Sec. 30. [144.492] DEFINITIONS.

Subdivision 1. Applicability. For the purposes of sections 144.492 to 144.494, the terms defined in this section have the meanings given them.

Subd. 2. Commissioner. "Commissioner" means the commissioner of health.

Subd. 3. Joint commission. "Joint commission" means the independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States.

Subd. 4. Stroke. "Stroke" means the sudden death of brain cells in a localized area due to inadequate blood flow.

Sec. 31. **[144.493] CRITERIA.**

Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a comprehensive stroke center if the hospital has been certified as a comprehensive stroke center by the joint commission or another nationally recognized accreditation entity.

Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke center if the hospital has been certified as a primary stroke center by the joint commission or another nationally recognized accreditation entity.

Subd. 3. **Acute stroke ready hospital.** A hospital meets the criteria for an acute stroke ready hospital if the hospital has the following elements of an acute stroke ready hospital:

- (1) an acute stroke team available or on-call 24 hours a days, seven days a week;
- (2) written stroke protocols, including triage, stabilization of vital functions, initial diagnostic tests, and use of medications;
- (3) a written plan and letter of cooperation with emergency medical services regarding triage and communication that are consistent with regional patient care procedures;
- (4) emergency department personnel who are trained in diagnosing and treating acute stroke;
- (5) the capacity to complete basic laboratory tests, electrocardiograms, and chest x-rays 24 hours a day, seven days a week;
- (6) the capacity to perform and interpret brain injury imaging studies 24 hours a day, seven days a week;
- (7) written protocols that detail available emergent therapies and reflect current treatment guidelines, which include performance measures and are revised at least annually;
- (8) a neurosurgery coverage plan, call schedule, and a triage and transportation plan;
- (9) transfer protocols and agreements for stroke patients; and
- (10) a designated medical director with experience and expertise in acute stroke care.

Sec. 32. **[144.494] DESIGNATING STROKE CENTERS AND STROKE HOSPITALS.**

Subdivision 1. **Naming privileges.** Unless it has been designated as a stroke center or stroke hospital pursuant to section 144.493, no hospital shall use the term "stroke center" or "stroke hospital" in its name or its advertising or shall otherwise indicate it has stroke treatment capabilities.

Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive stroke center, primary stroke center, or acute stroke ready hospital may apply to the commissioner for designation, and upon the commissioner's review and approval of the application, shall be designated as a comprehensive stroke center, a primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke center or primary stroke center from the joint commission or other nationally recognized accreditation entity, its Minnesota designation shall be immediately withdrawn. Prior to the expiration of the three-year designation, a hospital seeking to remain part of the voluntary acute stroke system may reapply to the commissioner for designation.

Sec. 33. **[144.554] HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND FEES.**

For hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities, the commissioner shall collect a fee for the review and approval of architectural, mechanical, and electrical plans and specifications

submitted before construction begins for each project relative to construction of new buildings, additions to existing buildings, or remodeling or alterations of existing buildings. All fees collected in this section shall be deposited in the state treasury and credited to the state government special revenue fund. Fees must be paid at the time of submission of final plans for review and are not refundable. The fee is calculated as follows:

<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>
<u>\$350,001 - \$400,000</u>	<u>\$1,200</u>
<u>\$400,001 - \$450,000</u>	<u>\$1,350</u>
<u>\$450,001 - \$500,000</u>	<u>\$1,500</u>
<u>\$500,001 - \$550,000</u>	<u>\$1,650</u>
<u>\$550,001 - \$600,000</u>	<u>\$1,800</u>
<u>\$600,001 - \$650,000</u>	<u>\$1,950</u>
<u>\$650,001 - \$700,000</u>	<u>\$2,100</u>
<u>\$700,001 - \$750,000</u>	<u>\$2,250</u>
<u>\$750,001 - \$800,000</u>	<u>\$2,400</u>
<u>\$800,001 - \$850,000</u>	<u>\$2,550</u>
<u>\$850,001 - \$900,000</u>	<u>\$2,700</u>
<u>\$900,001 - \$950,000</u>	<u>\$2,850</u>
<u>\$950,001 - \$1,000,000</u>	<u>\$3,000</u>
<u>\$1,000,001 - \$1,050,000</u>	<u>\$3,150</u>
<u>\$1,050,001 - \$1,100,000</u>	<u>\$3,300</u>
<u>\$1,100,001 - \$1,150,000</u>	<u>\$3,450</u>
<u>\$1,150,001 - \$1,200,000</u>	<u>\$3,600</u>
<u>\$1,200,001 - \$1,250,000</u>	<u>\$3,750</u>
<u>\$1,250,001 - \$1,300,000</u>	<u>\$3,900</u>
<u>\$1,300,001 - \$1,350,000</u>	<u>\$4,050</u>
<u>\$1,350,001 - \$1,400,000</u>	<u>\$4,200</u>
<u>\$1,400,001 - \$1,450,000</u>	<u>\$4,350</u>

<u>\$1,450,001 - \$1,500,000</u>	<u>\$4,500</u>
<u>\$1,500,001 and over</u>	<u>\$4,800</u>

Sec. 34. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing Minnesotans;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

- (15) a pediatric geneticist;
- (16) an otolaryngologist;
- (17) a representative from the Newborn Screening Advisory Committee under this subdivision; and
- (18) a representative of the Department of Education regional low-incidence facilitators.

The commissioner must complete the appointments required under this subdivision by September 1, 2007.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

- (d) This subdivision expires June 30, ~~2013~~ 2019.

Sec. 35. Minnesota Statutes 2012, section 144.966, subdivision 3a, is amended to read:

Subd. 3a. **Support services to families.** (a) The commissioner shall contract with a nonprofit organization to provide support and assistance to families with children who are deaf or have a hearing loss. The family support provided must include:

(1) direct hearing loss specific parent-to-parent assistance and unbiased information on communication, educational, and medical options; and

(2) individualized deaf or hard-of-hearing mentors who provide education, including instruction in American Sign Language as an available option.

The commissioner shall give preference to a nonprofit organization that has the ability to provide these services throughout the state.

- (b) Family participation in the support and assistance services is voluntary.

Sec. 36. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must be accompanied by the annual fees specified in this subdivision. The annual fees include:

(1) base accreditation fee, ~~\$1,500~~ \$600;

(2) sample preparation techniques fee, \$200 per technique;

(3) an administrative fee for laboratories located outside this state, ~~\$3,750~~ \$2,000; and

(4) test category fees.

(b) For the programs in subdivision 3a, the commissioner may accredit laboratories for fields of testing under the categories listed in clauses (1) to (10) upon completion of the application requirements provided by subdivision 6 and receipt of the fees for each category under each program that accreditation is requested. The categories offered and related fees include:

(1) microbiology, ~~\$450~~ \$200;

(2) inorganics, ~~\$450~~ \$200;

- (3) metals, ~~\$1,000~~ \$500;
- (4) volatile organics, ~~\$1,300~~ \$1,000;
- (5) other organics, ~~\$1,300~~ \$1,000;
- (6) radiochemistry, ~~\$1,500~~ \$750;
- (7) emerging contaminants, ~~\$1,500~~ \$1,000;
- (8) agricultural contaminants, ~~\$1,250~~ \$1,000;
- (9) toxicity (bioassay), ~~\$1,000~~ \$500; and
- (10) physical characterization, \$250.

(c) The total annual fee includes the base fee, the sample preparation techniques fees, the test category fees per program, and, when applicable, an administrative fee for out-of-state laboratories.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 37. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

Subd. 5. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 38. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 10. **Establishing a selection committee.** (a) The commissioner shall establish a selection committee for the purpose of recommending approval of qualified laboratory assessors and assessment bodies. Committee members shall demonstrate competence in assessment practices. The committee shall initially consist of seven members appointed by the commissioner as follows:

- (1) one member from a municipal laboratory accredited by the commissioner;
- (2) one member from an industrial treatment laboratory accredited by the commissioner;
- (3) one member from a commercial laboratory located in this state and accredited by the commissioner;
- (4) one member from a commercial laboratory located outside the state and accredited by the commissioner;
- (5) one member from a nongovernmental client of environmental laboratories;
- (6) one member from a professional organization with a demonstrated interest in environmental laboratory data and accreditation; and
- (7) one employee of the laboratory accreditation program administered by the department.

(b) Committee appointments begin on January 1 and end on December 31 of the same year.

(c) The commissioner shall appoint persons to fill vacant committee positions, expand the total number of appointed positions, or change the designated positions upon the advice of the committee.

(d) The commissioner shall rescind the appointment of a selection committee member for sufficient cause as the commissioner determines, such as:

- (1) neglect of duty;

- (2) failure to notify the commissioner of a real or perceived conflict of interest;
- (3) nonconformance with committee procedures;
- (4) failure to demonstrate competence in assessment practices; or
- (5) official misconduct.

(e) Members of the selection committee shall be compensated according to the provisions in section 15.059, subdivision 3.

Sec. 39. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 11. **Activities of the selection committee.** (a) The selection committee shall determine assessor and assessment organization application requirements, the frequency of application submittal, and the application review schedule. The commissioner shall publish the application requirements and procedures on the accreditation program Web site.

(b) In its selection process, the committee shall ensure its application requirements and review process:

- (1) meet the standards implemented in subdivision 2a;
- (2) ensure assessors have demonstrated competence in technical disciplines offered for accreditation by the commissioner; and
- (3) consider any history of repeated nonconformance or complaints regarding assessors or assessment bodies.

(c) The selection committee shall consider an application received from qualified applicants and shall supply a list of recommended assessors and assessment bodies to the commissioner of health no later than 90 days after the commissioner notifies the committee of the need for review of applications.

Sec. 40. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 12. **Commissioner approval of assessors and scheduling of assessments.** (a) The commissioner shall approve assessors who:

- (1) are employed by the commissioner for the purpose of accrediting laboratories and demonstrate competence in assessment practices for environmental laboratories; or
- (2) are employed by a state or federal agency with established agreements for mutual assistance or recognition with the commissioner and demonstrate competence in assessment practices for environmental laboratories.

(b) The commissioner may approve other assessors or assessment organizations who are recommended by the selection committee according to subdivision 11, paragraph (c). The commissioner shall publish the list of assessors and assessment organizations approved from the recommendations.

(c) The commissioner shall rescind approval for an assessor or assessment organization for sufficient cause as the commissioner determines, such as:

- (1) failure to meet the minimum qualifications for performing assessments;
- (2) lack of availability;
- (3) nonconformance with the applicable laws, rules, standards, policies, and procedures;
- (4) misrepresentation of application information regarding qualifications and training; or

(5) excessive cost to perform the assessment activities.

Sec. 41. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 13. Laboratory requirements for assessor selection and scheduling assessments. (a) A laboratory accredited or seeking accreditation that requires an assessment by the commissioner must select an assessor, group of assessors, or assessment organization from the published list specified in subdivision 12, paragraph (b). An accredited laboratory must complete an assessment and make all corrective actions at least once every 24 months. Unless the commissioner grants interim accreditation, a laboratory seeking accreditation must complete an assessment and make all corrective actions prior to, but no earlier than, 18 months prior to the date the application is submitted to the commissioner.

(b) A laboratory shall not select the same assessor more than twice in succession for assessments of the same facility unless the laboratory receives written approval from the commissioner for the selection. The laboratory must supply a written request to the commissioner for approval and must justify the reason for the request and provide the alternate options considered.

(c) A laboratory must select assessors appropriate to the size and scope of the laboratory's application or existing accreditation.

(d) A laboratory must enter into its own contract for direct payment of the assessors or assessment organization. The contract must authorize the assessor, assessment organization, or subcontractors to release all records to the commissioner regarding the assessment activity, when the assessment is performed in compliance with this section.

(e) A laboratory must agree to permit other assessors as selected by the commissioner to participate in the assessment activities.

(f) If the laboratory determines no approved assessor is available to perform the assessment, the laboratory must notify the commissioner in writing and provide a justification for the determination. If the commissioner confirms no approved assessor is available, the commissioner may designate an alternate assessor from those approved in subdivision 12, paragraph (a), or the commissioner may delay the assessment until an assessor is available. If an approved alternate assessor performs the assessment, the commissioner may collect fees equivalent to the cost of performing the assessment activities.

(g) Fees collected under this section are deposited in a special account and are annually appropriated to the commissioner for the purpose of performing assessment activities.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 42. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:

Subd. 4. Administrative penalty orders. (a) The commissioner may issue an order requiring violations to be corrected and administratively assessing monetary penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The procedures in section 144.991 must be followed when issuing administrative penalty orders. Except in the case of repeated or serious violations, the penalty assessed in the order must be forgiven if the person who is subject to the order demonstrates in writing to the commissioner before the 31st day after receiving the order that the person has corrected the violation or has developed a corrective plan acceptable to the commissioner. The maximum amount of an administrative penalty order is \$10,000 for each violator for all violations by that violator identified in an inspection or review of compliance.

(b) Notwithstanding paragraph (a), the commissioner may issue to a large public water supply, serving a population of more than 10,000 persons, an administrative penalty order imposing a penalty of at least

\$1,000 per day per violation, not to exceed \$10,000 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

(c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead firm or person performing regulated lead work, an administrative penalty order imposing a penalty of at least \$5,000 per violation per day, not to exceed \$10,000 for each violation of sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from monetary penalties in this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 43. **[145.4716] SAFE HARBOR FOR SEXUALLY EXPLOITED YOUTH.**

Subdivision 1. **Director.** The commissioner of health shall establish a position for a director of child sex trafficking prevention.

Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible for the following:

(1) developing and providing comprehensive training on sexual exploitation of youth for social service professionals, medical professionals, public health workers, and criminal justice professionals;

(2) collecting, organizing, maintaining, and disseminating information on sexual exploitation and services across the state, including maintaining a list of resources on the Department of Health Web site;

(3) monitoring and applying for federal funding for antitrafficking efforts that may benefit victims in the state;

(4) managing grant programs established under this act;

(5) identifying best practices in serving sexually exploited youth, as defined in section 260C.007, subdivision 31;

(6) providing oversight of and technical support to regional navigators pursuant to section 145.4717;

(7) conducting a comprehensive evaluation of the statewide program for safe harbor of sexually exploited youth; and

(8) developing a policy, consistent with the requirements of chapter 13, for sharing data related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among regional navigators and community-based advocates.

Sec. 44. **[145.4717] REGIONAL NAVIGATOR GRANTS.**

The commissioner of health, through its director of child sex trafficking prevention, established in section 145.4716, shall provide grants to regional navigators serving six regions of the state to be determined by the commissioner. Each regional navigator must develop and annually submit a work plan to the director of child sex trafficking prevention. The work plans must include, but are not limited to, the following information:

(1) a needs statement specific to the region, including an examination of the population at risk;

(2) regional resources available to sexually exploited youth, as defined in section 260C.007, subdivision 31;

(3) grant goals and measurable outcomes; and

(4) grant activities including timelines.

Sec. 45. **[145.4718] PROGRAM EVALUATION.**

(a) The director of child sex trafficking prevention, established under section 145.4716, must conduct, or contract for, comprehensive evaluation of the statewide program for safe harbor for sexually exploited youth. The first evaluation must be completed by June 30, 2015, and must be submitted to the commissioner of health by September 1, 2015, and every two years thereafter. The evaluation must consider whether the program is reaching intended victims and whether support services are available, accessible, and adequate for sexually exploited youth, as defined in section 260C.007, subdivision 31.

(b) In conducting the evaluation, the director of child sex trafficking prevention must consider evaluation of outcomes, including whether the program increases identification of sexually exploited youth, coordination of investigations, access to services and housing available for sexually exploited youth, and improved effectiveness of services. The evaluation must also include examination of the ways in which penalties under section 609.3241 are assessed, collected, and distributed to ensure funding for investigation, prosecution, and victim services to combat sexual exploitation of youth.

Sec. 46. Minnesota Statutes 2012, section 145.906, is amended to read:

145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.

(a) The commissioner of health shall work with health care facilities, licensed health and mental health care professionals, the women, infants, and children (WIC) program, mental health advocates, consumers, and families in the state to develop materials and information about postpartum depression, including treatment resources, and develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must have available to women and their families information about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources.

(d) Information about postpartum depression, including its symptoms, potential impact on families, and treatment resources, must be available at WIC sites.

(e) The commissioner of health, in collaboration with the commissioner of human services and to the extent authorized by the federal Centers for Disease Control and Prevention, shall review the materials and information related to postpartum depression to determine their effectiveness in transmitting the information in a way that reduces racial health disparities as reported in surveys of maternal attitudes and experiences before, during, and after pregnancy, including those conducted by the commissioner of health. The commissioner shall implement changes to reduce racial health disparities in the information reviewed, as needed, and ensure that women of color are receiving the information.

Sec. 47. **[145.907] MATERNAL DEPRESSION; DEFINITION.**

"Maternal depression" means depression or other perinatal mood or anxiety disorder experienced by a woman during pregnancy or during the first year following the birth of her child.

Sec. 48. Minnesota Statutes 2012, section 145.986, is amended to read:

145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.

Subdivision 1. ~~Grants to local communities~~ **Purpose.** The purpose of the statewide health improvement program is to:

(1) address the top three leading preventable causes of illness and death: tobacco use and exposure, poor diet, and lack of regular physical activity;

(2) promote the development, availability, and use of evidence-based, community level, comprehensive strategies to create healthy communities; and

(3) measure the impact of the evidence-based, community health improvement practices which over time work to contain health care costs and reduce chronic diseases.

Subd. 1a. Grants to local communities. (a) Beginning July 1, 2009, the commissioner of health shall award competitive grants to community health boards established pursuant to section 145A.09 and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco. Grants shall be awarded to all community health boards and tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and other requirements of this section.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, worksite, and health care settings; ~~and~~

(5) be focused on policy, systems, and environmental changes that support healthy behaviors; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the ~~interventions~~ strategies, and modify or discontinue ~~interventions~~ strategies found to be ineffective.

~~(f) By January 15, 2011, the commissioner of health shall recommend whether any funding should be distributed to community health boards and tribal governments based on health disparities demonstrated in the populations served.~~

~~(g)~~ (f) Grant recipients shall report their activities and their progress toward the outcomes established under subdivision 2 to the commissioner in a format and at a time specified by the commissioner.

~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 2. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

Subd. 2. Outcomes. (a) The commissioner shall set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of grant recipients in meeting the outcomes.

(b) The commissioner shall measure current public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide content expertise, technical expertise, and training to grant recipients and advice on evidence-based strategies, including those based on populations and types of communities served. The commissioner shall ensure that the statewide health improvement program meets the outcomes established under subdivision 2 by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

(b) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

- (1) community engagement and capacity building;
- (2) tribal support;
- (3) community asset building and risk behavior reduction;
- (4) legal;
- (5) communications;
- (6) community, school, health care, work site, and other site-specific strategies; and
- (7) health equity.

Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

(b) Grant recipients will collect, monitor, and submit to the Department of Health baseline and annual data and provide information to improve the quality and impact of community health improvement strategies.

(c) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in designing and implementing evaluation systems.

(d) Contracts awarded under paragraph (c) may be used to:

- (1) develop grantee monitoring and reporting systems to track grantee progress, including aggregated and disaggregated data;
- (2) manage, analyze, and report program evaluation data results; and
- (3) utilize innovative support tools to analyze and predict the impact of prevention strategies on health outcomes and state health care costs over time.

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. ~~These reports~~ The report must include information on each grant recipients recipient, including the activities that were conducted by the grantee using grant funds, evaluation data, and outcome measures, if available. the grantee's progress toward achieving the measurable outcomes established under subdivision 2, and the data provided to the commissioner by the grantee to measure these outcomes for grant activities. The commissioner shall provide information on grants in which a corrective action plan was required under subdivision 1a, the types of plan action, and the progress that has been made toward meeting the measurable outcomes. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January

15 of every other year, beginning in 2010. ~~In the report due on January 15, 2010, the commissioner shall include recommendations on a sustainable funding source for the statewide health improvement program other than the health care access fund~~ In the report due on January 15, 2014, the commissioner shall include a description of the contracts awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems that were designed and implemented under these contracts.

Subd. 6. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs that work to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco, or replace discontinued state or federal funds previously used to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco. Funds must not be used to supplant current state or local funding to community health boards or tribal governments used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use.

Sec. 49. Minnesota Statutes 2012, section 145A.17, subdivision 1, is amended to read:

Subdivision 1. **Establishment; goals.** The commissioner shall establish a program to fund family home visiting programs designed to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. Programs must begin prenatally whenever possible and must be targeted to families with:

- (1) adolescent parents;
- (2) a history of alcohol or other drug abuse;
- (3) a history of child abuse, domestic abuse, or other types of violence;
- (4) a history of domestic abuse, rape, or other forms of victimization;
- (5) reduced cognitive functioning;
- (6) a lack of knowledge of child growth and development stages;
- (7) low resiliency to adversities and environmental stresses;
- (8) insufficient financial resources to meet family needs;
- (9) a history of homelessness;
- (10) a risk of long-term welfare dependence or family instability due to employment barriers; or
- (11) a serious mental health disorder, including maternal depression as defined in section 145.907; or
- (H) (12) other risk factors as determined by the commissioner.

Sec. 50. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead human body to essential elements through ~~exposure to a combination of heat and alkaline hydrolysis and the repositioning or movement of the body during the process to facilitate reduction;~~ a water-based dissolution process using alkaline chemicals, heat, agitation, and pressure to accelerate natural decomposition; the processing of the hydrolyzed remains after removal from the alkaline hydrolysis ~~chamber,~~ vessel; placement of the processed

remains in a hydrolyzed remains container; and release of the hydrolyzed remains to an appropriate party. Alkaline hydrolysis is a form of final disposition.

Sec. 51. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1b. Alkaline hydrolysis container. "Alkaline hydrolysis container" means a hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily fluids that encases the body and into which a dead human body is placed prior to insertion into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or biodegradable alternative containers or caskets.

Sec. 52. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1c. Alkaline hydrolysis facility. "Alkaline hydrolysis facility" means a building or structure containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead human bodies.

Sec. 53. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1d. Alkaline hydrolysis vessel. "Alkaline hydrolysis vessel" means the container in which the alkaline hydrolysis of a dead human body is performed.

Sec. 54. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:

Subd. 2. Alternative container. "Alternative container" means a nonmetal receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed for the encasement of dead human bodies and is made of hydrolyzable or biodegradable materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

Sec. 55. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:

Subd. 3. Arrangements for disposition. "Arrangements for disposition" means any action normally taken by a funeral provider in anticipation of or preparation for the entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

Sec. 56. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:

Subd. 4. Cash advance item. "Cash advance item" means any item of service or merchandise described to a purchaser as a "cash advance," "accommodation," "cash disbursement," or similar term. A cash advance item is also any item obtained from a third party and paid for by the funeral provider on the purchaser's behalf. Cash advance items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services, pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary notices, gratuities, and death records.

Sec. 57. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:

Subd. 5. Casket. "Casket" means a rigid container which is designed for the encasement of a dead human body and is usually constructed of hydrolyzable or biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented and lined with fabric.

Sec. 58. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 12a. Crypt. "Crypt" means a space in a mausoleum of sufficient size, used or intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

Sec. 59. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a final disposition of a dead human body by alkaline hydrolysis, without formal viewing, visitation, or ceremony with the body present.

Sec. 60. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:

Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

Sec. 61. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:

Subd. 23. **Funeral services.** "Funeral services" means any services which may be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis, cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral ceremony or the final disposition of dead human bodies.

Sec. 62. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 24a. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not include pacemakers, prostheses, or similar foreign materials.

Sec. 63. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 24b. **Hydrolyzed remains container.** "Hydrolyzed remains container" means a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage jewelry.

Sec. 64. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

Sec. 65. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:

Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued a license to practice mortuary science, to operate a funeral establishment, to operate an alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner of health.

Sec. 66. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be used, for the placement of hydrolyzed or cremated remains.

Sec. 67. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 32a. **Placement.** "Placement" means the placing of a container holding hydrolyzed or cremated remains in a crypt, vault, or niche.

Sec. 68. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:

Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of the body into an appropriate cremation or alkaline hydrolysis container, embalming of the body or such items of care as washing, disinfecting, shaving, positioning of features, restorative procedures, application of cosmetics, dressing, and casketing.

Sec. 69. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:

Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance appropriate for final disposition.

Sec. 70. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:

Subd. 37. **Public transportation.** "Public transportation" means all manner of transportation via common carrier available to the general public including airlines, buses, railroads, and ships. For purposes of this chapter, a livery service providing transportation to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public transportation.

Sec. 71. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed or cremated remains in a defined area of a dedicated cemetery or in areas where no local prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable to the public, are not in a container, and that the person who has control over disposition of the hydrolyzed or cremated remains has obtained written permission of the property owner or governing agency to scatter on the property.

Sec. 72. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains. Vault may also mean a sealed and lined casket enclosure.

Sec. 73. Minnesota Statutes 2012, section 149A.03, is amended to read:

149A.03 DUTIES OF COMMISSIONER.

The commissioner shall:

- (1) enforce all laws and adopt and enforce rules relating to the:
 - (i) removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies;
 - (ii) licensure and professional conduct of funeral directors, morticians, interns, practicum students, and clinical students;
 - (iii) licensing and operation of a funeral establishment; ~~and~~
 - (iv) licensing and operation of an alkaline hydrolysis facility; and
 - ~~(iv)~~ (v) licensing and operation of a crematory;
- (2) provide copies of the requirements for licensure and permits to all applicants;
- (3) administer examinations and issue licenses and permits to qualified persons and other legal entities;
- (4) maintain a record of the name and location of all current licensees and interns;
- (5) perform periodic compliance reviews and premise inspections of licensees;
- (6) accept and investigate complaints relating to conduct governed by this chapter;
- (7) maintain a record of all current preneed arrangement trust accounts;

(8) maintain a schedule of application, examination, permit, and licensure fees, initial and renewal, sufficient to cover all necessary operating expenses;

(9) educate the public about the existence and content of the laws and rules for mortuary science licensing and the removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies to enable consumers to file complaints against licensees and others who may have violated those laws or rules;

(10) evaluate the laws, rules, and procedures regulating the practice of mortuary science in order to refine the standards for licensing and to improve the regulatory and enforcement methods used; and

(11) initiate proceedings to address and remedy deficiencies and inconsistencies in the laws, rules, or procedures governing the practice of mortuary science and the removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies.

Sec. 74. [149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS FACILITY.

Subdivision 1. License requirement. Except as provided in section 149A.01, subdivision 3, a place or premise shall not be maintained, managed, or operated which is devoted to or used in the holding and alkaline hydrolysis of a dead human body without possessing a valid license to operate an alkaline hydrolysis facility issued by the commissioner of health.

Subd. 2. Requirements for an alkaline hydrolysis facility. (a) An alkaline hydrolysis facility licensed under this section must consist of:

(1) a building or structure that complies with applicable local and state building codes, zoning laws and ordinances, and wastewater management and environmental standards, containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead human bodies;

(2) a method approved by the commissioner of health to dry the hydrolyzed remains and which is located within the licensed facility;

(3) a means approved by the commissioner of health for refrigeration of dead human bodies awaiting alkaline hydrolysis;

(4) an appropriate means of processing hydrolyzed remains to a granulated appearance appropriate for final disposition; and

(5) an appropriate holding facility for dead human bodies awaiting alkaline hydrolysis.

(b) An alkaline hydrolysis facility licensed under this section may also contain a display room for funeral goods.

Subd. 3. Application procedure; documentation; initial inspection. An application to license and operate an alkaline hydrolysis facility shall be submitted to the commissioner of health. A completed application includes:

(1) a completed application form, as provided by the commissioner;

(2) proof of business form and ownership;

(3) proof of liability insurance coverage or other financial documentation, as determined by the commissioner, that demonstrates the applicant's ability to respond in damages for liability arising from the ownership, maintenance management, or operation of an alkaline hydrolysis facility; and

(4) copies of wastewater and other environmental regulatory permits and environmental regulatory licenses necessary to conduct operations.

Upon receipt of the application and appropriate fee, the commissioner shall review and verify all information. Upon completion of the verification process and resolution of any deficiencies in the application information, the commissioner shall conduct an initial inspection of the premises to be licensed. After the inspection and resolution of any deficiencies found and any reinspections as may be necessary, the commissioner shall make a determination, based on all the information available, to grant or deny licensure. If the commissioner's determination is to grant the license, the applicant shall be notified and the license shall issue and remain valid for a period prescribed on the license, but not to exceed one calendar year from the date of issuance of the license. If the commissioner's determination is to deny the license, the commissioner must notify the applicant in writing of the denial and provide the specific reason for denial.

Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis facility is not assignable or transferable and shall not be valid for any entity other than the one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the location identified on the license. A 50 percent or more change in ownership or location of the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall be required of two or more persons or other legal entities operating from the same location.

Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis facility must be conspicuously displayed in the alkaline hydrolysis facility at all times. Conspicuous display means in a location where a member of the general public within the alkaline hydrolysis facility is able to observe and read the license.

Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility issued by the commissioner are valid for a period of one calendar year beginning on July 1 and ending on June 30, regardless of the date of issuance.

Subd. 7. **Reporting changes in license information.** Any change of license information must be reported to the commissioner, on forms provided by the commissioner, no later than 30 calendar days after the change occurs. Failure to report changes is grounds for disciplinary action.

Subd. 8. **Notification to the commissioner.** If the licensee is operating under a wastewater or an environmental permit or license that is subsequently revoked, denied, or terminated, the licensee shall notify the commissioner.

Subd. 9. **Application information.** All information submitted to the commissioner for a license to operate an alkaline hydrolysis facility is classified as licensing data under section 13.41, subdivision 5.

Sec. 75. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE HYDROLYSIS FACILITY.**

Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis facility issued by the commissioner expire on June 30 following the date of issuance of the license and must be renewed to remain valid.

Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew their licenses must submit to the commissioner a completed renewal application no later than June 30 following the date the license was issued. A completed renewal application includes:

(1) a completed renewal application form, as provided by the commissioner; and

(2) proof of liability insurance coverage or other financial documentation, as determined by the commissioner, that demonstrates the applicant's ability to respond in damages for liability arising from the ownership, maintenance, management, or operation of an alkaline hydrolysis facility.

Upon receipt of the completed renewal application, the commissioner shall review and verify the information. Upon completion of the verification process and resolution of any deficiencies in the renewal

application information, the commissioner shall make a determination, based on all the information available, to reissue or refuse to reissue the license. If the commissioner's determination is to reissue the license, the applicant shall be notified and the license shall issue and remain valid for a period prescribed on the license, but not to exceed one calendar year from the date of issuance of the license. If the commissioner's determination is to refuse to reissue the license, section 149A.09, subdivision 2, applies.

Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration date of a license will result in the assessment of a late filing penalty. The late filing penalty must be paid before the reissuance of the license and received by the commissioner no later than 31 calendar days after the expiration date of the license.

Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities shall automatically lapse when a completed renewal application is not received by the commissioner within 31 calendar days after the expiration date of a license, or a late filing penalty assessed under subdivision 3 is not received by the commissioner within 31 calendar days after the expiration of a license.

Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom the license was issued is no longer licensed to operate an alkaline hydrolysis facility in Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue any additional lawful remedies as justified by the case.

Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed license upon receipt and review of a completed renewal application, receipt of the late filing penalty, and reinspection of the premises, provided that the receipt is made within one calendar year from the expiration date of the lapsed license and the cease and desist order issued by the commissioner has not been violated. If a lapsed license is not restored within one calendar year from the expiration date of the lapsed license, the holder of the lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

Subd. 7. **Reporting changes in license information.** Any change of license information must be reported to the commissioner, on forms provided by the commissioner, no later than 30 calendar days after the change occurs. Failure to report changes is grounds for disciplinary action.

Subd. 8. **Application information.** All information submitted to the commissioner by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is classified as licensing data under section 13.41, subdivision 5.

Sec. 76. Minnesota Statutes 2012, section 149A.65, is amended by adding a subdivision to read:

Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline hydrolysis facility is \$300. The late fee charge for a license renewal is \$25.

Sec. 77. Minnesota Statutes 2012, section 149A.65, is amended by adding a subdivision to read:

Subd. 7. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 78. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:

Subdivision 1. **Use of titles.** Only a person holding a valid license to practice mortuary science issued by the commissioner may use the title of mortician, funeral director, or any other title implying that the licensee is engaged in the business or practice of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis facility issued by the commissioner may use the title of alkaline hydrolysis facility, water cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or any other title, word, or term implying that the licensee operates an alkaline hydrolysis facility. Only the holder of a valid license to operate a funeral establishment issued by the commissioner may use the title of funeral

home, funeral chapel, funeral service, or any other title, word, or term implying that the licensee is engaged in the business or practice of mortuary science. Only the holder of a valid license to operate a crematory issued by the commissioner may use the title of crematory, crematorium, green-cremation, or any other title, word, or term implying that the licensee operates a crematory or crematorium.

Sec. 79. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:

Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or crematory shall not do business in a location that is not licensed as a funeral establishment, alkaline hydrolysis facility, or crematory and shall not advertise a service that is available from an unlicensed location.

Sec. 80. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:

Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern shall publish or disseminate false, misleading, or deceptive advertising. False, misleading, or deceptive advertising includes, but is not limited to:

(1) identifying, by using the names or pictures of, persons who are not licensed to practice mortuary science in a way that leads the public to believe that those persons will provide mortuary science services;

(2) using any name other than the names under which the funeral establishment, alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

(3) using a surname not directly, actively, or presently associated with a licensed funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had been previously and continuously used by the licensed funeral establishment, alkaline hydrolysis facility, or crematory; and

(4) using a founding or establishing date or total years of service not directly or continuously related to a name under which the funeral establishment, alkaline hydrolysis facility, or crematory is currently or was previously licensed.

Any advertising or other printed material that contains the names or pictures of persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory shall state the position held by the persons and shall identify each person who is licensed or unlicensed under this chapter.

Sec. 81. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:

Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other reimbursement in consideration for recommending or causing a dead human body to be disposed of by a specific body donation program, funeral establishment, alkaline hydrolysis facility, crematory, mausoleum, or cemetery.

Sec. 82. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:

Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or practices, the requirements of this subdivision must be met.

(b) Funeral providers must tell persons who ask by telephone about the funeral provider's offerings or prices any accurate information from the price lists described in paragraphs (c) to (e) and any other readily available information that reasonably answers the questions asked.

(c) Funeral providers must make available for viewing to people who inquire in person about the offerings or prices of funeral goods or burial site goods, separate printed or typewritten price lists using a ten-point font or larger. Each funeral provider must have a separate price list for each of the following types of goods that are sold or offered for sale:

- (1) caskets;
- (2) alternative containers;
- (3) outer burial containers;
- (4) alkaline hydrolysis containers;
- ~~(4)~~ (5) cremation containers;
- (6) hydrolyzed remains containers;
- ~~(5)~~ (7) cremated remains containers;
- ~~(6)~~ (8) markers; and
- ~~(7)~~ (9) headstones.

(d) Each separate price list must contain the name of the funeral provider's place of business, address, and telephone number and a caption describing the list as a price list for one of the types of funeral goods or burial site goods described in paragraph (c), clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion of, but in any event before showing, the specific funeral goods or burial site goods and must provide a photocopy of the price list, for retention, if so asked by the consumer. The list must contain, at least, the retail prices of all the specific funeral goods and burial site goods offered which do not require special ordering, enough information to identify each, and the effective date for the price list. However, funeral providers are not required to make a specific price list available if the funeral providers place the information required by this paragraph on the general price list described in paragraph (e).

(e) Funeral providers must give a printed price list, for retention, to persons who inquire in person about the funeral goods, funeral services, burial site goods, or burial site services or prices offered by the funeral provider. The funeral provider must give the list upon beginning discussion of either the prices of or the overall type of funeral service or disposition or specific funeral goods, funeral services, burial site goods, or burial site services offered by the provider. This requirement applies whether the discussion takes place in the funeral establishment or elsewhere. However, when the deceased is removed for transportation to the funeral establishment, an in-person request for authorization to embalm does not, by itself, trigger the requirement to offer the general price list. If the provider, in making an in-person request for authorization to embalm, discloses that embalming is not required by law except in certain special cases, the provider is not required to offer the general price list. Any other discussion during that time about prices or the selection of funeral goods, funeral services, burial site goods, or burial site services triggers the requirement to give the consumer a general price list. The general price list must contain the following information:

- (1) the name, address, and telephone number of the funeral provider's place of business;
- (2) a caption describing the list as a "general price list";
- (3) the effective date for the price list;
- (4) the retail prices, in any order, expressed either as a flat fee or as the prices per hour, mile, or other unit of computation, and other information described as follows:
 - (i) forwarding of remains to another funeral establishment, together with a list of the services provided for any quoted price;
 - (ii) receiving remains from another funeral establishment, together with a list of the services provided for any quoted price;
 - (iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral provider, with the price including an alternative container or alkaline hydrolysis or cremation container, any alkaline hydrolysis

or crematory charges, and a description of the services and container included in the price, where applicable, and the price of alkaline hydrolysis or cremation where the purchaser provides the container;

(iv) separate prices for each immediate burial offered by the funeral provider, including a casket or alternative container, and a description of the services and container included in that price, and the price of immediate burial where the purchaser provides the casket or alternative container;

(v) transfer of remains to the funeral establishment or other location;

(vi) embalming;

(vii) other preparation of the body;

(viii) use of facilities, equipment, or staff for viewing;

(ix) use of facilities, equipment, or staff for funeral ceremony;

(x) use of facilities, equipment, or staff for memorial service;

(xi) use of equipment or staff for graveside service;

(xii) hearse or funeral coach;

(xiii) limousine; and

(xiv) separate prices for all cemetery-specific goods and services, including all goods and services associated with interment and burial site goods and services and excluding markers and headstones;

(5) the price range for the caskets offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or casket sale location." or the prices of individual caskets, as disclosed in the manner described in paragraphs (c) and (d);

(6) the price range for the alternative containers offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or alternative container sale location." or the prices of individual alternative containers, as disclosed in the manner described in paragraphs (c) and (d);

(7) the price range for the outer burial containers offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or outer burial container sale location." or the prices of individual outer burial containers, as disclosed in the manner described in paragraphs (c) and (d);

(8) the price range for the alkaline hydrolysis container offered by the funeral provider, together with the statement: "A complete price list will be provided at the funeral establishment or alkaline hydrolysis container sale location.", or the prices of individual alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c) and (d);

(9) the price range for the hydrolyzed remains container offered by the funeral provider, together with the statement: "A complete price list will be provided at the funeral establishment or hydrolyzed remains container sale location.", or the prices of individual hydrolyzed remains container, as disclosed in the manner described in paragraphs (c) and (d);

~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or cremation container sale location." or the prices of individual cremation containers ~~and cremated remains containers~~, as disclosed in the manner described in paragraphs (c) and (d);

~~(9)~~ (11) the price range for the cremated remains containers offered by the funeral provider, together with the statement, "A complete price list will be provided at the funeral establishment or cremation cremated

remains container sale location," or the prices of individual cremation containers as disclosed in the manner described in paragraphs (c) and (d);

~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a list of the principal basic services provided for any quoted price and, if the charge cannot be declined by the purchaser, the statement "This fee for our basic services will be added to the total cost of the funeral arrangements you select. (This fee is already included in our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted price shall include all charges for the recovery of unallocated funeral provider overhead, and funeral providers may include in the required disclosure the phrase "and overhead" after the word "services." This services fee is the only funeral provider fee for services, facilities, or unallocated overhead permitted by this subdivision to be nondeclinable, unless otherwise required by law;

~~(11)~~ (13) the price range for the markers and headstones offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or marker or headstone sale location." or the prices of individual markers and headstones, as disclosed in the manner described in paragraphs (c) and (d); and

~~(12)~~ (14) any package priced funerals offered must be listed in addition to and following the information required in paragraph (e) and must clearly state the funeral goods and services being offered, the price being charged for those goods and services, and the discounted savings.

(f) Funeral providers must give an itemized written statement, for retention, to each consumer who arranges an at-need funeral or other disposition of human remains at the conclusion of the discussion of the arrangements. The itemized written statement must be signed by the consumer selecting the goods and services as required in section 149A.80. If the statement is provided by a funeral establishment, the statement must be signed by the licensed funeral director or mortician planning the arrangements. If the statement is provided by any other funeral provider, the statement must be signed by an authorized agent of the funeral provider. The statement must list the funeral goods, funeral services, burial site goods, or burial site services selected by that consumer and the prices to be paid for each item, specifically itemized cash advance items (these prices must be given to the extent then known or reasonably ascertainable if the prices are not known or reasonably ascertainable, a good faith estimate shall be given and a written statement of the actual charges shall be provided before the final bill is paid), and the total cost of goods and services selected. At the conclusion of an at-need arrangement, the funeral provider is required to give the consumer a copy of the signed itemized written contract that must contain the information required in this paragraph.

(g) Upon receiving actual notice of the death of an individual with whom a funeral provider has entered a preneed funeral agreement, the funeral provider must provide a copy of all preneed funeral agreement documents to the person who controls final disposition of the human remains or to the designee of the person controlling disposition. The person controlling final disposition shall be provided with these documents at the time of the person's first in-person contact with the funeral provider, if the first contact occurs in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place of business of the funeral provider. If the contact occurs by other means or at another location, the documents must be provided within 24 hours of the first contact.

Sec. 83. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

Subd. 4. **Casket, alternate container, alkaline hydrolysis container, and cremation container sales; records; required disclosures.** Any funeral provider who sells or offers to sell a casket, alternate container, or alkaline hydrolysis container, hydrolyzed remains container, cremation container, or cremated remains container to the public must maintain a record of each sale that includes the name of the purchaser, the purchaser's mailing address, the name of the decedent, the date of the decedent's death, and the place of death. These records shall be open to inspection by the regulatory agency. Any funeral provider selling a

casket, alternate container, or cremation container to the public, and not having charge of the final disposition of the dead human body, shall provide a copy of the statutes and rules controlling the removal, preparation, transportation, arrangements for disposition, and final disposition of a dead human body. This subdivision does not apply to morticians, funeral directors, funeral establishments, crematories, or wholesale distributors of caskets, alternate containers, alkaline hydrolysis containers, or cremation containers.

Sec. 84. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:

Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts or practices.** In selling or offering to sell funeral goods or funeral services to the public, it is a deceptive act or practice for a funeral provider to represent that a casket is required for alkaline hydrolysis or cremations by state or local law or otherwise.

Sec. 85. Minnesota Statutes 2012, section 149A.72, is amended by adding a subdivision to read:

Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To prevent deceptive acts or practices, funeral providers must place the following disclosure in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota law does not require you to purchase a casket for alkaline hydrolysis. If you want to arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily fluids that encases the body and into which a dead human body is placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide are (specify containers provided)." This disclosure is required only if the funeral provider arranges alkaline hydrolysis.

Sec. 86. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:

Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site goods, or burial site services to the public, it is a deceptive act or practice for a funeral provider to represent that federal, state, or local laws, or particular cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral goods, funeral services, burial site goods, or burial site services when that is not the case.

Sec. 87. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site goods, or burial site services to the public, it is a deceptive act or practice for a funeral provider to require that a casket be purchased for alkaline hydrolysis or cremation.

Sec. 88. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.** To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline hydrolysis or cremations, they must make a an alkaline hydrolysis container or cremation container available for alkaline hydrolysis or cremations.

Sec. 89. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

Subd. 4. **Required purchases of funeral goods or services; preventive requirements.** To prevent unfair or deceptive acts or practices, funeral providers must place the following disclosure in the general price list, immediately above the prices required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods and services shown below are those we can provide to our customers. You may choose only the items you desire. If legal or other requirements mean that you must buy any items you

did not specifically ask for, we will explain the reason in writing on the statement we provide describing the funeral goods, funeral services, burial site goods, and burial site services you selected." However, if the charge for "services of funeral director and staff" cannot be declined by the purchaser, the statement shall include the sentence "However, any funeral arrangements you select will include a charge for our basic services." between the second and third sentences of the sentences specified in this subdivision. The statement may include the phrase "and overhead" after the word "services" if the fee includes a charge for the recovery of unallocated funeral overhead. If the funeral provider does not include this disclosure statement, then the following disclosure statement must be placed in the statement of funeral goods, funeral services, burial site goods, and burial site services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges are only for those items that you selected or that are required. If we are required by law or by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain the reasons in writing below." A funeral provider is not in violation of this subdivision by failing to comply with a request for a combination of goods or services which would be impossible, impractical, or excessively burdensome to provide.

Sec. 90. Minnesota Statutes 2012, section 149A.74, is amended to read:

149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.

Subdivision 1. **Services provided without prior approval; deceptive acts or practices.** In selling or offering to sell funeral goods or funeral services to the public, it is a deceptive act or practice for any funeral provider to embalm a dead human body unless state or local law or regulation requires embalming in the particular circumstances regardless of any funeral choice which might be made, or prior approval for embalming has been obtained from an individual legally authorized to make such a decision. In seeking approval to embalm, the funeral provider must disclose that embalming is not required by law except in certain circumstances; that a fee will be charged if a funeral is selected which requires embalming, such as a funeral with viewing; and that no embalming fee will be charged if the family selects a service which does not require embalming, such as direct alkaline hydrolysis, direct cremation, or immediate burial.

Subd. 2. **Services provided without prior approval; preventive requirement.** To prevent unfair or deceptive acts or practices, funeral providers must include on the itemized statement of funeral goods or services, as described in section 149A.71, subdivision 2, paragraph (f), the statement "If you selected a funeral that may require embalming, such as a funeral with viewing, you may have to pay for embalming. You do not have to pay for embalming you did not approve if you selected arrangements such as direct alkaline hydrolysis, direct cremation, or immediate burial. If we charged for embalming, we will explain why below."

Sec. 91. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:

Subd. 9. **Embalmed Bodies awaiting final disposition.** All **embalmed** bodies awaiting final disposition shall be kept in an appropriate holding facility or preparation and embalming room. The holding facility must be secure from access by anyone except the authorized personnel of the funeral establishment, preserve the dignity and integrity of the body, and protect the health and safety of the personnel of the funeral establishment.

Sec. 92. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:

Subd. 3. **Disposition permit.** A disposition permit is required before a body can be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be issued until a fact of death record has been completed and filed with the local or state registrar of vital statistics.

Sec. 93. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:

Subd. 6. **Conveyances permitted for transportation.** A dead human body may be transported by means of private vehicle or private aircraft, provided that the body must be encased in an appropriate container, that meets the following standards:

- (1) promotes respect for and preserves the dignity of the dead human body;
- (2) shields the body from being viewed from outside of the conveyance;
- (3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container, or cremation container in a horizontal position;
- (4) is designed to permit loading and unloading of the body without excessive tilting of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container, or cremation container; and
- (5) if used for the transportation of more than one dead human body at one time, the vehicle must be designed so that a body or container does not rest directly on top of another body or container and that each body or container is secured to prevent the body or container from excessive movement within the conveyance.

A vehicle that is a dignified conveyance and was specified for use by the deceased or by the family of the deceased may be used to transport the body to the place of final disposition.

Sec. 94. Minnesota Statutes 2012, section 149A.94, is amended to read:

149A.94 FINAL DISPOSITION.

Subdivision 1. **Generally.** Every dead human body lying within the state, except unclaimed bodies delivered for dissection by the medical examiner, those delivered for anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through the state for the purpose of disposition elsewhere; and the remains of any dead human body after dissection or anatomical study, shall be decently buried; or entombed in a public or private cemetery, alkaline hydrolyzed or cremated; within a reasonable time after death. Where final disposition of a body will not be accomplished within 72 hours following death or release of the body by a competent authority with jurisdiction over the body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry ice for a period that exceeds four calendar days, from the time of death or release of the body from the coroner or medical examiner.

Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or cremated without a disposition permit. The disposition permit must be filed with the person in charge of the place of final disposition. Where a dead human body will be transported out of this state for final disposition, the body must be accompanied by a certificate of removal.

Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or cremated remains and release to an appropriate party is considered final disposition and no further permits or authorizations are required for transportation, interment, entombment, or placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

Sec. 95. **[149A.94] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE HYDROLYSIS.**

Subdivision 1. **License required.** A dead human body may only be hydrolyzed in this state at an alkaline hydrolysis facility licensed by the commissioner of health.

Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis facility must comply with all applicable local and state building codes, zoning laws and ordinances, wastewater management regulations, and environmental statutes, rules, and standards. An alkaline hydrolysis facility must have, on site, a purpose built human alkaline hydrolysis system approved by the commissioner of

health, a system approved by the commissioner of health for drying the hydrolyzed remains, a motorized mechanical device approved by the commissioner of health for processing hydrolyzed remains, and in the building a holding facility approved by the commissioner of health for the retention of dead human bodies awaiting alkaline hydrolysis. The holding facility must be secure from access by anyone except the authorized personnel of the alkaline hydrolysis facility, preserve the dignity of the remains, and protect the health and safety of the alkaline hydrolysis facility personnel.

Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall be properly lit and ventilated with an exhaust fan that provides at least 12 air changes per hour.

Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines, plumbing vents, and waste drains shall be properly vented and connected pursuant to the Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a functional sink with hot and cold running water.

Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall have nonporous flooring, so that a sanitary condition is provided. The walls and ceiling of the room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall run from floor to ceiling and be covered with tile, or by plaster or sheetrock painted with washable paint or other appropriate material so that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be constructed to prevent odors from entering any other part of the building. All windows or other openings to the outside must be screened, and all windows must be treated in a manner that prevents viewing into the room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place. A viewing window for authorized family members or their designees is not a violation of this subdivision.

Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a functional emergency eye wash and quick drench shower.

Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place must be private and have no general passageway through it. The room shall, at all times, be secure from the entrance of unauthorized persons. Authorized persons are:

(1) licensed morticians;

(2) registered interns or students as described in section 149A.91, subdivision 6;

(3) public officials or representatives in the discharge of their official duties;

(4) trained alkaline hydrolysis facility operators; and

(5) the person or persons with the right to control the dead human body as defined in section 149A.80, subdivision 2, and their designees.

(b) Each door allowing ingress or egress shall carry a sign that indicates that the room is private and access is limited. All authorized persons who are present in or enter the room where the alkaline hydrolysis vessel is located while a body is being prepared for final disposition must be attired according to all applicable state and federal regulations regarding the control of infectious disease and occupational and workplace health and safety.

Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place and all fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies stored or used in the room must be maintained in a clean and sanitary condition at all times.

Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline hydrolysis vessel for its operation, all state and local regulations for that boiler must be followed.

Subd. 10. **Occupational and workplace safety.** All applicable provisions of state and federal regulations regarding exposure to workplace hazards and accidents shall be followed in order to protect the health and safety of all authorized persons at the alkaline hydrolysis facility.

Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body. It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for compliance with this chapter and other applicable state and federal regulations regarding occupational and workplace health and safety.

Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part without receiving written authorization to do so from the person or persons who have the legal right to control disposition as described in section 149A.80 or the person's legal designee. The written authorization must include:

- (1) the name of the deceased and the date of death of the deceased;
- (2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;
- (3) the name, address, telephone number, relationship to the deceased, and signature of the person or persons with legal right to control final disposition or a legal designee;
- (4) directions for the disposition of any nonhydrolyzed materials or items recovered from the alkaline hydrolysis vessel;
- (5) acknowledgment that the hydrolyzed remains will be dried and mechanically reduced to a granulated appearance and placed in an appropriate container and authorization to place any hydrolyzed remains that a selected urn or container will not accommodate into a temporary container;
- (6) acknowledgment that, even with the exercise of reasonable care, it is not possible to recover all particles of the hydrolyzed remains and that some particles may inadvertently become commingled with particles of other hydrolyzed remains that remain in the alkaline hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;
- (7) directions for the ultimate disposition of the hydrolyzed remains; and
- (8) a statement that includes, but is not limited to, the following information: "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an alkaline solution is used to chemically break down the human tissue and the hydrolyzable alkaline hydrolysis container. After the process is complete, the liquid effluent solution contains the chemical by-products of the alkaline hydrolysis process except for the deceased's bone fragments. The solution is cooled and released according to local environmental regulations. A water rinse is applied to the hydrolyzed remains which are then dried and processed to facilitate inurnment or scattering."

Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis facility.

Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be accepted for final disposition by alkaline hydrolysis unless:

- (1) encased in an appropriate alkaline hydrolysis container;
- (2) accompanied by a disposition permit issued pursuant to section 149A.93, subdivision 3, including a photocopy of the completed death record or a signed release authorizing alkaline hydrolysis of the body received from the coroner or medical examiner; and

(3) accompanied by an alkaline hydrolysis authorization that complies with subdivision 12.

(b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline hydrolysis container where there is:

(1) evidence of leakage of fluids from the alkaline hydrolysis container;

(2) a known dispute concerning hydrolysis of the body delivered;

(3) a reasonable basis for questioning any of the representations made on the written authorization to hydrolyze; or

(4) any other lawful reason.

Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of the body.

Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.** All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for dead human bodies shall use universal precautions and otherwise exercise all reasonable precautions to minimize the risk of transmitting any communicable disease from the body. No dead human body shall be removed from the container in which it is delivered.

Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall develop, implement, and maintain an identification procedure whereby dead human bodies can be identified from the time the alkaline hydrolysis facility accepts delivery of the remains until the hydrolyzed remains are released to an authorized party. After hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the hydrolyzed remains container before the hydrolyzed remains are released from the alkaline hydrolysis facility. Each identification disk, tab, or label shall have a number that shall be recorded on all paperwork regarding the decedent. This procedure shall be designed to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the inability to individually identify the hydrolyzed remains is a violation of this subdivision.

Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for infectious disease control.

Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is written authorization from the person with the legal right to control the disposition, only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains prohibited.** Except with the express written permission of the person with the legal right to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze a dead human body and other human remains at the same time and in the same alkaline hydrolysis vessel. This section does not apply where commingling of human remains during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is not a violation of this subdivision.

Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed human remains and dispose of these materials in a lawful manner, by the alkaline hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate container to be transported to the processing area.

Subd. 22. **Drying device or mechanical processor procedures; commingling of hydrolyzed remains prohibited.** Except with the express written permission of the person with the legal right to control the final disposition or otherwise provided by law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed human remains of more than one body at a time in the same drying device or mechanical processor, or introduce the hydrolyzed human remains of a second body into a drying device or mechanical processor until processing of any preceding hydrolyzed human remains has been terminated and reasonable efforts have been employed to remove all fragments of the preceding hydrolyzed remains. The fact that there is incidental and unavoidable residue in the drying device, the mechanical processor, or any container used in a prior alkaline hydrolysis process, is not a violation of this provision.

Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The hydrolyzed human remains shall be dried and then reduced by a motorized mechanical device to a granulated appearance appropriate for final disposition and placed in an alkaline hydrolysis remains container along with the appropriate identifying disk, tab, or permanent label. Processing must take place within the licensed alkaline hydrolysis facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they can be identified, may be removed prior to processing the hydrolyzed remains, only by staff licensed or registered by the commissioner of health; however, any dental gold and silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains container unless otherwise directed by the person or persons having the right to control the final disposition. Every person who removes or possesses dental gold or silver, jewelry, or mementos from any hydrolyzed remains without specific written permission of the person or persons having the right to control those remains is guilty of a misdemeanor. The fact that residue and any unavoidable dental gold or dental silver, or other precious metals remain in the alkaline hydrolysis vessel or other equipment or any container used in a prior hydrolysis is not a violation of this section.

Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.** If a hydrolyzed remains container is of insufficient capacity to accommodate all hydrolyzed remains of a given dead human body, subject to directives provided in the written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the second container, in a manner so as not to be easily detached through incidental contact, to the primary alkaline hydrolysis remains container. The secondary container shall contain a duplicate of the identification disk, tab, or permanent label that was placed in the primary container and all paperwork regarding the given body shall include a notation that the hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature hydrolyzed remains containers are not subject to the requirements of this subdivision.

Subd. 25. **Disposition procedures; commingling of hydrolyzed remains prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in a location where the hydrolyzed remains are commingled with those of another person without the express written permission of the person with the legal right to control disposition or as otherwise provided by law. This subdivision does not apply to the scattering or burial of hydrolyzed remains at sea or in a body of water from individual containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to the disposal in a dedicated cemetery of accumulated residue removed from an alkaline hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members of the same family in a common container designed for the hydrolyzed remains of more than one body, or to the inurnment in a container or interment in a space that

has been previously designated, at the time of sale or purchase, as being intended for the inurnment or interment of the hydrolyzed remains of more than one person.

Subd. 26. **Alkaline hydrolysis procedures; disposition of accumulated residue.** Every alkaline hydrolysis facility shall provide for the removal and disposition in a dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel, drying device, mechanical processor, container, or other equipment used in alkaline hydrolysis. Disposition of accumulated residue shall be according to the regulations of the dedicated cemetery and any applicable local ordinances.

Subd. 27. **Alkaline hydrolysis procedures; release of hydrolyzed remains.** Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be released according to the instructions given on the written authorization to hydrolyze. If the hydrolyzed remains are to be shipped, they must be securely packaged and transported by a method which has an internal tracing system available and which provides for a receipt signed by the person accepting delivery. Where there is a dispute over release or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit the hydrolyzed remains with a court of competent jurisdiction pending resolution of the dispute or retain the hydrolyzed remains until the person with the legal right to control disposition presents satisfactory indication that the dispute is resolved.

Subd. 28. **Unclaimed hydrolyzed remains.** If, after 30 calendar days following the inurnment, the hydrolyzed remains are not claimed or disposed of according to the written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment may give written notice, by certified mail, to the person with the legal right to control the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and requesting further release directions. Should the hydrolyzed remains be unclaimed 120 calendar days following the mailing of the written notification, the alkaline hydrolysis facility or funeral establishment may dispose of the hydrolyzed remains in any lawful manner deemed appropriate.

Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and maintain on its premises or other business location in Minnesota an accurate record of every hydrolyzation provided. The record shall include all of the following information for each hydrolyzation:

- (1) the name of the person or funeral establishment delivering the body for alkaline hydrolysis;
- (2) the name of the deceased and the identification number assigned to the body;
- (3) the date of acceptance of delivery;
- (4) the names of the alkaline hydrolysis vessel, drying device, and mechanical processor operator;
- (5) the time and date that the body was placed in and removed from the alkaline hydrolysis vessel;
- (6) the time and date that processing and inurnment of the hydrolyzed remains was completed;
- (7) the time, date, and manner of release of the hydrolyzed remains;
- (8) the name and address of the person who signed the authorization to hydrolyze;
- (9) all supporting documentation, including any transit or disposition permits, a photocopy of the death record, and the authorization to hydrolyze; and
- (10) the type of alkaline hydrolysis container.

Subd. 30. **Retention of records.** Records required under subdivision 29 shall be maintained for a period of three calendar years after the release of the hydrolyzed remains. Following this period and subject to any other laws requiring retention of records, the alkaline hydrolysis facility may then place the records in storage or reduce them to microfilm, microfiche, laser disc, or any other method that can produce an accurate reproduction of the original record, for retention for a period of ten calendar years from the date of release of the hydrolyzed remains. At the end of this period and subject to any other laws requiring retention

of records, the alkaline hydrolysis facility may destroy the records by shredding, incineration, or any other manner that protects the privacy of the individuals identified.

Sec. 96. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:

Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95, subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an appropriate party is considered final disposition and no further permits or authorizations are required for disinterment, transportation, or placement of the hydrolyzed or cremated remains.

Sec. 97. Minnesota Statutes 2012, section 257.75, subdivision 7, is amended to read:

Subd. 7. **Hospital and Department of Health; recognition form.** Hospitals that provide obstetric services and the state registrar of vital statistics shall distribute the educational materials and recognition of parentage forms prepared by the commissioner of human services to new parents, shall assist parents in understanding the recognition of parentage form, including following the provisions for notice under subdivision 5, shall provide notary services for parents who complete the recognition of parentage form, and shall timely file the completed recognition of parentage form with the Office of ~~the State Registrar of Vital Statistics~~ Records unless otherwise instructed by the Office of ~~the State Registrar of Vital Statistics~~ Records. ~~On and after January 1, 1994, hospitals may not distribute the declaration of parentage forms.~~

Sec. 98. Minnesota Statutes 2012, section 260C.635, subdivision 1, is amended to read:

Subdivision 1. **Legal effect.** (a) Upon adoption, the adopted child becomes the legal child of the adopting parent and the adopting parent becomes the legal parent of the child with all the rights and duties between them of a birth parent and child.

(b) The child shall inherit from the adoptive parent and the adoptive parent's relatives the same as though the child were the birth child of the parent, and in case of the child's death intestate, the adoptive parent and the adoptive parent's relatives shall inherit the child's estate as if the child had been the adoptive parent's birth child.

(c) After a decree of adoption is entered, the birth parents or previous legal parents of the child shall be relieved of all parental responsibilities for the child except child support that has accrued to the date of the order for guardianship to the commissioner which continues to be due and owing. The child's birth or previous legal parent shall not exercise or have any rights over the adopted child or the adopted child's property, person, privacy, or reputation.

(d) The adopted child shall not owe the birth parents or the birth parent's relatives any legal duty nor shall the adopted child inherit from the birth parents or kindred unless otherwise provided for in a will of the birth parent or kindred.

(e) Upon adoption, the court shall complete a certificate of adoption form and mail the form to the Office of ~~the State Registrar~~ Vital Records at the Minnesota Department of Health. Upon receiving the certificate of adoption, the state registrar shall register a replacement vital record in the new name of the adopted child as required under section 144.218.

Sec. 99. Minnesota Statutes 2012, section 517.001, is amended to read:

517.001 DEFINITION.

As used in this chapter, "local registrar" ~~has the meaning given in section 144.212, subdivision 10~~ means an individual designated by the county board of commissioners to register marriages.

Sec. 100. Laws 2011, First Special Session chapter 9, article 2, section 27, is amended to read:

Sec. 27. MINNESOTA TASK FORCE ON PREMATURITY.

Subdivision 1. **Establishment.** The Minnesota Task Force on Prematurity is established to evaluate and make recommendations on methods for reducing prematurity and improving premature infant health care in the state.

Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of at least the following members, who serve at the pleasure of their appointing authority:

(1) ~~15~~ 11 representatives of the Minnesota Prematurity Coalition including, but not limited to, health care providers who treat pregnant women or neonates, organizations focused on preterm births, early childhood education and development professionals, and families affected by prematurity;

(2) one representative appointed by the commissioner of human services;

(3) two representatives appointed by the commissioner of health;

(4) one representative appointed by the commissioner of education;

(5) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader; and

(6) two members of the senate, appointed according to the rules of the senate.

(b) Members of the task force serve without compensation or payment of expenses.

(c) The commissioner of health must convene the first meeting of the Minnesota Task Force on Prematurity by July 31, 2011. The task force must continue to meet at least quarterly. Staffing and technical assistance shall be provided by the Minnesota Perinatal Coalition.

Subd. 3. **Duties.** The task force must report the current state of prematurity in Minnesota and develop recommendations on strategies for reducing prematurity and improving premature infant health care in the state by ~~considering the following~~:

(1) ~~promoting adherence to standards of care for premature infants born less than 37 weeks gestational age, including recommendations to improve utilization of appropriate hospital discharge and follow-up care procedures;~~

(2) ~~coordination of information among appropriate professional and advocacy organizations on measures to improve health care for infants born prematurely;~~

(3) ~~identification and centralization of available resources to improve access and awareness for caregivers of premature infants; and~~

(4) ~~development and dissemination of evidence-based practices through networking and educational opportunities;~~

(5) ~~a review of relevant evidence-based research regarding the causes and effects of premature births in Minnesota;~~

(6) ~~a review of relevant evidence-based research regarding premature infant health care, including methods for improving quality of and access to care for premature infants;~~

(7) (4) ~~a review of the potential improvements in health status related to the use of health care homes to provide and coordinate pregnancy-related services; and~~

(8) ~~identification of gaps in public reporting measures and possible effects of these measures on prematurity rates.~~

Subd. 4. **Report; expiration.** (a) ~~By November 30, 2011~~ January 15, 2015, the task force must submit a final report to the chairs and ranking minority members of the legislative policy committees on health and human services on the current state of prematurity in Minnesota to the chairs of the legislative

policy committees on health and human services, including any recommendations to reduce premature births and improve premature infant health in the state.

~~(b) By January 15, 2013, the task force must report its final recommendations, including any draft legislation necessary for implementation, to the chairs of the legislative policy committees on health and human services.~~

~~(c)~~ (b) This task force expires on January 31, ~~2013~~ 2015, or upon submission of the final report required in paragraph ~~(b)~~ (a), whichever is earlier.

Sec. 101. **FUNERAL ESTABLISHMENTS; BRANCH LOCATIONS.**

The commissioner of health shall review the statutory requirements for preparation and embalming rooms and develop legislation with input from stakeholders that provides appropriate health and safety protection for funeral home locations where deceased bodies are present, but are branch locations associated through a majority ownership of a licensed funeral establishment that meets the requirements of Minnesota Statutes, sections 149A.50 and 149A.92, subdivisions 2 to 10. The review shall include consideration of distance between the main location and branch, and other health and safety issues.

Sec. 102. **HEALTH EQUITY REPORT.**

By February 1, 2014, the commissioner of health, in consultation with local public health, health care, and community partners, must submit a report to the chairs and ranking minority members of the committees with jurisdiction over health policy and finance, on a plan for advancing health equity in Minnesota. The report must include the following:

(1) assessment of health disparities that exist in the state and how these disparities relate to health equity;

(2) identification of policies, processes, and systems that contribute to health inequity in the state;

(3) recommendations for changes to policies, processes and systems within the Department of Health that would increase the department's leadership in addressing health inequities;

(4) identification of best practices for local public health, health care, and community partners to provide culturally responsive services and advance health equity; and

(5) recommendations for strategies for the use of data to document and monitor existing health inequities and to evaluate effectiveness of policies, processes, systems, and environmental changes that will advance health equity.

Sec. 103. **GUARANTEED RENEWABILITY STUDY.**

The commissioner of commerce, in consultation with the commissioner of health, and representatives of health carriers and consumer advocates, shall study guaranteed renewability of health plans in the individual market and assess the need for statutory provisions related to permitting the discontinuance or modification of health plan coverage in the individual market by a health carrier. The commissioner shall submit recommendations and draft legislation, if needed, to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance policy issues by February 1, 2014.

Sec. 104. **CAPITAL RESERVES LIMITS STUDY.**

By February 1, 2014, the commissioner of health, in consultation with the commissioners of human services and commerce, shall study methodologies for determining appropriate levels for capital reserves of health maintenance organizations and requirements for reducing capital reserves to any recommended maximum levels. In conducting the study, the commissioner shall consult with health maintenance

organizations, stakeholders, consumers, and other states' insurance regulators. The commissioner shall make recommendations on the need for a level of capital reserves, and framework for implementing any recommended levels. The commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services.

Sec. 105. STUDY AND RECOMMENDATIONS REGARDING MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION.

By August 15, 2013, the Department of Commerce shall study and report to the legislature on reasonable and efficient options for coverage for high-quality, medically necessary, evidence-based treatment of autism spectrum disorders up to age 18, including whether the Minnesota Comprehensive Health Association could provide coverage options through January 1, 2016, under Minnesota Statutes, chapter 62E.

Sec. 106. ESSENTIAL HEALTH BENEFITS.

By December 31, 2014, the Department of Commerce shall request that the United States Department of Human Services include autism services in Minnesota's Essential Health Benefits when the next benefit set is selected in 2016. These services should include but not be limited to the services listed in Minnesota Statutes, section 62A.3094, subdivision 2, paragraph (a).

Sec. 107. ATTORNEY GENERAL LEGAL OPINION REQUIRED.

Pursuant to the requirements of Minnesota Statutes, section 8.05, and no later than October 1, 2013, the attorney general shall give a written legal opinion on whether a health plan, as defined by Minnesota Statutes, section 62Q.01, subdivision 3, is required to provide coverage of treatment for mental health and mental health-related illnesses, including autism spectrum disorders and any other mental health condition as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. The attorney general shall provide copies of this legal opinion to the commissioners of commerce and human services, the board of directors of the Minnesota Insurance Marketplace, and the legislative chairs with jurisdiction over commerce and health policy.

Sec. 108. REVISOR'S INSTRUCTION.

The revisor shall substitute the term "vertical heat exchangers" or "vertical heat exchanger" with "bored geothermal heat exchangers" or "bored geothermal heat exchanger" wherever it appears in Minnesota Statutes, sections 103I.005, subdivisions 2 and 12; 103I.101, subdivisions 2 and 5; 103I.105; 103I.205, subdivision 4; 103I.208, subdivision 2; 103I.501; 103I.531, subdivision 5; and 103I.641, subdivisions 1, 2, and 3.

Sec. 109. REPEALER.

(a) Minnesota Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9; and 485.14, are repealed.

(b) Minnesota Statutes 2012, section 144.123, subdivision 2, is repealed effective July 1, 2014.

ARTICLE 13**PAYMENT METHODOLOGIES FOR HOME AND COMMUNITY-BASED SERVICES**

Section 1. Minnesota Statutes 2012, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day training and habilitation services for adults with developmental disabilities.** "Day training and habilitation services for adults with developmental disabilities" means services that:

(1) include supervision, training, assistance, and supported employment, work-related activities, or other community-integrated activities designed and implemented in accordance with the individual service and individual habilitation plans required under Minnesota Rules, parts 9525.0015 to 9525.0165, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community; and

(2) are provided ~~under contract with the county where the services are delivered~~ by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to provide day training and habilitation services.

Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 2. Minnesota Statutes 2012, section 252.42, is amended to read:

252.42 SERVICE PRINCIPLES.

The design and delivery of services eligible for reimbursement ~~under the rates established in section 252.46~~ should reflect the following principles:

(1) services must suit a person's chronological age and be provided in the least restrictive environment possible, consistent with the needs identified in the person's individual service and individual habilitation plans under Minnesota Rules, parts 9525.0015 to 9525.0165;

(2) a person with a developmental disability whose individual service and individual habilitation plans authorize employment or employment-related activities shall be given the opportunity to participate in employment and employment-related activities in which nondisabled persons participate;

(3) a person with a developmental disability participating in work shall be paid wages commensurate with the rate for comparable work and productivity except as regional centers are governed by section 246.151;

(4) a person with a developmental disability shall receive services which include services offered in settings used by the general public and designed to increase the person's active participation in ordinary community activities;

(5) a person with a developmental disability shall participate in the patterns, conditions, and rhythms of everyday living and working that are consistent with the norms of the mainstream of society.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 3. Minnesota Statutes 2012, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

The commissioner shall supervise county boards' provision of day training and habilitation services to adults with developmental disabilities. The commissioner shall:

- (1) determine the need for day training and habilitation services under section 252.28;
- (2) ~~approve~~ establish payment rates ~~established by a county under section 252.46, subdivision 1 as provided under section 256B.4914;~~
- (3) adopt rules for the administration and provision of day training and habilitation services under sections ~~252.40~~ 252.41 to 252.46 and sections 245A.01 to 245A.16 and 252.28, subdivision 2;
- (4) enter into interagency agreements necessary to ensure effective coordination and provision of day training and habilitation services;
- (5) monitor and evaluate the costs and effectiveness of day training and habilitation services; and
- (6) provide information and technical help to county boards and vendors in their administration and provision of day training and habilitation services.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 4. Minnesota Statutes 2012, section 252.44, is amended to read:

252.44 COUNTY BOARD RESPONSIBILITIES.

(a) When the need for day training and habilitation services in a county has been determined under section 252.28, the board of commissioners for that county shall:

(1) authorize the delivery of services according to the individual service and habilitation plans required as part of the county's provision of case management services under Minnesota Rules, parts 9525.0015 to 9525.0165. For calendar years for which section 252.46, subdivisions 2 to 10, apply, the county board shall not authorize a change in service days from the number of days authorized for the previous calendar year unless there is documentation for the change in the individual service plan. An increase in service days must also be supported by documentation that the goals and objectives assigned to the vendor cannot be met more economically and effectively by other available community services and that without the additional days of service the individual service plan could not be implemented in a manner consistent with the service principles in section 252.42;

~~(2) contract with licensed vendors, as specified in paragraph (b), under sections 256E.12 and 256B.092 and rules adopted under those sections;~~

~~(3)~~ (2) ensure that transportation is provided or arranged by the vendor in the most efficient and reasonable way possible; and

~~(4) set payment rates under section 252.46;~~

~~(5)~~ (3) monitor and evaluate the cost and effectiveness of the services; and

~~(6) reimburse vendors for the provision of authorized services according to the rates, procedures, and regulations governing reimbursement.~~

~~(b) With all vendors except regional centers, the contract must include the approved payment rates, the projected budget for the contract period, and any actual expenditures of previous and current contract periods. With all vendors, including regional centers, the contract must also include the amount,~~

~~availability, and components of day training and habilitation services to be provided, the performance standards governing service provision and evaluation, and the time period in which the contract is effective.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 5. Minnesota Statutes 2012, section 252.45, is amended to read:

252.45 VENDOR'S DUTIES.

~~A vendor's responsibility~~ vendor enrolled with the commissioner is responsible for items under clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable under state and federal law. A vendor ~~under contract with a county board to provide~~ providing day training and habilitation services shall:

- (1) provide the amount and type of services authorized in the individual service plan under Minnesota Rules, parts 9525.0015 to 9525.0165;
- (2) design the services to achieve the outcomes assigned to the vendor in the individual service plan;
- (3) provide or arrange for transportation of persons receiving services to and from service sites;
- (4) enter into agreements with community-based intermediate care facilities for persons with developmental disabilities to ensure compliance with applicable federal regulations; and
- (5) comply with state and federal law.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 6. Minnesota Statutes 2012, section 252.46, subdivision 1a, is amended to read:

Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish a statewide rate-setting methodology for all day training and habilitation services as provided under section 256B.4914. The rate-setting methodology must abide by the principles of transparency and equitability across the state. The methodology must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 7. Minnesota Statutes 2012, section 256B.4912, subdivision 2, is amended to read:

Subd. 2. **Payment methodologies.** (a) The commissioner shall establish, as defined under section 256B.4914, statewide payment methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. The payment methodologies must abide by the principles of transparency and equitability across the state. The methodologies must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

(b) As of January 1, 2012, counties shall not implement changes to established processes for rate-setting methodologies for individuals using components of or data from research rates.

Sec. 8. Minnesota Statutes 2012, section 256B.4912, subdivision 3, is amended to read:

Subd. 3. **Payment requirements.** The payment methodologies established under this section shall accommodate:

- (1) supervision costs;
- (2) ~~staffing patterns~~ staff compensation;

- (3) staffing and supervisory patterns;
- ~~(3)~~ (4) program-related expenses;
- ~~(4)~~ (5) general and administrative expenses; and
- ~~(5)~~ (6) consideration of recipient intensity.

Sec. 9. Minnesota Statutes 2012, section 256B.4913, is amended by adding a subdivision to read:

Subd. 4a. Rate stabilization adjustment. (a) For purposes of this subdivision, "implementation period" shall mean the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based services.

(b) For purposes of this subdivision, the banding value for all service recipients shall mean the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1)(i) for day training and habilitation pilot program service recipients, the banding value shall be the authorized rate for the provider in the county of service effective December 1, 2013, if the recipient: was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014; and

(ii) for all other unit or day service recipients, the banding value shall be the weighted average authorized rate for each provider number in the county of service effective December 1, 2013, if the recipient: was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014; and

(2) for residential service recipients who change providers on or after January 1, 2014, the banding value shall be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the banding value for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 1.0 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3); and

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4).

(d) This subdivision shall not apply to rates for recipients served by providers new to a given county after January 1, 2014.

Sec. 10. Minnesota Statutes 2012, section 256B.4913, subdivision 5, is amended to read:

Subd. 5. Stakeholder consultation. The commissioner shall continue consultation on regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, and exchange ideas for the legislative proposals for to assist

in the full implementation of the new rate payment system and to make pertinent information available to the public through the department's Web site.

Sec. 11. Minnesota Statutes 2012, section 256B.4913, subdivision 6, is amended to read:

Subd. 6. **Implementation.** (a) The commissioner ~~may~~ shall implement changes ~~no sooner than on~~ January 1, 2014, to payment rates for individuals receiving home and community-based waived services after the enactment of legislation that establishes specific payment methodology frameworks, processes for rate calculations, and specific values to populate the ~~payment methodology frameworks~~ disability waiver rates system.

(b) On January 1, 2014, all new service authorizations must use the disability waiver rates system. Beginning January 1, 2014, all renewing individual service plans must use the disability waiver rates system as reassessment and reauthorization occurs. By December 31, 2014, data for all recipients must be entered into the disability waiver rates system.

Sec. 12. **[256B.4914] HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.**

Subdivision 1. Application. The payment methodologies in this section apply to home and community-based services waivers under sections 256B.092 and 256B.49. This section does not change existing waiver policies and procedures.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(e) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

(f) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waived services under sections 256B.092 and 256B.49.

(g) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

(h) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

(i) "Rates management system" means a Web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

(j) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24 hour customized living;

- (2) adult day care;
- (3) adult day care bath;
- (4) behavioral programming;
- (5) companion services;
- (6) customized living;
- (7) day training and habilitation;
- (8) housing access coordination;
- (9) independent living skills;
- (10) in-home family support;
- (11) night supervision;
- (12) personal support;
- (13) prevocational services;
- (14) residential care services;
- (15) residential support services;
- (16) respite services;
- (17) structured day services;
- (18) supported employment services;
- (19) supported living services;
- (20) transportation services; and

(21) other services as approved by the federal government in the state home and community-based services plan.

Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and community-based waived services, including rate exceptions under subdivision 12, are set by the rates management system.

(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a manner prescribed by the commissioner.

(c) Data and information in the rates management system may be used to calculate an individual's rate.

(d) Service providers, with information from the community support plan and oversight by lead agencies, shall provide values and information needed to calculate an individual's rate into the rates management system. These values and information include:

- (1) shared staffing hours;
- (2) individual staffing hours;
- (3) direct RN hours;
- (4) direct LPN hours;
- (5) staffing ratios;

(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;

(7) shared or individualized arrangements for unit-based services, including the staffing ratio;

(8) number of trips and miles for transportation services; and

(9) service hours provided through monitoring technology.

(e) Updates to individual data shall include:

(1) data for each individual that is updated annually when renewing service plans; and

(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation.

(f) Lead agencies shall review and approve values to calculate the final payment rate for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead agencies to correct it. Lead agencies must respond to these requests.

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook shall be used. The base wage index shall be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing aide (SOC code 31-1012); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage will be \$7.66 per hour, except in a family foster care setting, the wage is \$2.80 per hour;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 50 percent of the median wage for community and social services specialist (SOC code 21-1099); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for supported employment staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(12) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(13) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(15) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(16) for supervisory staff, the basic wage is \$17.43 per hour with exception of the supervisor of behavior analyst and behavior specialists, which shall be \$30.75 per hour;

(17) for RN, the basic wage is \$30.82 per hour; and

(18) for LPN, the basic wage is \$18.64 per hour.

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: 3.1 percent;

(5) client programming and supports ratio: 8.6 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 3.1 percent;

(5) client programming and support ratio: 8.6 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 6.1 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (b) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (c) for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.

Subd. 6. Payments for residential support services. (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of shared and individual direct staff hours to meet a recipient's needs provided on-site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of shared and individual direct staff hours provided on-site or through monitoring technology and direct nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours provided on-site or through monitoring technology and direct nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

(8) for client programming and supports, the commissioner shall add \$2,179; and

(9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if customized for adapted transport, per year.

(b) The total rate shall be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The payment methodology for customized living, 24-hour customized living, and residential care services shall be the customized living tool. Revisions to the customized living tool shall be made to reflect the services and activities unique to disability-related recipient needs.

(d) The commissioner shall establish a Monitoring Technology Review Panel to annually review and approve the plans, safeguards, and rates that include residential direct care provided remotely through monitoring technology. Lead agencies shall submit individual service plans that include supervision using monitoring technology to the Monitoring Technology Review Panel for approval. Individual service plans that include supervision using monitoring technology as of December 31, 2013, shall be submitted to the Monitoring Technology Review Panel, but the plans are not subject to approval.

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of day program direct staff hours and direct nursing hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

(10) for program facility costs, add \$19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add \$7.01 per 15 minute unit;

(12) this is the subtotal rate;

(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(16) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a vehicle with a lift;

(ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a vehicle with a lift;

(iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a vehicle with a lift; or

(iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle with a lift;

(17) for transportation provide as part of day training and habilitation for an individual who does require a lift, add:

(i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and \$15.05 for a shared ride in a vehicle with a lift;

(ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and \$28.16 for a shared ride in a vehicle with a lift;

(iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and \$58.76 for a shared ride in a vehicle with a lift; or

(iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and \$80.93 for a shared ride in a vehicle with a lift.

Subd. 8. Payments for unit-based services with programming. Payments for unit-based with program services, including behavior programming, housing access coordination, in-home family support, independent living skills training, hourly supported living services, and supported employment provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for supported employment provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed three. For independent living skills training provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Subd. 9. Payments for unit-based services without programming. Payments for unit-based without program services, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of daily units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3).

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Subd. 10. Updating payment values and additional information. (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) The commissioner shall, within available resources, conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage and utilization of transportation for all day and unit-based services.

(c) Using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels.

(d) The commissioner, in consultation with stakeholders, shall review and evaluate the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates for day services;

(2) values for transportation rates in residential services;

(3) values for services where monitoring technology replaces staff time;

(4) values for indirect services;

(5) values for nursing;

(6) component values for independent living skills;

(7) component values for family foster care that reflect licensing requirements;

(8) adjustments to other components to replace the budget neutrality factor;

(9) remote monitoring technology for nonresidential services;

(10) values for basic and intensive services in residential services;

(11) values for the facility use rate in day services;

(12) values for workers compensation as part of employee-related expenses;

(13) values for unemployment insurance as part of employee-related expenses;

(14) a component value to reflect costs for individuals with rates previously adjusted for the inclusion of group residential housing rate 3 costs, only for any individual enrolled as of December 31, 2013; and

(15) any changes in state or federal law with an impact on the underlying cost of providing home and community-based services.

(e) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (b) to (d) on the following dates:

(1) January 15, 2015, with preliminary results and data;

(2) January 15, 2016, with a status implementation update, and additional data and summary information;

(3) January 15, 2017, with the full report; and

(4) January 15, 2019, with another full report, and a full report once every four years thereafter.

(f) Based on the commissioner's evaluation of the information and data collected in paragraphs (b) to (d), the commissioner may make recommendations to the legislature to address any potential issues.

(g) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

(h) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

- (1) calculation values including derived wage rates and related employee and administrative factors;
- (2) service utilization;
- (3) county and tribal allocation changes; and
- (4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice shall be effective January 1 of the following year.

Subd. 11. **Payment implementation.** Upon implementation of the payment methodologies under this section, those payment rates supersede rates established in county contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

Subd. 12. **Customization of rates for individuals.** (a) For persons determined to have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be increased by an adjustment factor prior to calculating the rate under subdivisions 6, 7, 8, and 9. The customization rate with respect to deaf or hard-of-hearing persons shall be \$2.50 per hour for waiver recipients who meet the respective criteria as determined by the commissioner.

(b) For the purposes of this section, "deaf and hard-of-hearing" means:

(1) the person has a developmental disability and an assessment score which indicates a hearing impairment that is severe or that the person has no useful hearing;

(2) the person has a developmental disability and an expressive communications score that indicates the person uses single signs or gestures, uses an augmentative communication aid, or does not have functional communication, or the person's expressive communications is unknown; and

(3) the person has a developmental disability and a communication score which indicates the person comprehends signs, gestures and modeling prompts or does not comprehend verbal, visual or gestural communication or that the person's receptive communication score is unknown; or

(4) the person receives long-term care services and has an assessment score that indicates they hear only very loud sounds, have no useful hearing, or a determination cannot be made; and the person receives long-term care services and has an assessment that indicates the person communicates needs with sign language, symbol board, written messages, gestures or an interpreter; communicates with inappropriate content, makes garbled sounds or displays echolalia, or does not communicate needs.

Subd. 13. **Transportation.** The commissioner shall require that the purchase of transportation services be cost-effective and be limited to market rates where the transportation mode is generally available and accessible.

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals.

(b) Lead agencies must submit exception requests to the state.

(c) An application for a rate exception may be submitted for the following criteria:

- (1) an individual has service needs that cannot be met through additional units of service; or
- (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results in an individual being discharged.

(d) Exception requests must include the following information:

- (1) the service needs required by each individual that are not accounted for in subdivisions 6, 7, 8, and 9;
- (2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 9;
- (3) a basis for the underlying costs used for the rate exception and any accompanying documentation;
- (4) the duration of the rate exception; and
- (5) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient of its decision and the reasons for denying the request in writing no later than 30 days after the individual's request has been made.

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

Subd. 15. County or tribal allocations. (a) Upon implementation of the disability waiver rates management system on January 1, 2014, the commissioner shall establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) Beginning January 1, 2014, the commissioner shall make annual adjustments to lead agencies' home and community-based waived service budget allocations to adjust for rate differences and the resulting impact on county allocations upon implementation of the disability waiver rates system.

Subd. 16. Budget neutrality adjustments. (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

- (1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

Sec. 13. **FEDERAL APPROVAL.**

During the transition to a new disability waivers payment methodology system, the commissioner of human services has the authority to manage the disability home and community-based service waiver programs within federally required parameters. The commissioner may negotiate an agreement with the Centers for Medicare and Medicaid Services for the implementation of the disability waivers payment methodology system in order to prevent federal action that would withhold or disallow federal funding for current waiver recipients, or new waiver recipients as authorized by the legislature. The commissioner must provide for public notice and comment, as required by state and federal law, to changes related to federal approval of the disability waivers payment methodology system. If the Centers for Medicare and Medicaid Services requires changes to the disability waivers payment rate methodology implementation plan, the commissioner shall implement the changes in accordance with Minnesota Statutes, section 256B.4914, subdivision 16, and upon:

(1) public notice;

(2) federal approval;

(3) Legislative Advisory Commission review and recommendation, in a manner described under Minnesota Statutes, section 3.3005, subdivision 4; and

(4) recommendation of necessary legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2014. The changed implementation plan must provide for a transition from the historical to the new rate setting methodology.

Sec. 14. **REPEALER.**

(a) Minnesota Statutes 2012, sections 252.40; 252.46, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, and 21; 256B.4913, subdivisions 1, 2, 3, and 4; and 256B.501, subdivision 8, are repealed effective January 1, 2014.

(b) Minnesota Rules, part 9525.1860, subparts 3, items B and C and 4, item D, are repealed effective January 1, 2014.

ARTICLE 14

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2014" and "2015" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2014, or June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal year 2015. "The biennium" is fiscal years 2014 and 2015.

<u>APPROPRIATIONS</u>	
<u>Available for the Year</u>	
<u>Ending June 30</u>	
<u>2014</u>	<u>2015</u>

Sec. 2. COMMISSIONER OF HUMAN SERVICES

<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>6,438,485,000</u>	<u>\$</u>	<u>6,457,117,000</u>
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<u>Appropriations by Fund</u>		
	<u>2014</u>	<u>2015</u>
<u>General</u>	<u>5,654,765,000</u>	<u>5,677,458,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>4,099,000</u>	<u>4,510,000</u>
<u>Health Care Access</u>	<u>519,816,000</u>	<u>518,446,000</u>
<u>Federal TANF</u>	<u>257,915,000</u>	<u>254,813,000</u>
<u>Lottery Prize Fund</u>	<u>1,890,000</u>	<u>1,890,000</u>

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of Minnesota information technology services, funded by the legislature, and approved by the commissioner of management and budget, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

ARRA Supplemental Nutrition Assistance Benefit Increases. The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

Supplemental Nutrition Assistance Program Employment and Training. (1) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal Supplemental Nutrition Assistance employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures for diversionary work program participants and child care assistance program expenditures must be deposited in the general fund. The amount of funds must be limited to \$4,900,000 per year in fiscal years 2014 and 2015, and to \$4,400,000 per year in fiscal years 2016 and 2017, contingent on approval by the federal Food and Nutrition Service.

(2) Consistent with the receipt of the federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2017.

TANF Maintenance of Effort. (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(e) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision and subdivisions 2 and 3.

(f) Notwithstanding any contrary provision in this article, paragraphs (a) to (e) expire June 30, 2017.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF maintenance of effort up to \$6,707,000 per year of working family credit expenditures in each fiscal year.

Subd. 2. Working Family Credit to be Claimed for TANF/MOE

The commissioner may count the following amounts of working family credit expenditures as TANF/MOE:

(1) fiscal year 2014, \$50,272,000;

(2) fiscal year 2015, \$34,894,000;

(3) fiscal year 2016, \$0; and

(4) fiscal year 2017, \$1,283,000.

Subd. 3. TANF Transfer to Federal Child Care and Development Fund

(a) The following TANF fund amounts are appropriated to the commissioner for purposes of MFIP/transition year child care assistance under Minnesota Statutes, section 119B.05:

(1) fiscal year 2014; \$14,020,000; and

(2) fiscal year 2015, \$14,020,000.

(b) The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and

shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Subd. 4. Central Office

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Operations

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>101,979,000</u>	<u>96,858,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>3,974,000</u>	<u>4,385,000</u>
<u>Health Care Access</u>	<u>13,177,000</u>	<u>13,004,000</u>
<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

DHS Receipt Center Accounting. The commissioner is authorized to transfer appropriations to, and account for DHS receipt center operations in, the special revenue fund.

Administrative Recovery; Set-Aside. The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

- (1) Minnesota Statutes, section 125A.744, subdivision 3;
- (2) Minnesota Statutes, section 245.495, paragraph (b);
- (3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);
- (4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);
- (5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and
- (6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

Systems Modernization. The following amounts are appropriated for transfer to the state systems account authorized in Minnesota Statutes, section 256.014:

- (1) \$1,825,000 in fiscal year 2014 and \$2,502,000 in fiscal year 2015 is for the state share of

Medicaid-allocated costs of the health insurance exchange information technology and operational structure. The funding base is \$3,222,000 in fiscal year 2016 and \$3,037,000 in fiscal year 2017 but shall not be included in the base thereafter; and

(2) \$9,344,000 in fiscal year 2014 and \$3,660,000 in fiscal year 2015 are for the modernization and streamlining of agency eligibility and child support systems. The funding base is \$5,921,000 in fiscal year 2016 and \$1,792,000 in fiscal year 2017 but shall not be included in the base thereafter.

The unexpended balance of the \$9,344,000 appropriation in fiscal year 2014 and the \$3,660,000 appropriation in fiscal year 2015 must be transferred from the Department of Human Services state systems account to the Office of Enterprise Technology when the Office of Enterprise Technology has negotiated a federally approved internal service fund rates and billing process with sufficient internal accounting controls to properly maximize federal reimbursement to Minnesota for human services system modernization projects, but not later than June 30, 2015.

If contingent funding is fully or partially disbursed under article 15, section 3, and transferred to the state systems account, the unexpended balance of that appropriation must be transferred to the Office of Enterprise Technology in accordance with this clause. Contingent funding must not exceed \$11,598,000 for the biennium.

Base Adjustment. The general fund base is increased by \$2,868,000 in fiscal year 2016 and decreased by \$1,206,000 in fiscal year 2017. The health access fund base is decreased by \$551,000 in fiscal years 2016 and 2017. The state government special revenue fund base is increased by \$4,000 in fiscal year 2016 and decreased by \$236,000 in fiscal year 2017.

(b) Children and Families

<u>Appropriations by Fund</u>		
<u>General</u>	<u>8,023,000</u>	<u>8,015,000</u>
<u>Federal TANF</u>	<u>2,282,000</u>	<u>2,282,000</u>

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to \$310,000 each year in fiscal years 2014 and 2015 from

the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Base Adjustment. The general fund base is decreased by \$300,000 in fiscal years 2016 and 2017. The TANF fund base is increased by \$300,000 in fiscal years 2016 and 2017.

(c) Health Care

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>14,028,000</u>	<u>13,826,000</u>
<u>Health Care Access</u>	<u>28,442,000</u>	<u>31,137,000</u>

Base Adjustment. The general fund base is decreased by \$86,000 in fiscal year 2016 and by \$86,000 in fiscal year 2017. The health care access fund base is increased by \$6,954,000 in fiscal year 2016 and by \$5,489,000 in fiscal year 2017.

(d) Continuing Care

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>20,993,000</u>	<u>22,359,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

Base Adjustment. The general fund base is increased by \$1,690,000 in fiscal year 2016 and by \$798,000 in fiscal year 2017.

(e) Chemical and Mental Health

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>4,639,000</u>	<u>4,490,000</u>
<u>Lottery Prize Fund</u>	<u>157,000</u>	<u>157,000</u>

Subd. 5. Forecasted Programs

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MFIP/DWP

<u>Appropriations by Fund</u>		
<u>General</u>	<u>72,583,000</u>	<u>76,927,000</u>
<u>Federal TANF</u>	<u>80,342,000</u>	<u>76,851,000</u>
<u>(b) MFIP Child Care Assistance</u>	<u>61,701,000</u>	<u>69,294,000</u>
<u>(c) General Assistance</u>	<u>54,787,000</u>	<u>56,068,000</u>
<u>General Assistance Standard.</u> The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at \$203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.		
<u>Emergency General Assistance.</u> The amount appropriated for emergency general assistance funds is limited to no more than \$6,729,812 in fiscal year 2014 and \$6,729,812 in fiscal year 2015. Funds to counties shall be allocated by the commissioner using the allocation method in Minnesota Statutes, section 256D.06.		
<u>(d) MN Supplemental Assistance</u>	<u>38,646,000</u>	<u>39,821,000</u>
<u>(e) Group Residential Housing</u>	<u>141,138,000</u>	<u>150,988,000</u>
<u>(f) MinnesotaCare</u>	<u>297,707,000</u>	<u>247,284,000</u>

This appropriation is from the health care access fund.

(g) Medical Assistance

<u>Appropriations by Fund</u>		
<u>General</u>	<u>4,443,768,000</u>	<u>4,431,612,000</u>
<u>Health Care Access</u>	<u>179,550,000</u>	<u>226,081,000</u>

Spending to be apportioned. The commissioner shall apportion expenditures under this paragraph consistent with the requirements of section 12.

Support Services for Deaf and Hard-of-Hearing. \$121,000 in fiscal year 2014 and \$141,000 in fiscal year 2015; and \$10,000 in fiscal year 2014 and \$13,000 in fiscal year 2015 are from the health care access fund for the hospital reimbursement increase

in Minnesota Statutes, section 256.969, subdivision 29, paragraph (b).

Disproportionate Share Payments. Effective for services provided on or after July 1, 2011, through June 30, 2015, the commissioner of human services shall deposit, in the health care access fund, additional federal matching funds received under Minnesota Statutes, section 256B.199, paragraph (e), as disproportionate share hospital payments for inpatient hospital services provided under MinnesotaCare to lawfully present noncitizens who are not eligible for MinnesotaCare with federal financial participation due to immigration status. The amount deposited shall not exceed \$2,200,000 for the time period specified.

Funding for Services Provided to EMA Recipients. \$2,200,000 in fiscal year 2014 is from the health care access fund to provide services to emergency medical assistance recipients under Minnesota Statutes, section 256B.06, subdivision 4, paragraph (l). This is a onetime appropriation and is available in either year of the biennium.

(h) Alternative Care

50,776,000

54,922,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) CD Treatment Fund

81,440,000

74,875,000

Balance Transfer. The commissioner must transfer \$18,188,000 from the consolidated chemical dependency treatment fund to the general fund by September 30, 2013.

Subd. 6. Grant Programs

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Support Services Grants

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>8,915,000</u>	<u>13,333,000</u>
<u>Federal TANF</u>	<u>94,611,000</u>	<u>94,611,000</u>

Paid Work Experience. \$2,168,000 each year in fiscal years 2015 and 2016 is from the general fund for paid work experience for long-term MFIP recipients. Paid work includes full and partial wage subsidies and other related services such as job development, marketing, preworksite training, job coaching, and postplacement services. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Work Study Funding for MFIP Participants. \$250,000 each year in fiscal years 2015 and 2016 is from the general fund to pilot work study jobs for MFIP recipients in approved postsecondary education programs. This is a onetime appropriation. Unexpended funds for fiscal year 2015 do not cancel, but are available for this purpose in fiscal year 2016.

Local Strategies to Reduce Disparities. \$2,000,000 each year in fiscal years 2015 and 2016 is from the general fund for local projects that focus on services for subgroups within the MFIP caseload who are experiencing poor employment outcomes. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Home Visiting Collaborations for MFIP Teen Parents. \$200,000 per year in fiscal years 2014 and 2015 is from the general fund and \$200,000 in fiscal year 2016 is from the federal TANF fund for technical assistance and training to support local collaborations that provide home visiting services for MFIP teen parents. The general fund appropriation is onetime. The federal TANF fund appropriation is added to the base.

Performance Bonus Funds for Counties. The TANF fund base is increased by \$1,500,000 each year in fiscal years 2016 and 2017. The commissioner must allocate this amount each year to counties that exceed their expected range of performance on the annualized three-year self-support index as defined in Minnesota Statutes, section 256J.751, subdivision 2, clause (6). This is a permanent base adjustment. Notwithstanding any contrary provisions in this article, this provision expires June 30, 2016.

Base Adjustment. The general fund base is decreased by \$200,000 in fiscal year 2016 and \$4,618,000 in

fiscal year 2017. The TANF fund base is increased by \$1,700,000 in fiscal years 2016 and 2017.

<u>(b) Basic Sliding Fee Child Care Assistance Grants</u>	<u>36,836,000</u>	<u>42,318,000</u>
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Base Adjustment. The general fund base is increased by \$3,778,000 in fiscal year 2016 and by \$3,849,000 in fiscal year 2017.

<u>(c) Child Care Development Grants</u>	<u>1,612,000</u>	<u>1,737,000</u>
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<u>(d) Child Support Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
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Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under United States Code, title 42, section 1315, is appropriated to the commissioner for this activity.

(e) Children's Services Grants

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>49,760,000</u>	<u>52,961,000</u>
<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

Adoption Assistance and Relative Custody Assistance. \$37,453,000 in fiscal year 2014 and \$37,453,000 in fiscal year 2015 is for the adoption assistance and relative custody assistance programs. The commissioner shall determine with the commissioner of Minnesota Management and Budget the appropriation for Northstar Care for Children effective January 1, 2015. The commissioner may transfer appropriations for adoption assistance, relative custody assistance, and Northstar Care for Children between fiscal years and among programs to adjust for transfers across the programs.

Title IV-E Adoption Assistance. Additional federal reimbursements to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance are appropriated for postadoption services, including a parent-to-parent support network.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is

appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2014 and 2015 for adoption incentive grants are appropriated for postadoption services, including a parent-to-parent support network.

Base Adjustment. The general fund base is increased by \$5,913,000 in fiscal year 2016 and by \$10,297,000 in fiscal year 2017.

<u>(f) Child and Community Service Grants</u>	<u>53,301,000</u>	<u>53,301,000</u>
<u>(g) Child and Economic Support Grants</u>	<u>21,047,000</u>	<u>20,848,000</u>

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2014 do not cancel but are available for this purpose in fiscal year 2015.

Transitional Housing. \$250,000 each year is for the transitional housing programs under Minnesota Statutes, section 256E.33.

Emergency Services. \$250,000 each year is for emergency services grants under Minnesota Statutes, section 256E.36.

Family Assets for Independence. \$250,000 each year is for the Family Assets for Independence Minnesota program. This appropriation is available in either year of the biennium and may be transferred between fiscal years.

Food Shelf Programs. \$375,000 in fiscal year 2014 and \$375,000 in fiscal year 2015 are for food shelf programs under Minnesota Statutes, section 256E.34. If the appropriation for either year is insufficient, the appropriation for the other year is available for it. Notwithstanding Minnesota Statutes, section 256E.34, subdivision 4, no portion of this appropriation may be used by Hunger Solutions for its administrative expenses, including but not limited to rent and salaries.

Homeless Youth Act. \$2,000,000 in fiscal year 2014 and \$2,000,000 in fiscal year 2015 is for purposes of Minnesota Statutes, section 256K.45.

Safe Harbor Shelter and Housing. \$500,000 in fiscal year 2014 and \$500,000 in fiscal year 2015 is for a safe harbor shelter and housing fund for housing

and supportive services for youth who are sexually exploited.

(h) Health Care Grants

<u>Appropriations by Fund</u>		
<u>General</u>	<u>190,000</u>	<u>190,000</u>
<u>Health Care Access</u>	<u>190,000</u>	<u>190,000</u>

Emergency Medical Assistance Referral and Assistance Grants. (a) The commissioner of human services shall award grants to nonprofit programs that provide immigration legal services based on indigency to provide legal services for immigration assistance to individuals with emergency medical conditions or complex and chronic health conditions who are not currently eligible for medical assistance or other public health care programs, but who may meet eligibility requirements with immigration assistance.

(b) The grantees, in collaboration with hospitals and safety net providers, shall provide referral assistance to connect individuals identified in paragraph (a) with alternative resources and services to assist in meeting their health care needs. \$100,000 is appropriated in fiscal year 2014 and \$100,000 in fiscal year 2015. This is a onetime appropriation.

Base Adjustment. The general fund is decreased by \$100,000 in fiscal year 2016 and \$100,000 in fiscal year 2017.

(i) Aging and Adult Services Grants 14,827,000 15,010,000

Base Adjustment. The general fund is increased by \$1,150,000 in fiscal year 2016 and \$1,151,000 in fiscal year 2017.

Community Service Development Grants and Community Services Grants. Community service development grants and community services grants are reduced by \$1,150,000 each year. This is a onetime reduction.

(j) Deaf and Hard-of-Hearing Grants 1,771,000 1,785,000

(k) Disabilities Grants 18,605,000 18,823,000

Advocating Change Together. \$310,000 in fiscal year 2014 is for a grant to Advocating Change

Together (ACT) to maintain and promote services for persons with intellectual and developmental disabilities throughout the state. This appropriation is onetime. Of this appropriation:

(1) \$120,000 is for direct costs associated with the delivery and evaluation of peer-to-peer training programs administered throughout the state, focusing on education, employment, housing, transportation, and voting;

(2) \$100,000 is for delivery of statewide conferences focusing on leadership and skill development within the disability community; and

(3) \$90,000 is for administrative and general operating costs associated with managing or maintaining facilities, program delivery, staff, and technology.

Base Adjustment. The general fund base is increased by \$535,000 in fiscal year 2016 and by \$709,000 in fiscal year 2017.

(l) Adult Mental Health Grants

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>71,199,000</u>	<u>69,530,000</u>
<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

Problem Gambling. \$225,000 in fiscal year 2014 and \$225,000 in fiscal year 2015 is appropriated from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling.

Funding Usage. Up to 75 percent of a fiscal year's appropriations for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is decreased by \$4,427,000 in fiscal years 2016 and 2017.

Mental Health Pilot Project. \$230,000 each year is for a grant to the Zumbro Valley Mental Health Center. The grant shall be used to implement a pilot project to

test an integrated behavioral health care coordination model. The grant recipient must report measurable outcomes and savings to the commissioner of human services by January 15, 2016. This is a onetime appropriation.

High-risk adults. \$200,000 in fiscal year 2014 is for a grant to the nonprofit organization selected to administer the demonstration project for high-risk adults under Laws 2007, chapter 54, article 1, section 19, in order to complete the project. This is a onetime appropriation.

(m) Child Mental Health Grants

18,246,000

20,636,000

Text Message Suicide Prevention Program. \$625,000 in fiscal year 2014 and \$625,000 in fiscal year 2015 is for a grant to a nonprofit organization to establish and implement a statewide text message suicide prevention program. The program shall implement a suicide prevention counseling text line designed to use text messaging to connect with crisis counselors and to obtain emergency information and referrals to local resources in the local community. The program shall include training within schools and communities to encourage the use of the program.

Mental Health First Aid Training. \$22,000 in fiscal year 2014 and \$23,000 in fiscal year 2015 is to train teachers, social service personnel, law enforcement, and others who come into contact with children with mental illnesses, in children and adolescents mental health first aid training.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(n) CD Treatment Support Grants

1,816,000

1,816,000

SBIRT Training. (1) \$300,000 each year is for grants to train primary care clinicians to provide substance abuse brief intervention and referral to treatment (SBIRT). This is a onetime appropriation. The commissioner of human services shall apply to SAMHSA for an SBIRT professional training grant.

(2) If the commissioner of human services receives a grant under clause (1) funds appropriated under this clause, equal to the grant amount, up to the available appropriation, shall be transferred to the

Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). MOFAS must use the funds for grants. Grant recipients must be selected from communities that are not currently served by federal Substance Abuse Prevention and Treatment Block Grant funds. Grant money must be used to reduce the rates of fetal alcohol syndrome and fetal alcohol effects, and the number of drug-exposed infants. Grant money may be used for prevention and intervention services and programs, including, but not limited to, community grants, professional education, public awareness, and diagnosis.

Fetal Alcohol Syndrome Grant. \$180,000 each year from the general fund is for a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to support nonprofit Fetal Alcohol Spectrum Disorders (FASD) outreach prevention programs in Olmsted County. This is a onetime appropriation.

Base Adjustment. The general fund base is decreased by \$480,000 in fiscal year 2016 and \$480,000 in fiscal year 2017.

Subd. 7. State-Operated Services

Transfer Authority Related to State-Operated Services. Money appropriated for state-operated services may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

The amounts that may be spent from the appropriation for each purpose are as follows:

<u>(a) SOS Mental Health</u>	<u>115,738,000</u>	<u>115,738,000</u>
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Dedicated Receipts Available. Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a), \$1,000,000 each year is available for the purposes of paragraph (b), clause (1), of that subdivision, \$1,000,000 each year is available to transfer to the adult mental health budget activity for the purposes of paragraph (b), clause (2), of that subdivision, and up to \$2,713,000 each year is available for the purposes of paragraph (b), clause (3), of that subdivision.

<u>(b) SOS MN Security Hospital</u>	<u>69,582,000</u>	<u>69,582,000</u>
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<u>Subd. 8. Sex Offender Program</u>	<u>76,769,000</u>	<u>79,745,000</u>
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Transfer Authority Related to Minnesota Sex Offender Program. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 9. **Technical Activities** 80,440,000 80,829,000

This appropriation is from the federal TANF fund.

Base Adjustment. The federal TANF fund base is increased by \$278,000 in fiscal year 2016 and increased by \$651,000 in fiscal year 2017.

Subd. 10. **C.A.R.E.**

(a) Notwithstanding Minnesota Statutes, section 254B.06, subdivision 1, \$2,200,000 is transferred from the consolidated chemical dependency treatment fund administrative account in the special revenue fund and deposited into the enterprise fund for the Community Addiction Recovery Enterprise in fiscal year 2013.

(b) Notwithstanding Minnesota Statutes, section 245.037, \$1,000,000 must be transferred from the dedicated services - Lease Income Brainerd account in the special revenue fund and deposited into the enterprise fund for the Community Addiction Recovery Enterprise in fiscal year 2013.

(c) Paragraphs (a) and (b) are effective the day following final enactment.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** \$ 169,326,000 \$ 165,531,000

<u>Appropriations by Fund</u>		
	<u>2014</u>	<u>2015</u>
<u>General</u>	<u>79,476,000</u>	<u>74,256,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>48,094,000</u>	<u>50,119,000</u>
<u>Health Care Access</u>	<u>29,743,000</u>	<u>29,143,000</u>
<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
<u>Special Revenue</u>	<u>300,000</u>	<u>300,000</u>

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. Health Improvement

<u>Appropriations by Fund</u>		
<u>General</u>	<u>52,864,000</u>	<u>47,644,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>1,033,000</u>	<u>1,033,000</u>
<u>Health Care Access</u>	<u>17,500,000</u>	<u>17,500,000</u>
<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

Notwithstanding the cancellation requirement in Minnesota Statutes, section 256J.02, subdivision 6, TANF funds awarded under Minnesota Statutes, section 145.928, during fiscal year 2013 to grantees determined during the application process to have limited financial capacity, are available until June 30, 2014.

Statewide Health Improvement Program.

\$17,500,000 in fiscal year 2014 and \$17,500,000 in fiscal year 2015 is from the health care access fund for the statewide health improvement program under Minnesota Statutes, section 145.986. Funds appropriated under this paragraph are available until expended. No more than 16 percent of the SHIP budget may be used for administration, technical assistance, and state-level evaluation costs. The commissioner shall incorporate strategies for improving health outcomes and reducing health care costs in populations over age 60 to the menu of statewide health improvement program strategies.

Statewide Cancer Surveillance System. Of the general fund appropriation, \$350,000 in fiscal year 2014 and \$350,000 in fiscal year 2015 is to develop and implement a new cancer reporting system under Minnesota Statutes, sections 144.671 to 144.69. Any information technology development or support costs necessary for the cancer surveillance system must be incorporated into the agency's service level agreement and paid to the Office of Enterprise Technology.

Minnesota Poison Information Center. \$500,000 in fiscal year 2014 and \$500,000 in fiscal year 2015 from the general fund is for regional poison information centers according to Minnesota Statutes, section 145.93.

Support Services for Deaf and Hard-of-Hearing.

(a) \$365,000 in fiscal year 2014 and \$349,000 in fiscal year 2015 are for providing support services to

families as required under Minnesota Statutes, section 144.966, subdivision 3a.

(b) \$164,000 in fiscal year 2014 and \$156,000 in fiscal year 2015 are for home-based education in American Sign Language for families with children who are deaf or have hearing loss, as required under Minnesota Statutes, section 144.966, subdivision 3a.

Reproductive Health Strategic Plan to Reduce Health Disparities for Somali Women. To the extent funds are available for fiscal years 2014 and 2015 for grants provided pursuant to Minnesota Statutes, section 145.928, the commissioner shall provide a grant to a Somali-based organization located in the metropolitan area to develop a reproductive health strategic plan to eliminate reproductive health disparities for Somali women. The plan shall develop initiatives to provide educational and information resources to health care providers, community organizations, and Somali women to ensure effective interaction with Somali culture and western medicine and the delivery of appropriate health care services, and the achievement of better health outcomes for Somali women. The plan must engage health care providers, the Somali community, and Somali health-centered organizations. The commissioner shall submit a report to the chairs and ranking minority members of the senate and house committees with jurisdiction over health policy on the strategic plan developed under this grant for eliminating reproductive health disparities for Somali women. The report must be submitted by February 15, 2014.

Sexual Violence Prevention. Within available appropriations, by January 15, 2015, the commissioner must report to the legislature on its activities to prevent sexual violence, including activities to promote coordination of existing state programs and services to achieve maximum impact on addressing the root causes of sexual violence.

Safe Harbor for Sexually Exploited Youth. (a) \$375,000 in fiscal year 2014 and \$375,000 in fiscal year 2015 are for grants to six regional navigators under Minnesota Statutes, section 145.4717.

(b) \$100,000 in fiscal year 2014 and \$100,000 in fiscal year 2015 are for the director of child sex trafficking prevention position.

(c) \$50,000 in fiscal year 2015 is for program evaluation required under Minnesota Statutes, section 145.4718.

TANF Appropriations. (1) \$1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) \$3,579,000 of the TANF funds is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) \$2,000,000 of the TANF funds is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) \$4,978,000 of the TANF funds is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. \$4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. \$978,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Subd. 3. Policy Quality and Compliance

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>9,391,000</u>	<u>9,391,000</u>

<u>State Government</u>		
<u>Special Revenue</u>	<u>14,428,000</u>	<u>16,450,000</u>
<u>Health Care Access</u>	<u>12,243,000</u>	<u>11,643,000</u>

The health care access fund appropriation includes the base appropriation for health care homes activities.

Base Level Adjustment. The health care access base shall be increased by \$600,000 in fiscal year 2016.

Criminal Background Checks. The state government special revenue fund base for fiscal year 2017 includes \$111,000 for the implementation of criminal background checks for occupational therapy practitioners, speech-language pathologists, audiologists, and hearing aid dispensers, if the Sunset Advisory Commission under Minnesota Statutes, section 3D.03, is repealed before June 30, 2014.

Subd. 4. Health Protection

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>9,201,000</u>	<u>9,201,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>32,633,000</u>	<u>32,636,000</u>
<u>Special Revenue</u>	<u>300,000</u>	<u>300,000</u>

Infectious Disease Laboratory. Of the general fund appropriation, \$200,000 in fiscal year 2014 and \$200,000 in fiscal year 2015 are to monitor infectious disease trends and investigate infectious disease outbreaks.

Surveillance for Elevated Blood Lead Levels. Of the general fund appropriation, \$100,000 in fiscal year 2014 and \$100,000 in fiscal year 2015 are for the blood lead surveillance system under Minnesota Statutes, section 144.9502.

Base Level Adjustment. The state government special revenue base is increased by \$6,000 in fiscal year 2016 and by \$13,000 in fiscal year 2017.

<u>Subd. 5. Administrative Support Services</u>	<u>8,020,000</u>	<u>8,020,000</u>
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The general fund appropriation includes the base appropriation for the Office of the State Epidemiologist.

Regional Support for Local Public Health Departments. \$350,000 in fiscal year 2014 and

\$350,000 in fiscal year 2015 is for regional staff who provide specialized expertise to local public health departments.

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. <u>Total Appropriation</u>	<u>\$</u>	<u>20,040,000</u>	<u>\$</u>	<u>18,446,000</u>
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This appropriation is from the state government special revenue fund.

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. <u>Board of Chiropractic Examiners</u>	<u>508,000</u>	<u>490,000</u>
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This appropriation includes \$10,000 for information technology hardware to streamline board operations. This is a onetime appropriation. \$15,000 is for a LEAN evaluation. This is a onetime appropriation. \$2,000 in fiscal years 2014 and 2015 is for rental of additional storage space.

Subd. 3. <u>Board of Dentistry</u>	<u>2,059,000</u>	<u>2,056,000</u>
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This appropriation includes \$843,000 in fiscal year 2014 and \$837,000 in fiscal year 2015 for the health professional services program.

\$15,000 in fiscal year 2014 is for repairs, maintenance, furnishings, and ergonomic upgrades. This is a onetime appropriation. \$35,000 in fiscal years 2014 and 2015 is for additional staff to implement new regulatory activity. \$20,000 in fiscal years 2014 and 2015 is for database upgrades for regulatory and licensing activities. \$10,000 in fiscal years 2014 and 2015 is for professional and technical contracts for expert consultants to review complex complaints, advise on specialty dentistry areas, and to serve as expert witnesses in contested case matters.

Subd. 4. <u>Board of Dietetic and Nutrition Practice</u>	<u>111,000</u>	<u>111,000</u>
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Subd. 5. <u>Board of Marriage and Family Therapy</u>	<u>254,000</u>	<u>226,000</u>
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This appropriation includes \$25,000 in fiscal year 2014 for rulemaking. This is a onetime appropriation. \$31,000 in fiscal year 2014 and \$27,000 in fiscal year 2015 are for additional staff to improve licensing and licensing renewal activities. \$30,000 in fiscal year

2014 and \$31,000 in fiscal year 2015 are to increase the executive director to a full-time position.

The remaining balance of the state government special revenue fund appropriation in Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 5, for Board of Marriage and Family Therapy rulemaking, estimated to be \$25,000, is canceled. This paragraph is effective the day following final enactment.

<u>Subd. 6. Board of Medical Practice</u>	<u>3,867,000</u>	<u>3,867,000</u>
<u>Subd. 7. Board of Nursing</u>	<u>3,637,000</u>	<u>3,637,000</u>
<u>Subd. 8. Board of Nursing Home Administrators</u>	<u>3,742,000</u>	<u>2,252,000</u>

Administrative Services Unit - Operating Costs. Of this appropriation, \$676,000 in fiscal year 2014 and \$626,000 in fiscal year 2015 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, \$150,000 in fiscal year 2014 and \$150,000 in fiscal year 2015 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, \$200,000 in fiscal year 2014 and \$200,000 in fiscal year 2015 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget.

This appropriation includes \$44,000 in fiscal year 2014 for rulemaking. This is a onetime appropriation. \$1,441,000 in fiscal year 2014 and \$420,000 in fiscal year 2015 are for the development of a shared

disciplinary, regulatory, licensing, and information management system. \$391,000 in fiscal year 2014 is a onetime appropriation for retirement costs in the health-related boards. This funding may be transferred to the health boards incurring retirement costs. These funds are available either year of the biennium.

This appropriation includes \$16,000 in fiscal years 2014 and 2015 for evening security, \$2,000 in fiscal years 2014 and 2015 for a state vehicle lease, and \$18,000 in fiscal years 2014 and 2015 for shared office space and administrative support. \$205,000 in fiscal year 2014 and \$221,000 in fiscal year 2015 are for shared information technology services, equipment, and maintenance.

The remaining balance of the state government special revenue fund appropriation in Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 8, for Board of Nursing Home Administrators rulemaking, estimated to be \$44,000, is canceled, and the remaining balance of the state government special revenue fund appropriation in Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 8, for electronic licensing system adaptors, estimated to be \$761,000, and for the development and implementation of a disciplinary, regulatory, licensing, and information management system, estimated to be \$1,100,000, are canceled. This paragraph is effective the day following final enactment.

Base Adjustment. The base is decreased by \$370,000 in fiscal years 2016 and 2017.

<u>Subd. 9. Board of Optometry</u>	<u>107,000</u>	<u>107,000</u>
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<u>Subd. 10. Board of Pharmacy</u>	<u>2,555,000</u>	<u>2,555,000</u>
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Prescription Electronic Reporting. Of this appropriation, \$356,000 in fiscal year 2014 and \$356,000 in fiscal year 2015 from the state government special revenue fund are to the board to operate the prescription monitoring program in Minnesota Statutes, section 152.126.

<u>Subd. 11. Board of Physical Therapy</u>	<u>390,000</u>	<u>346,000</u>
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This appropriation includes \$44,000 in fiscal year 2014 for rulemaking. This is a onetime appropriation.

The remaining balance of the state government special revenue fund appropriation in Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 11, for Board of Physical Therapy rulemaking, estimated to be \$44,000, is canceled. This paragraph is effective the day following final enactment.

Subd. 12. Board of Podiatry	<u>76,000</u>	<u>76,000</u>
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Subd. 13. Board of Psychology	<u>892,000</u>	<u>892,000</u>
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This appropriation includes \$15,000 in fiscal years 2014 and 2015 for continuing educational programming. \$5,000 in fiscal years 2014 and 2015 are for a public education program. \$25,000 in fiscal years 2014 and 2015 are for development of educational materials. This is a onetime appropriation.

Base Adjustment. The base is decreased by \$45,000 in fiscal years 2016 and 2017.

Subd. 14. Board of Social Work	<u>1,109,000</u>	<u>1,110,000</u>
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This appropriation includes \$55,000 in fiscal year 2014 and \$56,000 in fiscal year 2015 for additional staff to enhance the board's complaint resolution process.

Subd. 15. Board of Veterinary Medicine	<u>262,000</u>	<u>256,000</u>
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This appropriation includes \$32,000 in fiscal year 2014 and \$26,000 in fiscal year 2015 for additional staff to improve the board's complaint resolution process.

Subd. 16. Board of Behavioral Health and Therapy	<u>471,000</u>	<u>465,000</u>
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This appropriation includes \$56,000 in fiscal year 2014 and \$50,000 in fiscal year 2015 for additional staff to enhance the licensing and complaint resolution processes of the board.

Sec. 5. EMERGENCY MEDICAL SERVICES REGULATORY BOARD	<u>\$ 2,741,000</u>	<u>\$ 2,741,000</u>
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Regional Grants. \$585,000 in fiscal year 2014 and \$585,000 in fiscal year 2015 are for regional emergency medical services programs, to be

distributed equally to the eight emergency medical service regions.

Cooper/Sams Volunteer Ambulance Program. \$700,000 in fiscal year 2014 and \$700,000 in fiscal year 2015 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(a) Of this amount, \$611,000 in fiscal year 2014 and \$611,000 in fiscal year 2015 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) Of this amount, \$89,000 in fiscal year 2014 and \$89,000 in fiscal year 2015 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

Ambulance Training Grant. \$361,000 in fiscal year 2014 and \$361,000 in fiscal year 2015 are for training grants.

EMSRB Board Operations. \$1,095,000 in fiscal year 2014 and \$1,095,000 in fiscal year 2015 are for operations.

Sec. 6. <u>COUNCIL ON DISABILITY</u>	<u>\$</u>	<u>614,000</u>	<u>\$</u>	<u>614,000</u>
Sec. 7. <u>OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES</u>	<u>\$</u>	<u>1,654,000</u>	<u>\$</u>	<u>1,654,000</u>
Sec. 8. <u>OMBUDSPERSON FOR FAMILIES</u>	<u>\$</u>	<u>333,000</u>	<u>\$</u>	<u>334,000</u>

Sec. 9. Minnesota Statutes 2012, section 256.01, subdivision 34, is amended to read:

Subd. 34. **Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

- (1) reimbursement for the Minnesota senior health options project; ~~and~~
- (2) reimbursement related to prior authorization and inpatient admission certification by a professional review organization. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance; ~~and~~
- (3) reimbursement resulting from the federal child support grant expenditures authorized under United States Code, title 42, section 1315.

Sec. 10. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 36. **Federal reimbursement for privatized adoption grants.** Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Sec. 11. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 37. **DHS receipt center accounting.** The commissioner may transfer appropriations to, and account for DHS receipt center operations in, the special revenue fund.

Sec. 12. **APPROPRIATION ADJUSTMENTS.**

(a) The general fund appropriation in section 2, subdivision 5, paragraph (g), includes up to \$53,391,000 in fiscal year 2014; \$216,637,000 in fiscal year 2015; \$261,660,000 in fiscal year 2016; and \$279,984,000 in fiscal year 2017, for medical assistance eligibility and administration changes related to:

(1) eligibility for children age two to 18 with income up to 275 percent of the federal poverty guidelines;

(2) eligibility for pregnant women with income up to 275 percent of the federal poverty guidelines;

(3) Affordable Care Act enrollment and renewal processes, including elimination of six-month renewals, ex parte eligibility reviews, preprinted renewal forms, changes in verification requirements, and other changes in the eligibility determination and enrollment and renewal process;

(4) automatic eligibility for children who turn 18 in foster care until they reach age 26;

(5) eligibility related to spousal impoverishment provisions for waiver recipients; and

(6) presumptive eligibility determinations by hospitals.

(b) The commissioner of human services shall determine the difference between the actual or forecasted costs to the medical assistance program attributable to the program changes in paragraph (a), clauses (1) to (6), and the costs of paragraph (a), clauses (1) to (6), that were estimated during the 2013 legislative session based on data from the 2013 February forecast. The costs in this paragraph must be calculated between January 1, 2014, and June 30, 2017.

(c) For each fiscal year from 2014 to 2017, the commissioner of human services shall certify the actual or forecasted cost differences to the medical assistance program determined under paragraph (b), and report the difference in costs to the commissioner of management and budget at least four weeks prior to a forecast under Minnesota Statutes, section 16A.103. No later than three weeks before the release of the forecast under Minnesota Statutes, section 16A.103, the commissioner of management and budget shall reduce the health care access fund appropriation in section 2, subdivision 5, paragraph (g), by the cumulative difference in costs determined in paragraph (b). If for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is positive, no adjustment shall be made to the health care access fund appropriation. If for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is less than the original appropriation, the appropriation for that fiscal year is zero.

(d) This section expires on January 1, 2018.

Sec. 13. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2015, within fiscal years among the MFIP, general assistance, general assistance medical care under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota

supplemental aid, group residential housing programs, the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this provision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Human Services and Health as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this provision.

Sec. 14. INDIRECT COSTS NOT TO FUND PROGRAMS.

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 15. EXPIRATION OF UNCODIFIED LANGUAGE.

All uncodified language contained in this article expires on June 30, 2015, unless a different expiration date is explicit.

Sec. 16. EFFECTIVE DATE.

This article is effective July 1, 2013, unless a different effective date is specified.

ARTICLE 15

REFORM 2020 CONTINGENT APPROPRIATIONS

Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2014" and "2015" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2014, or June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal year 2015. "The biennium" is fiscal years 2014 and 2015.

<u>APPROPRIATIONS</u>	
<u>Available for the Year</u>	
<u>Ending June 30</u>	
<u>2014</u>	<u>2015</u>

Sec. 2. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. <u>Total Appropriation</u>	\$	<u>2,144,000</u>	\$	<u>214,000</u>
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Subd. 2. Central Office

The amounts that may be spent from this appropriation for each purpose are as follows:

<u>(a) Operations</u>	<u>2,909,000</u>	<u>8,957,000</u>
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Base Adjustment. The general fund base is decreased by \$8,916,000 in fiscal year 2016 and \$8,916,000 in fiscal year 2017.

<u>(b) Children and Families</u>	<u>109,000</u>	<u>206,000</u>
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<u>(c) Continuing Care</u>	<u>2,849,000</u>	<u>3,574,000</u>
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Base Adjustment. The general fund base is decreased by \$2,000 in fiscal year 2016 and by \$27,000 in fiscal year 2017.

<u>(d) Group Residential Housing</u>	<u>(1,166,000)</u>	<u>(8,602,000)</u>
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<u>(e) Medical Assistance</u>	<u>(3,950,000)</u>	<u>(6,420,000)</u>
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<u>(f) Alternative Care</u>	<u>(7,386,000)</u>	<u>(6,851,000)</u>
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<u>(g) Child and Community Service Grants</u>	<u>3,000,000</u>	<u>3,000,000</u>
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<u>(h) Aging and Adult Services Grants</u>	<u>5,365,000</u>	<u>5,936,000</u>
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Gaps Analysis. In fiscal year 2014, and in each even-numbered year thereafter, \$435,000 is appropriated to conduct an analysis of gaps in long-term care services under Minnesota Statutes, section 144A.351. This is a biennial appropriation. The base is increased by \$435,000 in fiscal year 2016. Notwithstanding any contrary provisions in this article, this provision does not expire.

Base Adjustment. The general fund base is increased by \$498,000 in fiscal year 2016, and decreased by \$124,000 in fiscal year 2017.

<u>(i) Disabilities Grants</u>	<u>414,000</u>	<u>414,000</u>
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Sec. 3. **FEDERAL APPROVAL.**

(a) The implementation of this article and article 2 is contingent on federal approval.

(b) Upon full or partial approval of the waiver application, the commissioner of human services shall submit to the commissioner of management and budget a plan for implementing the provisions in this article that received federal approval as well as any provisions that do not require federal approval. The plan must:

<u>(b) MFIP Child Care Assistance Grants</u>	<u>10,113,000</u>
<u>(c) General Assistance Grants</u>	<u>3,230,000</u>
<u>(d) Minnesota Supplemental Aid Grants</u>	<u>(1,008,000)</u>
<u>(e) Group Residential Housing Grants</u>	<u>(5,423,000)</u>
<u>(f) MinnesotaCare Grants</u>	<u>(7,179,000)</u>
<u>This appropriation is from the health care access fund.</u>	
<u>(g) Medical Assistance Grants</u>	<u>(159,733,000)</u>
<u>(h) Alternative Care Grants</u>	<u>-0-</u>
<u>(i) CD Entitlement Grants</u>	<u>2,364,000</u>
<u>Subd. 3. Technical Activities</u>	<u>417,000</u>

This appropriation is from the TANF fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 17

NORTHSTAR CARE FOR CHILDREN

Section 1. Minnesota Statutes 2012, section 256.0112, is amended by adding a subdivision to read:

Subd. 10. **Contracts for child foster care services.** When local agencies negotiate lead county contracts or purchase of service contracts for child foster care services, the foster care maintenance payment made on behalf of the child shall follow the provisions of Northstar Care for Children, chapter 256N. Foster care maintenance payments as defined in section 256N.02, subdivision 15, represent costs for activities similar in nature to those expected of parents and do not cover services rendered by the licensed or tribally approved foster parent, facility, or administrative costs or fees. Payments made to foster parents must follow the requirements of section 256N.26, subdivision 15. The legally responsible agency must provide foster parents with the assessment and notice as specified in section 256N.24. The financially responsible agency is permitted to make additional payments for specific services provided by the foster parents or facility, as permitted in section 256N.21, subdivision 5. These additional payments are not considered foster care maintenance.

Sec. 2. Minnesota Statutes 2012, section 256.82, subdivision 2, is amended to read:

Subd. 2. **Foster care maintenance payments.** ~~Beginning January 1, 1986,~~ For the purpose of foster care maintenance payments under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, the county paying the maintenance costs must be reimbursed for the costs from the federal money available for the purpose. Beginning July 1, 1997, for the purposes of determining a child's eligibility under

title IV-E of the Social Security Act, the placing agency shall use AFDC requirements in effect on July 16, 1996.

Sec. 3. Minnesota Statutes 2012, section 256.82, subdivision 3, is amended to read:

Subd. 3. **Setting foster care standard rates.** (a) The commissioner shall annually establish minimum ~~standard maintenance~~ rates for foster care maintenance ~~and including supplemental~~ difficulty of care payments for all children in foster care eligible for Northstar Care for Children under chapter 256N.

(b) All children entering foster care on or after January 1, 2015, are eligible for Northstar Care for Children under chapter 256N. Any increase in rates shall in no case exceed three percent per annum.

(c) All children in foster care on December 31, 2014, must remain in the pre-Northstar Care for Children foster care program under sections 256N.21, subdivision 6, and 260C.4411, subdivision 1. The rates for the pre-Northstar Care for Children foster care program shall remain those in effect on January 1, 2013.

Sec. 4. **[256N.001] CITATION.**

Sections 256N.001 to 256N.28 may be cited as the "Northstar Care for Children Act." Sections 256N.001 to 256N.28 establish Northstar Care for Children, which authorizes certain benefits to support a child in need who is served by the Minnesota child welfare system and who is the responsibility of the state, local county social service agencies, or tribal social service agencies authorized under section 256.01, subdivision 14b, or are otherwise eligible for federal adoption assistance. A child eligible under this chapter has experienced a child welfare intervention that has resulted in the child being placed away from the child's parents' care and is receiving foster care services consistent with chapter 260B, 260C, or 260D, or is in the permanent care of relatives through a transfer of permanent legal and physical custody, or in the permanent care of adoptive parents.

Sec. 5. **[256N.01] PUBLIC POLICY.**

(a) The legislature declares that the public policy of this state is to keep children safe from harm and to ensure that when children suffer harmful or injurious experiences in their lives, appropriate services are immediately available to keep them safe.

(b) Children do best in permanent, safe, nurturing homes where they can maintain lifelong relationships with adults. Whenever safely possible, children are best served when they can be nurtured and raised by their parents. Where services cannot be provided to allow a child to remain safely at home, an out-of-home placement may be required. When this occurs, reunification should be sought if it can be accomplished safely. When it is not possible for parents to provide safety and permanency for their children, an alternative permanent home must quickly be made available to the child, drawing from kinship sources whenever possible.

(c) Minnesota understands the importance of having a comprehensive approach to temporary out-of-home care and to permanent homes for children who cannot be reunited with their families. It is critical that stable benefits be available to caregivers to ensure that the child's needs can be met whether the child's situation and best interests call for temporary foster care, transfer of permanent legal and physical custody to a relative, or adoption. Northstar Care for Children focuses on the child's needs and strengths, and the actual level of care provided by the caregiver, without consideration for the type of placement setting. In this way caregivers are not faced with the burden of making specific long-term decisions based upon competing financial incentives.

Sec. 6. **[256N.02] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of sections 256N.001 to 256N.28, the terms defined in this section have the meanings given them.

Subd. 2. **Adoption assistance.** "Adoption assistance" means medical coverage as allowable under section 256B.055 and reimbursement of nonrecurring expenses associated with adoption and may include financial support provided under agreement with the financially responsible agency, the commissioner, and the parents of an adoptive child whose special needs would otherwise make it difficult to place the child for adoption to assist with the cost of caring for the child. Financial support may include a basic rate payment and a supplemental difficulty of care rate.

Subd. 3. **Assessment.** "Assessment" means the process under section 256N.24 that determines the benefits an eligible child may receive under section 256N.26.

Subd. 4. **At-risk child.** "At-risk child" means a child who does not have a documented disability but who is at risk of developing a physical, mental, emotional, or behavioral disability based on being related within the first or second degree to persons who have an inheritable physical, mental, emotional, or behavioral disabling condition, or from a background which has the potential to cause the child to develop a physical, mental, emotional, or behavioral disability that the child is at risk of developing. The disability must manifest during childhood.

Subd. 5. **Basic rate.** "Basic rate" means the maintenance payment made on behalf of a child to support the costs caregivers incur to provide for a child's needs consistent with the care parents customarily provide, including: food, clothing, shelter, daily supervision, school supplies, and a child's personal incidentals. It also supports typical travel to the child's home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement.

Subd. 6. **Caregiver.** "Caregiver" means the foster parent or parents of a child in foster care who meet the requirements of emergency relative placement, licensed foster parents under chapter 245A, or foster parents licensed or approved by a tribe; the relative custodian or custodians; or the adoptive parent or parents who have legally adopted a child.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of human services or any employee of the Department of Human Services to whom the commissioner has delegated appropriate authority.

Subd. 8. **County board.** "County board" means the board of county commissioners in each county.

Subd. 9. **Disability.** "Disability" means a physical, mental, emotional, or behavioral impairment that substantially limits one or more major life activities. Major life activities include, but are not limited to: thinking, walking, hearing, breathing, working, seeing, speaking, communicating, learning, developing and maintaining healthy relationships, safely caring for oneself, and performing manual tasks. The nature, duration, and severity of the impairment must be considered in determining if the limitation is substantial.

Subd. 10. **Financially responsible agency.** "Financially responsible agency" means the agency that is financially responsible for a child. These agencies include both local social service agencies under section 393.07 and tribal social service agencies authorized in section 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative, and Minnesota tribes who assume financial responsibility of children from other states. Under Northstar Care for Children, the agency that is financially responsible at the time of placement for foster care continues to be responsible under section 256N.27 for the local share of any maintenance payments, even after finalization of the adoption or transfer of permanent legal and physical custody of a child.

Subd. 11. **Guardianship assistance.** "Guardianship assistance" means medical coverage, as allowable under section 256B.055, and reimbursement of nonrecurring expenses associated with obtaining permanent legal and physical custody of a child, and may include financial support provided under

agreement with the financially responsible agency, the commissioner, and the relative who has received a transfer of permanent legal and physical custody of a child. Financial support may include a basic rate payment and a supplemental difficulty of care rate to assist with the cost of caring for the child.

Subd. 12. **Human services board.** "Human services board" means a board established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

Subd. 13. **Initial assessment.** "Initial assessment" means the assessment conducted within the first 30 days of a child's initial placement into foster care under section 256N.24, subdivisions 4 and 5.

Subd. 14. **Legally responsible agency.** "Legally responsible agency" means the Minnesota agency that is assigned responsibility for placement, care, and supervision of the child through a court order, voluntary placement agreement, or voluntary relinquishment. These agencies include local social service agencies under section 393.07, tribal social service agencies authorized in section 256.01, subdivision 14b, and Minnesota tribes that assume court jurisdiction when legal responsibility is transferred to the tribal social service agency through a Minnesota district court order. A Minnesota local social service agency is otherwise financially responsible.

Subd. 15. **Maintenance payments.** "Maintenance payments" means the basic rate plus any supplemental difficulty of care rate under Northstar Care for Children. It specifically does not include the cost of initial clothing allowance, payment for social services, or administrative payments to a child-placing agency. Payments are paid consistent with section 256N.26.

Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical custody" means a transfer of permanent legal and physical custody to a relative ordered by a Minnesota juvenile court under section 260C.515, subdivision 4, or for a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code which means that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood.

Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment through the process under section 256N.24 for a child who has been continuously eligible for Northstar Care for Children, or when a child identified as an at-risk child (Level A) under guardianship or adoption assistance has manifested the disability upon which eligibility for the agreement was based according to section 256N.25, subdivision 3, paragraph (b). A reassessment may be used to update an initial assessment, a special assessment, or a previous reassessment.

Subd. 18. **Relative.** "Relative," as described in section 260C.007, subdivision 27, means a person related to the child by blood, marriage, or adoption, or an individual who is an important friend with whom the child has resided or had significant contact. For an Indian child, relative includes members of the extended family as defined by the law or custom of the Indian child's tribe or, in the absence of law or custom, nieces, nephews, or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1903.

Subd. 19. **Relative custodian.** "Relative custodian" means a person to whom permanent legal and physical custody of a child has been transferred under section 260C.515, subdivision 4, or for a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code, which means that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood.

Subd. 20. **Special assessment.** "Special assessment" means an assessment performed under section 256N.24 that determines the benefits that an eligible child may receive under section 256N.26 at the time when a special assessment is required. A special assessment is used when a child's status within

Northstar Care is shifted from a pre-Northstar Care program into Northstar Care for Children and when the commissioner determines that a special assessment is appropriate instead of assigning the transition child to a level under section 256N.28.

Subd. 21. **Supplemental difficulty of care rate.** "Supplemental difficulty of care rate" means the supplemental payment under section 256N.26, if any, as determined by the financially responsible agency or the state, based upon an assessment under section 256N.24. The rate must support activities consistent with the care a parent provides a child with special needs and not the equivalent of a purchased service. The rate must consider the capacity and intensity of the activities associated with parenting duties provided in the home to nurture the child, preserve the child's connections, and support the child's functioning in the home and community.

Sec. 7. [256N.20] NORTHSTAR CARE FOR CHILDREN; GENERALLY.

Subdivision 1. **Eligibility.** A child is eligible for Northstar Care for Children if the child is eligible for:

- (1) foster care under section 256N.21;
- (2) guardianship assistance under section 256N.22; or
- (3) adoption assistance under section 256N.23.

Subd. 2. **Assessments.** Except as otherwise specified, a child eligible for Northstar Care for Children shall receive an assessment under section 256N.24.

Subd. 3. **Agreements.** When a child is eligible for guardianship assistance or adoption assistance, negotiations with caregivers and the development of a written, binding agreement must be conducted under section 256N.25.

Subd. 4. **Benefits and payments.** A child eligible for Northstar Care for Children is entitled to benefits specified in section 256N.26, based primarily on assessments under section 256N.24, and, if appropriate, negotiations and agreements under section 256N.25. Although paid to the caregiver, these benefits must be considered benefits of the child rather than of the caregiver.

Subd. 5. **Federal, state, and local shares.** The cost of Northstar Care for Children must be shared among the federal government, state, counties of financial responsibility, and certain tribes as specified in section 256N.27.

Subd. 6. **Administration and appeals.** The commissioner and financially responsible agency, or other agency designated by the commissioner, shall administer Northstar Care for Children according to section 256N.28. The notification and fair hearing process applicable to this chapter is defined in section 256N.28.

Subd. 7. **Transition.** A child in foster care, relative custody assistance, or adoption assistance prior to January 1, 2015, who remains with the same caregivers continues to receive benefits under programs preceding Northstar Care for Children, unless the child moves to a new foster care placement, permanency is obtained for the child, or the commissioner initiates transition of a child receiving pre-Northstar Care for Children relative custody assistance, guardianship assistance, or adoption assistance under this chapter. Provisions for the transition to Northstar Care for Children for certain children in preceding programs are specified in section 256N.28, subdivisions 2 and 7. Additional provisions for children in: foster care are specified in section 256N.21, subdivision 6; relative custody assistance under section 257.85 are specified in section 256N.22, subdivision 12; and adoption assistance under chapter 259A are specified in section 256N.23, subdivision 13.

Sec. 8. [256N.21] ELIGIBILITY FOR FOSTER CARE BENEFITS.

Subdivision 1. **General eligibility requirements.** (a) A child is eligible for foster care benefits under this section if the child meets the requirements of subdivision 2 on or after January 1, 2015.

(b) The financially responsible agency shall make a title IV-E eligibility determination for all foster children meeting the requirements of subdivision 2, provided the agency has such authority under the state title IV-E plan. To be eligible for title IV-E foster care, a child must also meet any additional criteria specified in section 472 of the Social Security Act.

(c) Except as provided under section 256N.26, subdivision 1 or 6, the foster care benefit to the child under this section must be determined under sections 256N.24 and 256N.26 through an individual assessment. Information from this assessment must be used to determine a potential future benefit under guardianship assistance or adoption assistance, if needed.

(d) When a child is eligible for additional services, subdivisions 3 and 4 govern the co-occurrence of program eligibility.

Subd. 2. **Placement in foster care.** To be eligible for foster care benefits under this section, the child must be in placement away from the child's legal parent or guardian and all of the following criteria must be met:

(1) the legally responsible agency must have placement authority and care responsibility, including for a child 18 years old or older and under age 21, who maintains eligibility for foster care consistent with section 260C.451;

(2) the legally responsible agency must have authority to place the child with a voluntary placement agreement or a court order, consistent with sections 260B.198, 260C.001, 260D.01, or continued eligibility consistent with section 260C.451; and

(3) the child must be placed in an emergency relative placement under section 245A.035, a licensed foster family setting, foster residence setting, or treatment foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, a family foster home licensed or approved by a tribal agency or, for a child 18 years old or older and under age 21, an unlicensed supervised independent living setting approved by the agency responsible for the youth's care.

Subd. 3. **Minor parent.** A child who is a minor parent in placement with the minor parent's child in the same home is eligible for foster care benefits under this section. The foster care benefit is limited to the minor parent, unless the legally responsible agency has separate legal authority for placement of the minor parent's child.

Subd. 4. **Foster children ages 18 up to 21 placed in an unlicensed supervised independent living setting.** A foster child 18 years old or older and under age 21 who maintains eligibility consistent with section 260C.451 and who is placed in an unlicensed supervised independent living setting shall receive the level of benefit under section 256N.26.

Subd. 5. **Excluded activities.** The basic and supplemental difficulty of care payment represents costs for activities similar in nature to those expected of parents, and does not cover services rendered by the licensed or tribally approved foster parent, facility, or administrative costs or fees. The financially responsible agency may pay an additional fee for specific services provided by the licensed foster parent or facility. A foster parent or residence setting must distinguish such a service from the daily care of the child as assessed through the process under section 256N.24.

Subd. 6. **Transition from pre-Northstar Care for Children program.** (a) Section 256.82 establishes the pre-Northstar Care for Children foster care program for all children residing in family foster care on December 31, 2014. Unless transitioned under paragraph (b), a child in foster care with the same caregiver receives benefits under this pre-Northstar Care for Children foster care program.

(b) Transition from the pre-Northstar Care for Children foster care program to Northstar Care for Children takes place on or after January 1, 2015, when the child:

- (1) moves to a different foster home or unlicensed supervised independent living setting;
- (2) has permanent legal and physical custody transferred and, if applicable, meets eligibility requirements in section 256N.22;
- (3) is adopted and, if applicable, meets eligibility requirements in section 256N.23; or
- (4) re-enters foster care after reunification or a trial home visit.

(c) Upon becoming eligible, a foster child must be assessed according to section 256N.24 and then transitioned into Northstar Care for Children according to section 256N.28.

Sec. 9. **[256N.22] GUARDIANSHIP ASSISTANCE ELIGIBILITY.**

Subdivision 1. **General eligibility requirements.** (a) To be eligible for guardianship assistance under this section, there must be a judicial determination under section 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to a relative is in the child's best interest. For a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code indicating that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood, and that this is in the child's best interest is considered equivalent. Additionally, a child must:

(1) have been removed from the child's home pursuant to a voluntary placement agreement or court order;

(2)(i) have resided in foster care for at least six consecutive months in the home of the prospective relative custodian; or

(ii) have received an exemption from the requirement in item (i) from the court based on a determination that:

- (A) an expedited move to permanency is in the child's best interest;
- (B) expedited permanency cannot be completed without provision of guardianship assistance; and
- (C) the prospective relative custodian is uniquely qualified to meet the child's needs on a permanent basis;

(3) meet the agency determinations regarding permanency requirements in subdivision 2;

(4) meet the applicable citizenship and immigration requirements in subdivision 3;

(5) have been consulted regarding the proposed transfer of permanent legal and physical custody to a relative, if the child is at least 14 years of age or is expected to attain 14 years of age prior to the transfer of permanent legal and physical custody; and

(6) have a written, binding agreement under section 256N.25 among the caregiver or caregivers, the financially responsible agency, and the commissioner established prior to transfer of permanent legal and physical custody.

(b) In addition to the requirements in paragraph (a), the child's prospective relative custodian or custodians must meet the applicable background study requirements in subdivision 4.

(c) To be eligible for title IV-E guardianship assistance, a child must also meet any additional criteria in section 473(d) of the Social Security Act. The sibling of a child who meets the criteria for title IV-E guardianship assistance in section 473(d) of the Social Security Act is eligible for title IV-E guardianship

assistance if the child and sibling are placed with the same prospective relative custodian or custodians, and the legally responsible agency, relatives, and commissioner agree on the appropriateness of the arrangement for the sibling. A child who meets all eligibility criteria except those specific to title IV-E guardianship assistance is entitled to guardianship assistance paid through funds other than title IV-E.

Subd. 2. **Agency determinations regarding permanency.** (a) To be eligible for guardianship assistance, the legally responsible agency must complete the following determinations regarding permanency for the child prior to the transfer of permanent legal and physical custody:

(1) a determination that reunification and adoption are not appropriate permanency options for the child; and

(2) a determination that the child demonstrates a strong attachment to the prospective relative custodian and the prospective relative custodian has a strong commitment to caring permanently for the child.

(b) The legally responsible agency shall document the determinations in paragraph (a) and the supporting information for completing each determination in the case file and make them available for review as requested by the financially responsible agency and the commissioner during the guardianship assistance eligibility determination process.

Subd. 3. **Citizenship and immigration status.** A child must be a citizen of the United States or otherwise be eligible for federal public benefits according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for guardianship assistance.

Subd. 4. **Background study.** (a) A background study under section 245C.33 must be completed on each prospective relative custodian and any other adult residing in the home of the prospective relative custodian. A background study on the prospective relative custodian or adult residing in the household previously completed under section 245C.04 for the purposes of foster care licensure may be used for the purposes of this section, provided that the background study is current at the time of the application for guardianship assistance.

(b) If the background study reveals:

(1) a felony conviction at any time for:

(i) child abuse or neglect;

(ii) spousal abuse;

(iii) a crime against a child, including child pornography; or

(iv) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(2) a felony conviction within the past five years for:

(i) physical assault;

(ii) battery; or

(iii) a drug-related offense;

the prospective relative custodian is prohibited from receiving guardianship assistance on behalf of an otherwise eligible child.

Subd. 5. **Responsibility for determining guardianship assistance eligibility.** The commissioner shall determine eligibility for:

(1) a child under the legal custody or responsibility of a Minnesota county social service agency who would otherwise remain in foster care;

(2) a Minnesota child under tribal court jurisdiction who would otherwise remain in foster care; and

(3) an Indian child being placed in Minnesota who meets title IV-E eligibility defined in section 473(d) of the Social Security Act. The agency or entity assuming responsibility for the child is responsible for the nonfederal share of the guardianship assistance payment.

Subd. 6. **Exclusions.** (a) A child with a guardianship assistance agreement under Northstar Care for Children is not eligible for the Minnesota family investment program child-only grant under chapter 256J.

(b) The commissioner shall not enter into a guardianship assistance agreement with:

(1) a child's biological parent;

(2) an individual assuming permanent legal and physical custody of a child or the equivalent under tribal code without involvement of the child welfare system; or

(3) an individual assuming permanent legal and physical custody of a child who was placed in Minnesota by another state or a tribe outside of Minnesota.

Subd. 7. **Guardianship assistance eligibility determination.** The financially responsible agency shall prepare a guardianship assistance eligibility determination for review and final approval by the commissioner. The eligibility determination must be completed according to requirements and procedures and on forms prescribed by the commissioner. Supporting documentation for the eligibility determination must be provided to the commissioner. The financially responsible agency and the commissioner must make every effort to establish a child's eligibility for title IV-E guardianship assistance. A child who is determined to be eligible for guardianship assistance must have a guardianship assistance agreement negotiated on the child's behalf according to section 256N.25.

Subd. 8. **Termination of agreement.** (a) A guardianship assistance agreement must be terminated in any of the following circumstances:

(1) the child has attained the age of 18, or up to age 21 when the child meets a condition for extension in subdivision 11;

(2) the child has not attained the age of 18 years of age, but the commissioner determines the relative custodian is no longer legally responsible for support of the child;

(3) the commissioner determines the relative custodian is no longer providing financial support to the child up to age 21;

(4) the death of the child; or

(5) the relative custodian requests in writing termination of the guardianship assistance agreement.

(b) A relative custodian is considered no longer legally responsible for support of the child in any of the following circumstances:

(1) permanent legal and physical custody or guardianship of the child is transferred to another individual;

(2) the death of the relative custodian under subdivision 9;

(3) the child enlists in the military;

(4) the child gets married; or

(5) the child is determined an emancipated minor through legal action.

Subd. 9. **Death of relative custodian or dissolution of custody.** The guardianship assistance agreement ends upon death or dissolution of permanent legal and physical custody of both relative custodians in the case of assignment of custody to two individuals, or the sole relative custodian in the case of assignment of custody to one individual. Guardianship assistance eligibility may be continued according to subdivision 10.

Subd. 10. **Assigning a child's guardianship assistance to a court-appointed guardian or custodian.** (a) Guardianship assistance may be continued with the written consent of the commissioner to an individual who is a guardian or custodian appointed by a court for the child upon the death of both relative custodians in the case of assignment of custody to two individuals, or the sole relative custodian in the case of assignment of custody to one individual, unless the child is under the custody of a county, tribal, or child-placing agency.

(b) Temporary assignment of guardianship assistance may be approved for a maximum of six consecutive months from the death of the relative custodian or custodians as provided in paragraph (a) and must adhere to the policies and procedures prescribed by the commissioner. If a court has not appointed a permanent legal guardian or custodian within six months, the guardianship assistance must terminate and must not be resumed.

(c) Upon assignment of assistance payments under this subdivision, assistance must be provided from funds other than title IV-E.

Subd. 11. **Extension of guardianship assistance after age 18.** (a) Under the circumstances outlined in paragraph (e), a child may qualify for extension of the guardianship assistance agreement beyond the date the child attains age 18, up to the date the child attains the age of 21.

(b) A request for extension of the guardianship assistance agreement must be completed in writing and submitted, including all supporting documentation, by the relative custodian to the commissioner at least 60 calendar days prior to the date that the current agreement will terminate.

(c) A signed amendment to the current guardianship assistance agreement must be fully executed between the relative custodian and the commissioner at least ten business days prior to the termination of the current agreement. The request for extension and the fully executed amendment must be made according to requirements and procedures prescribed by the commissioner, including documentation of eligibility, and on forms prescribed by the commissioner.

(d) If an agency is certifying a child for guardianship assistance and the child will attain the age of 18 within 60 calendar days of submission, the request for extension must be completed in writing and submitted, including all supporting documentation, with the guardianship assistance application.

(e) A child who has attained the age of 16 prior to the effective date of the guardianship assistance agreement is eligible for extension of the agreement up to the date the child attains age 21 if the child:

(1) is dependent on the relative custodian for care and financial support; and

(2) meets at least one of the following conditions:

(i) is completing a secondary education program or a program leading to an equivalent credential;

(ii) is enrolled in an institution which provides postsecondary or vocational education;

(iii) is participating in a program or activity designed to promote or remove barriers to employment;

(iv) is employed for at least 80 hours per month; or

(v) is incapable of doing any of the activities described in items (i) to (iv) due to a medical condition where incapability is supported by professional documentation according to the requirements and procedures prescribed by the commissioner.

(f) A child who has not attained the age of 16 prior to the effective date of the guardianship assistance agreement is eligible for extension of the guardianship assistance agreement up to the date the child attains the age of 21 if the child is:

- (1) dependent on the relative custodian for care and financial support; and
- (2) possesses a physical or mental disability which impairs the capacity for independent living and warrants continuation of financial assistance, as determined by the commissioner.

Subd. 12. **Beginning guardianship assistance component of Northstar Care for Children.** Effective November 27, 2014, a child who meets the eligibility criteria for guardianship assistance in subdivision 1 may have a guardianship assistance agreement negotiated on the child's behalf according to section 256N.25. The effective date of the agreement must be January 1, 2015, or the date of the court order transferring permanent legal and physical custody, whichever is later. Except as provided under section 256N.26, subdivision 1, paragraph (c), the rate schedule for an agreement under this subdivision is determined under section 256N.26 based on the age of the child on the date that the prospective relative custodian signs the agreement.

Subd. 13. **Transition to guardianship assistance under Northstar Care for Children.** The commissioner may execute guardianship assistance agreements for a child with a relative custody agreement under section 257.85 executed on the child's behalf on or before November 26, 2014, in accordance with the priorities outlined in section 256N.28, subdivision 7, paragraph (b). To facilitate transition into the guardianship assistance program, the commissioner may waive any guardianship assistance eligibility requirements for a child with a relative custody agreement under section 257.85 executed on the child's behalf on or before November 26, 2014. Agreements negotiated under this subdivision must be done according to the process outlined in section 256N.28, subdivision 7. The maximum rate used in the negotiation process for an agreement under this subdivision must be as outlined in section 256N.28, subdivision 7.

Sec. 10. [256N.23] ADOPTION ASSISTANCE ELIGIBILITY.

Subdivision 1. **General eligibility requirements.** (a) To be eligible for adoption assistance under this section, a child must:

- (1) be determined to be a child with special needs under subdivision 2;
- (2) meet the applicable citizenship and immigration requirements in subdivision 3;
- (3)(i) meet the criteria in section 473 of the Social Security Act; or
 - (ii) have had foster care payments paid on the child's behalf while in out-of-home placement through the county or tribe and be either under the guardianship of the commissioner or under the jurisdiction of a Minnesota tribe and adoption, according to tribal law, is in the child's documented permanency plan; and
- (4) have a written, binding agreement under section 256N.25 among the adoptive parent, the financially responsible agency, or if there is no financially responsible agency, the agency designated by the commissioner, and the commissioner established prior to finalization of the adoption.

(b) In addition to the requirements in paragraph (a), an eligible child's adoptive parent or parents must meet the applicable background study requirements in subdivision 4.

(c) A child who meets all eligibility criteria except those specific to title IV-E adoption assistance shall receive adoption assistance paid through funds other than title IV-E.

Subd. 2. **Special needs determination.** (a) A child is considered a child with special needs under this section if the requirements in paragraphs (b) to (g) are met.

(b) There must be a determination that the child must not or should not be returned to the home of the child's parents as evidenced by:

(1) a court-ordered termination of parental rights;

(2) a petition to terminate parental rights;

(3) consent of parent to adoption accepted by the court under chapter 260C;

(4) in circumstances when tribal law permits the child to be adopted without a termination of parental rights, a judicial determination by a tribal court indicating the valid reason why the child cannot or should not return home;

(5) a voluntary relinquishment under section 259.25 or 259.47 or, if relinquishment occurred in another state, the applicable laws in that state; or

(6) the death of the legal parent or parents if the child has two legal parents.

(c) There exists a specific factor or condition of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance as evidenced by:

(1) a determination by the Social Security Administration that the child meets all medical or disability requirements of title XVI of the Social Security Act with respect to eligibility for Supplemental Security Income benefits;

(2) a documented physical, mental, emotional, or behavioral disability not covered under clause (1);

(3) a member of a sibling group being adopted at the same time by the same parent;

(4) an adoptive placement in the home of a parent who previously adopted a sibling for whom they receive adoption assistance; or

(5) documentation that the child is an at-risk child.

(d) A reasonable but unsuccessful effort must have been made to place the child with adoptive parents without providing adoption assistance as evidenced by:

(1) a documented search for an appropriate adoptive placement; or

(2) a determination by the commissioner that a search under clause (1) is not in the best interests of the child.

(e) The requirement for a documented search for an appropriate adoptive placement under paragraph (d), including the registration of the child with the state adoption exchange and other recruitment methods under paragraph (f), must be waived if:

(1) the child is being adopted by a relative and it is determined by the child-placing agency that adoption by the relative is in the best interests of the child;

(2) the child is being adopted by a foster parent with whom the child has developed significant emotional ties while in the foster parent's care as a foster child and it is determined by the child-placing agency that adoption by the foster parent is in the best interests of the child; or

(3) the child is being adopted by a parent that previously adopted a sibling of the child, and it is determined by the child-placing agency that adoption by this parent is in the best interests of the child.

For an Indian child covered by the Indian Child Welfare Act, a waiver must not be granted unless the child-placing agency has complied with the placement preferences required by the Indian Child Welfare Act, United States Code, title 25, section 1915(a).

(f) To meet the requirement of a documented search for an appropriate adoptive placement under paragraph (d), clause (1), the child-placing agency minimally must:

(1) conduct a relative search as required by section 260C.221 and give consideration to placement with a relative, as required by section 260C.212, subdivision 2;

(2) comply with the placement preferences required by the Indian Child Welfare Act when the Indian Child Welfare Act, United States Code, title 25, section 1915(a), applies;

(3) locate prospective adoptive families by registering the child on the state adoption exchange, as required under section 259.75; and

(4) if registration with the state adoption exchange does not result in the identification of an appropriate adoptive placement, the agency must employ additional recruitment methods prescribed by the commissioner.

(g) Once the legally responsible agency has determined that placement with an identified parent is in the child's best interests and made full written disclosure about the child's social and medical history, the agency must ask the prospective adoptive parent if the prospective adoptive parent is willing to adopt the child without receiving adoption assistance under this section. If the identified parent is either unwilling or unable to adopt the child without adoption assistance, the legally responsible agency must provide documentation as prescribed by the commissioner to fulfill the requirement to make a reasonable effort to place the child without adoption assistance. If the identified parent is willing to adopt the child without adoption assistance, the parent must provide a written statement to this effect to the legally responsible agency and the statement must be maintained in the permanent adoption record of the legally responsible agency. For children under guardianship of the commissioner, the legally responsible agency shall submit a copy of this statement to the commissioner to be maintained in the permanent adoption record.

Subd. 3. Citizenship and immigration status. (a) A child must be a citizen of the United States or otherwise eligible for federal public benefits according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for the title IV-E adoption assistance program.

(b) A child must be a citizen of the United States or meet the qualified alien requirements as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for adoption assistance paid through funds other than title IV-E.

Subd. 4. Background study. A background study under section 259.41 must be completed on each prospective adoptive parent. If the background study reveals:

(1) a felony conviction at any time for:

(i) child abuse or neglect;

(ii) spousal abuse;

(iii) a crime against a child, including child pornography; or

(iv) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(2) a felony conviction within the past five years for:

(i) physical assault;

(ii) battery; or

(iii) a drug-related offense;

the adoptive parent is prohibited from receiving adoption assistance on behalf of an otherwise eligible child.

Subd. 5. **Responsibility for determining adoption assistance eligibility.** The commissioner must determine eligibility for:

- (1) a child under the guardianship of the commissioner who would otherwise remain in foster care;
- (2) a child who is not under the guardianship of the commissioner who meets title IV-E eligibility defined in section 473 of the Social Security Act and no state agency has legal responsibility for placement and care of the child;
- (3) a Minnesota child under tribal jurisdiction who would otherwise remain in foster care; and
- (4) an Indian child being placed in Minnesota who meets title IV-E eligibility defined in section 473 of the Social Security Act. The agency or entity assuming responsibility for the child is responsible for the nonfederal share of the adoption assistance payment.

Subd. 6. **Exclusions.** The commissioner must not enter into an adoption assistance agreement with the following individuals:

- (1) a child's biological parent or stepparent;
- (2) a child's relative under section 260C.007, subdivision 27, with whom the child resided immediately prior to child welfare involvement unless:
 - (i) the child was in the custody of a Minnesota county or tribal agency pursuant to an order under chapter 260C or equivalent provisions of tribal code and the agency had placement and care responsibility for permanency planning for the child; and
 - (ii) the child is under guardianship of the commissioner of human services according to the requirements of section 260C.325, subdivision 1 or 3, or is a ward of a Minnesota tribal court after termination of parental rights, suspension of parental rights, or a finding by the tribal court that the child cannot safely return to the care of the parent;
- (3) an individual adopting a child who is the subject of a direct adoptive placement under section 259.47 or the equivalent in tribal code;
- (4) a child's legal custodian or guardian who is now adopting the child; or
- (5) an individual who is adopting a child who is not a citizen or resident of the United States and was either adopted in another country or brought to the United States for the purposes of adoption.

Subd. 7. **Adoption assistance eligibility determination.** (a) The financially responsible agency shall prepare an adoption assistance eligibility determination for review and final approval by the commissioner. When there is no financially responsible agency, the adoption assistance eligibility determination must be completed by the agency designated by the commissioner. The eligibility determination must be completed according to requirements and procedures and on forms prescribed by the commissioner. The financially responsible agency and the commissioner shall make every effort to establish a child's eligibility for title IV-E adoption assistance. Documentation from a qualified expert for the eligibility determination must be provided to the commissioner to verify that a child meets the special needs criteria in subdivision 2. A child who is determined to be eligible for adoption assistance must have an adoption assistance agreement negotiated on the child's behalf according to section 256N.25.

(b) Documentation from a qualified expert of a disability is limited to evidence deemed appropriate by the commissioner and must be submitted to the commissioner with the eligibility determination. Examples of appropriate documentation include, but are not limited to, medical records, psychological assessments, educational or early childhood evaluations, court findings, and social and medical history.

(c) Documentation that the child is at risk of developing physical, mental, emotional, or behavioral disabilities must be submitted according to policies and procedures prescribed by the commissioner.

Subd. 8. **Termination of agreement.** (a) An adoption assistance agreement must terminate in any of the following circumstances:

(1) the child has attained the age of 18, or up to age 21 when the child meets a condition for extension in subdivision 12;

(2) the child has not attained the age of 18, but the commissioner determines the adoptive parent is no longer legally responsible for support of the child;

(3) the commissioner determines the adoptive parent is no longer providing financial support to the child up to age 21;

(4) the death of the child; or

(5) the adoptive parent requests in writing the termination of the adoption assistance agreement.

(b) An adoptive parent is considered no longer legally responsible for support of the child in any of the following circumstances:

(1) parental rights to the child are legally terminated or a court accepted the parent's consent to adoption under chapter 260C;

(2) permanent legal and physical custody or guardianship of the child is transferred to another individual;

(3) death of the adoptive parent under subdivision 9;

(4) the child enlists in the military;

(5) the child gets married; or

(6) the child is determined an emancipated minor through legal action.

Subd. 9. **Death of adoptive parent or adoption dissolution.** The adoption assistance agreement ends upon death or termination of parental rights of both adoptive parents in the case of a two-parent adoption, or the sole adoptive parent in the case of a single-parent adoption. The child's adoption assistance eligibility may be continued according to subdivision 10.

Subd. 10. **Continuing a child's title IV-E adoption assistance in a subsequent adoption.** (a) The child maintains eligibility for title IV-E adoption assistance in a subsequent adoption if the following criteria are met:

(1) the child is determined to be a child with special needs as outlined in subdivision 2; and

(2) the subsequent adoptive parent resides in Minnesota.

(b) If a child had a title IV-E adoption assistance agreement in effect prior to the death of the adoptive parent or dissolution of the adoption, and the subsequent adoptive parent resides outside of Minnesota, the commissioner is not responsible for determining whether the child meets the definition of special needs, entering into the adoption assistance agreement, and making any adoption assistance payments outlined in the new agreement unless a state agency in Minnesota has responsibility for placement and care of the child at the time of the subsequent adoption. If there is no state agency in Minnesota that has responsibility for placement and care of the child at the time of the subsequent adoption, the public child welfare agency in the subsequent adoptive parent's residence is responsible for determining whether the child meets the definition of special needs and entering into the adoption assistance agreement.

Subd. 11. **Assigning a child's adoption assistance to a court-appointed guardian or custodian.** (a) State-funded adoption assistance may be continued with the written consent of the commissioner to an individual who is a guardian appointed by a court for the child upon the death of both the adoptive parents in

the case of a two-parent adoption, or the sole adoptive parent in the case of a single-parent adoption, unless the child is under the custody of a state agency.

(b) Temporary assignment of adoption assistance may be approved by the commissioner for a maximum of six consecutive months from the death of the adoptive parent or parents under subdivision 9 and must adhere to the requirements and procedures prescribed by the commissioner. If, within six months, the child has not been adopted by a person agreed upon by the commissioner, or a court has not appointed a permanent legal guardian under section 260C.325, 525.5-313, or similar law of another jurisdiction, the adoption assistance must terminate.

(c) Upon assignment of payments under this subdivision, assistance must be from funds other than title IV-E.

Subd. 12. Extension of adoption assistance agreement. (a) Under certain limited circumstances a child may qualify for extension of the adoption assistance agreement beyond the date the child attains age 18, up to the date the child attains the age of 21.

(b) A request for extension of the adoption assistance agreement must be completed in writing and submitted, including all supporting documentation, by the adoptive parent to the commissioner at least 60 calendar days prior to the date that the current agreement will terminate.

(c) A signed amendment to the current adoption assistance agreement must be fully executed between the adoptive parent and the commissioner at least ten business days prior to the termination of the current agreement. The request for extension and the fully executed amendment must be made according to the requirements and procedures prescribed by the commissioner, including documentation of eligibility, on forms prescribed by the commissioner.

(d) If an agency is certifying a child for adoption assistance and the child will attain the age of 18 within 60 calendar days of submission, the request for extension must be completed in writing and submitted, including all supporting documentation, with the adoption assistance application.

(e) A child who has attained the age of 16 prior to the finalization of the child's adoption is eligible for extension of the adoption assistance agreement up to the date the child attains age 21 if the child is:

(1) dependent on the adoptive parent for care and financial support; and

(2)(i) completing a secondary education program or a program leading to an equivalent credential;

(ii) enrolled in an institution that provides postsecondary or vocational education;

(iii) participating in a program or activity designed to promote or remove barriers to employment;

(iv) employed for at least 80 hours per month; or

(v) incapable of doing any of the activities described in items (i) to (iv) due to a medical condition where incapability is supported by documentation from an expert according to the requirements and procedures prescribed by the commissioner.

(f) A child who has not attained the age of 16 prior to finalization of the child's adoption is eligible for extension of the adoption assistance agreement up to the date the child attains the age of 21 if the child is:

(1) dependent on the adoptive parent for care and financial support; and

(2)(i) enrolled in a secondary education program or a program leading to the equivalent; or

(ii) possesses a physical or mental disability that impairs the capacity for independent living and warrants continuation of financial assistance as determined by the commissioner.

Subd. 13. **Beginning adoption assistance under Northstar Care for Children.** Effective November 27, 2014, a child who meets the eligibility criteria for adoption assistance in subdivision 1, may have an adoption assistance agreement negotiated on the child's behalf according to section 256N.25, and the effective date of the agreement must be January 1, 2015, or the date of the court order finalizing the adoption, whichever is later. Except as provided under section 256N.26, subdivision 1, paragraph (c), the maximum rate schedule for the agreement must be determined according to section 256N.26 based on the age of the child on the date that the prospective adoptive parent or parents sign the agreement.

Subd. 14. **Transition to adoption assistance under Northstar Care for Children.** The commissioner may offer adoption assistance agreements under this chapter to a child with an adoption assistance agreement under chapter 259A executed on the child's behalf on or before November 26, 2014, according to the priorities outlined in section 256N.28, subdivision 7, paragraph (b). To facilitate transition into the Northstar Care for Children adoption assistance program, the commissioner has the authority to waive any Northstar Care for Children adoption assistance eligibility requirements for a child with an adoption assistance agreement under chapter 259A executed on the child's behalf on or before November 26, 2014. Agreements negotiated under this subdivision must be in accordance with the process in section 256N.28, subdivision 7. The maximum rate used in the negotiation process for an agreement under this subdivision must be as outlined in section 256N.28, subdivision 7.

Sec. 11. **[256N.24] ASSESSMENTS.**

Subdivision 1. **Assessment.** (a) Each child eligible under sections 256N.21, 256N.22, and 256N.23, must be assessed to determine the benefits the child may receive under section 256N.26, in accordance with the assessment tool, process, and requirements specified in subdivision 2.

(b) If an agency applies the emergency foster care rate for initial placement under section 256N.26, the agency may wait up to 30 days to complete the initial assessment.

(c) Unless otherwise specified in paragraph (d), a child must be assessed at the basic level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

(d) An assessment must not be completed for:

(1) a child eligible for guardianship assistance under section 256N.22 or adoption assistance under section 256N.23 who is determined to be an at-risk child. A child under this clause must be assigned level A under section 256N.26, subdivision 1; and

(2) a child transitioning into Northstar Care for Children under section 256N.28, subdivision 7, unless the commissioner determines an assessment is appropriate.

Subd. 2. **Establishment of assessment tool, process, and requirements.** Consistent with sections 256N.001 to 256N.28, the commissioner shall establish an assessment tool to determine the basic and supplemental difficulty of care, and shall establish the process to be followed and other requirements, including appropriate documentation, when conducting the initial assessment of a child entering Northstar Care for Children or when the special assessment and reassessments may be needed for children continuing in the program. The assessment tool must take into consideration the strengths and needs of the child and the extra parenting provided by the caregiver to meet the child's needs.

Subd. 3. **Child care allowance portion of assessment.** (a) The assessment tool established under subdivision 2 must include consideration of the caregiver's need for child care under this subdivision, with greater consideration for children of younger ages.

(b) The child's assessment must include consideration of the caregiver's need for child care if the following criteria are met:

(1) the child is under age 13;

(2) all available adult caregivers are employed or attending educational or vocational training programs; and

(3) the caregiver does not receive child care assistance for the child under chapter 119B.

(c) For children younger than seven years of age, the level determined by the non-child care portions of the assessment must be adjusted based on the average number of hours child care is needed each week due to employment or attending a training or educational program as follows:

(1) fewer than ten hours or if the caregiver is participating in the child care assistance program under chapter 119B, no adjustment;

(2) ten to 19 hours or if needed during school summer vacation or equivalent only, increase one level;

(3) 20 to 29 hours, increase two levels;

(4) 30 to 39 hours, increase three levels; and

(5) 40 or more hours, increase four levels.

(d) For children at least seven years of age but younger than 13, the level determined by the non-child care portions of the assessment must be adjusted based on the average number of hours child care is needed each week due to employment or attending a training or educational program as follows:

(1) fewer than 20 hours, needed during school summer vacation or equivalent only, or if the caregiver is participating in the child care assistance program under chapter 119B, no adjustment;

(2) 20 to 39 hours, increase one level; and

(3) 40 or more hours, increase two levels.

(e) When the child attains the age of seven, the child care allowance must be reduced by reducing the level to that available under paragraph (d). For children in foster care, benefits under section 256N.26 must be automatically reduced when the child turns seven. For children who receive guardianship assistance or adoption assistance, agreements must include similar provisions to ensure that the benefit provided to these children does not exceed the benefit provided to children in foster care.

(f) When the child attains the age of 13, the child care allowance must be eliminated by reducing the level to that available prior to any consideration of the caregiver's need for child care. For children in foster care, benefits under section 256N.26 must be automatically reduced when the child attains the age of 13. For children who receive guardianship assistance or adoption assistance, agreements must include similar provisions to ensure that the benefit provided to these children does not exceed the benefit provided to children in foster care.

(g) The child care allowance under this subdivision is not available to caregivers who receive the child care assistance under chapter 119B. A caregiver receiving a child care allowance under this subdivision must notify the commissioner if the caregiver subsequently receives the child care assistance program under chapter 119B, and the level must be reduced to that available prior to any consideration of the caregiver's need for child care.

(h) In establishing the assessment tool under subdivision 2, the commissioner must design the tool so that the levels applicable to the non-child care portions of the assessment at a given age accommodate the requirements of this subdivision.

Subd. 4. Extraordinary levels. (a) The assessment tool established under subdivision 2 must provide a mechanism through which up to five levels can be added to the supplemental difficulty of care for a particular child under section 256N.26, subdivision 4. In establishing the assessment tool, the commissioner

must design the tool so that the levels applicable to the portions of the assessment other than the extraordinary levels can accommodate the requirements of this subdivision.

(b) These extraordinary levels are available when all of the following circumstances apply:

(1) the child has extraordinary needs as determined by the assessment tool provided for under subdivision 2, and the child meets other requirements established by the commissioner, such as a minimum score on the assessment tool;

(2) the child's extraordinary needs require extraordinary care and intense supervision that is provided by the child's caregiver as part of the parental duties as described in the supplemental difficulty of care rate, section 256N.02, subdivision 21. This extraordinary care provided by the caregiver is required so that the child can be safely cared for in the home and community, and prevents residential placement;

(3) the child is physically living in a foster family setting, as defined in Minnesota Rules, part 2960.3010, subpart 23, or physically living in the home with the adoptive parent or relative custodian; and

(4) the child is receiving the services for which the child is eligible through medical assistance programs or other programs that provide necessary services for children with disabilities or other medical and behavioral conditions to live with the child's family, but the agency with caregiver's input has identified a specific support gap that cannot be met through home and community support waivers or other programs that are designed to provide support for children with special needs.

(c) The agency completing an assessment, under subdivision 2, that suggests an extraordinary level must document as part of the assessment, the following:

(1) the assessment tool that determined that the child's needs or disabilities require extraordinary care and intense supervision;

(2) a summary of the extraordinary care and intense supervision that is provided by the caregiver as part of the parental duties as described in the supplemental difficulty of care rate, section 256N.02, subdivision 21;

(3) confirmation that the child is currently physically residing in the foster family setting or in the home with the adoptive parent or relative custodian;

(4) the efforts of the agency, caregiver, parents, and others to request support services in the home and community that would ease the degree of parental duties provided by the caregiver for the care and supervision of the child. This would include documentation of the services provided for the child's needs or disabilities, and the services that were denied or not available from the local social service agency, community agency, the local school district, local public health department, the parent or child's medical insurance provider;

(5) the specific support gap identified that places the child's safety and well-being at risk in the home or community and is necessary to prevent residential placement; and

(6) the extraordinary care and intense supervision provided by the foster, adoptive, or guardianship caregivers to maintain the child safely in the child's home and prevent residential placement that cannot be supported by medical assistance or other programs that provide services, necessary care for children with disabilities, or other medical or behavioral conditions in the home or community.

(d) An agency completing an assessment under subdivision 2 that suggests an extraordinary level is appropriate must forward the assessment and required documentation to the commissioner. If the commissioner approves, the extraordinary levels must be retroactive to the date the assessment was forwarded.

Subd. 5. **Timing of initial assessment.** For a child entering Northstar Care for Children under section 256N.21, the initial assessment must be completed within 30 days after the child is placed in foster care.

Subd. 6. **Completion of initial assessment.** (a) The assessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the assessment.

(b) Initial assessments are completed for foster children, eligible under section 256N.21.

(c) The initial assessment must be completed by the financially responsible agency, in consultation with the legally responsible agency if different, within 30 days of the child's placement in foster care.

(d) If the foster parent is unable or unwilling to cooperate with the assessment process, the child shall be assigned the basic level, level B under section 256N.26, subdivision 3.

(e) Notice to the foster parent shall be provided as specified in subdivision 12.

Subd. 7. **Timing of special assessment.** (a) A special assessment is required as part of the negotiation of the guardianship assistance agreement under section 256N.22 if:

(1) the child was not placed in foster care with the prospective relative custodian or custodians prior to the negotiation of the guardianship assistance agreement under section 256N.25; or

(2) any requirement for reassessment under subdivision 8 is met.

(b) A special assessment is required as part of the negotiation of the adoption assistance agreement under section 256N.23 if:

(1) the child was not placed in foster care with the prospective adoptive parent or parents prior to the negotiation of the adoption assistance agreement under section 256N.25; or

(2) any requirement for reassessment under subdivision 8 is met.

(c) A special assessment is required when a child transitions from a pre-Northstar Care for Children program into Northstar Care for Children if the commissioner determines that a special assessment is appropriate instead of assigning the transition child to a level under section 256N.28.

(d) The special assessment must be completed prior to the establishment of a guardianship assistance or adoption assistance agreement on behalf of the child.

Subd. 8. **Completing the special assessment.** (a) The special assessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the special assessment.

(b) If a new special assessment is required prior to the effective date of the guardianship assistance agreement, it must be completed by the financially responsible agency, in consultation with the legally responsible agency if different. If the prospective relative custodian is unable or unwilling to cooperate with the special assessment process, the child shall be assigned the basic level, level B under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in which case, the child shall be assigned level A under section 256N.26, subdivision 1.

(c) If a special assessment is required prior to the effective date of the adoption assistance agreement, it must be completed by the financially responsible agency, in consultation with the legally responsible agency if different. If there is no financially responsible agency, the special assessment must be completed by the agency designated by the commissioner. If the prospective adoptive parent is unable or unwilling to cooperate with the special assessment process, the child must be assigned the basic level, level B under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in which case, the child shall be assigned level A under section 256N.26, subdivision 1.

(d) Notice to the prospective relative custodians or prospective adoptive parents must be provided as specified in subdivision 12.

Subd. 9. **Timing of and requests for reassessments.** Reassessments for an eligible child must be completed within 30 days of any of the following events:

(1) for a child in continuous foster care, when six months have elapsed since completion of the last assessment;

(2) for a child in continuous foster care, change of placement location;

(3) for a child in foster care, at the request of the financially responsible agency or legally responsible agency;

(4) at the request of the commissioner; or

(5) at the request of the caregiver under subdivision 9.

Subd. 10. **Caregiver requests for reassessments.** (a) A caregiver may initiate a reassessment request for an eligible child in writing to the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner. The written request must include the reason for the request and the name, address, and contact information of the caregivers. For an eligible child with a guardianship assistance or adoption assistance agreement, the caregiver may request a reassessment if at least six months have elapsed since any previously requested review. For an eligible foster child, a foster parent may request reassessment in less than six months with written documentation that there have been significant changes in the child's needs that necessitate an earlier reassessment.

(b) A caregiver may request a reassessment of an at-risk child for whom a guardianship assistance or adoption assistance agreement has been executed if the caregiver has satisfied the commissioner with written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself, consistent with section 256N.25, subdivision 3, paragraph (b).

(c) If the reassessment cannot be completed within 30 days of the caregiver's request, the agency responsible for reassessment must notify the caregiver of the reason for the delay and a reasonable estimate of when the reassessment can be completed.

Subd. 11. **Completion of reassessment.** (a) The reassessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the reassessment.

(b) For foster children eligible under section 256N.21, reassessments must be completed by the financially responsible agency, in consultation with the legally responsible agency if different.

(c) If reassessment is required after the effective date of the guardianship assistance agreement, the reassessment must be completed by the financially responsible agency.

(d) If a reassessment is required after the effective date of the adoption assistance agreement, it must be completed by the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner.

(e) If the child's caregiver is unable or unwilling to cooperate with the reassessment, the child must be assessed at level B under section 256N.26, subdivision 3, unless the child has an adoption assistance or guardianship assistance agreement in place and is known to be an at-risk child, in which case the child must be assessed at level A under section 256N.26, subdivision 1.

Subd. 12. **Approval of initial assessments, special assessments, and reassessments.** (a) Any agency completing initial assessments, special assessments, or reassessments must designate one or more supervisors or other staff to examine and approve assessments completed by others in the agency

under subdivision 2. The person approving an assessment must not be the case manager or staff member completing that assessment.

(b) In cases where a special assessment or reassessment for guardian assistance and adoption assistance is required under subdivision 7 or 10, the commissioner shall review and approve the assessment as part of the eligibility determination process outlined in section 256N.22, subdivision 7, for guardianship assistance, or section 256N.23, subdivision 7, for adoption assistance. The assessment determines the maximum for the negotiated agreement amount under section 256N.25.

(c) The new rate is effective the calendar month that the assessment is approved, or the effective date of the agreement, whichever is later.

Subd. 13. **Notice for caregiver.** (a) The agency as defined in subdivision 5 or 10 that is responsible for completing the initial assessment or reassessment must provide the child's caregiver with written notice of the initial assessment or reassessment.

(b) Initial assessment notices must be sent within 15 days of completion of the initial assessment and must minimally include the following:

- (1) a summary of the child's completed individual assessment used to determine the initial rating;
- (2) statement of rating and benefit level;
- (3) statement of the circumstances under which the agency must reassess the child;
- (4) procedure to seek reassessment;

(5) notice that the caregiver has the right to a fair hearing review of the assessment and how to request a fair hearing, consistent with section 256.045, subdivision 3; and

(6) the name, telephone number, and e-mail, if available, of a contact person at the agency completing the assessment.

(c) Reassessment notices must be sent within 15 days after the completion of the reassessment and must minimally include the following:

- (1) a summary of the child's individual assessment used to determine the new rating;
- (2) any change in rating and its effective date;
- (3) procedure to seek reassessment;

(4) notice that if a change in rating results in a reduction of benefits, the caregiver has the right to a fair hearing review of the assessment and how to request a fair hearing consistent with section 256.045, subdivision 3;

(5) notice that a caregiver who requests a fair hearing of the reassessed rating within ten days may continue at the current rate pending the hearing, but the agency may recover any overpayment; and

(6) name, telephone number, and e-mail, if available, of a contact person at the agency completing the reassessment.

(d) Notice is not required for special assessments since the notice is part of the guardianship assistance or adoption assistance negotiated agreement completed according to section 256N.25.

Subd. 14. **Assessment tool determines rate of benefits.** The assessment tool established by the commissioner in subdivision 2 determines the monthly benefit level for children in foster care. The monthly payment for guardian assistance or adoption assistance may be negotiated up to the monthly benefit level under foster care for those children eligible for a payment under section 256N.26, subdivision 1.

Sec. 12. **[256N.25] AGREEMENTS.**

Subdivision 1. Agreement; guardianship assistance; adoption assistance. (a) In order to receive guardianship assistance or adoption assistance benefits on behalf of an eligible child, a written, binding agreement between the caregiver or caregivers, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, and the commissioner must be established prior to finalization of the adoption or a transfer of permanent legal and physical custody. The agreement must be negotiated with the caregiver or caregivers under subdivision 2.

(b) The agreement must be on a form approved by the commissioner and must specify the following:

(1) duration of the agreement;

(2) the nature and amount of any payment, services, and assistance to be provided under such agreement;

(3) the child's eligibility for Medicaid services;

(4) the terms of the payment, including any child care portion as specified in section 256N.24, subdivision 3;

(5) eligibility for reimbursement of nonrecurring expenses associated with adopting or obtaining permanent legal and physical custody of the child, to the extent that the total cost does not exceed \$2,000 per child;

(6) that the agreement must remain in effect regardless of the state of which the adoptive parents or relative custodians are residents at any given time;

(7) provisions for modification of the terms of the agreement, including renegotiation of the agreement; and

(8) the effective date of the agreement.

(c) The caregivers, the commissioner, and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must sign the agreement. A copy of the signed agreement must be given to each party. Once signed by all parties, the commissioner shall maintain the official record of the agreement.

(d) The effective date of the guardianship assistance agreement must be the date of the court order that transfers permanent legal and physical custody to the relative. The effective date of the adoption assistance agreement is the date of the finalized adoption decree.

(e) Termination or disruption of the preadoptive placement or the foster care placement prior to assignment of custody makes the agreement with that caregiver void.

Subd. 2. Negotiation of agreement. (a) When a child is determined to be eligible for guardianship assistance or adoption assistance, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must negotiate with the caregiver to develop an agreement under subdivision 1. If and when the caregiver and agency reach concurrence as to the terms of the agreement, both parties shall sign the agreement. The agency must submit the agreement, along with the eligibility determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to the commissioner for final review, approval, and signature according to subdivision 1.

(b) A monthly payment is provided as part of the adoption assistance or guardianship assistance agreement to support the care of children unless the child is determined to be an at-risk child, in which case the special at-risk monthly payment under section 256N.26, subdivision 7, must be made until the caregiver obtains written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself.

(1) The amount of the payment made on behalf of a child eligible for guardianship assistance or adoption assistance is determined through agreement between the prospective relative custodian or the adoptive parent and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the associated benefit and payments outlined in section 256N.26. Except as provided under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes the monthly benefit level for a child under foster care. The monthly payment under a guardianship assistance agreement or adoption assistance agreement may be negotiated up to the monthly benefit level under foster care. In no case may the amount of the payment under a guardianship assistance agreement or adoption assistance agreement exceed the foster care maintenance payment which would have been paid during the month if the child with respect to whom the guardianship assistance or adoption assistance payment is made had been in a foster family home in the state.

(2) The rate schedule for the agreement is determined based on the age of the child on the date that the prospective adoptive parent or parents or relative custodian or custodians sign the agreement.

(3) The income of the relative custodian or custodians or adoptive parent or parents must not be taken into consideration when determining eligibility for guardianship assistance or adoption assistance or the amount of the payments under section 256N.26.

(4) With the concurrence of the relative custodian or adoptive parent, the amount of the payment may be adjusted periodically using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under subdivision 3 when there is a change in the child's needs or the family's circumstances.

(5) The guardianship assistance or adoption assistance agreement of a child who is identified as at-risk receives the special at-risk monthly payment under section 256N.26, subdivision 7, unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly. A relative custodian or adoptive parent of an at-risk child with a guardianship assistance or adoption assistance agreement may request a reassessment of the child under section 256N.24, subdivision 9, and renegotiation of the guardianship assistance or adoption assistance agreement under subdivision 3 to include a monthly payment, if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner.

(c) For guardianship assistance agreements:

(1) the initial amount of the monthly guardianship assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets under section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to by the prospective relative custodian and specified in that agreement, unless the child is identified as at-risk or the guardianship assistance agreement is entered into when a child is under the age of six;

(2) an at-risk child must be assigned level A as outlined in section 256N.26 and receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless and until the potential disability manifests itself, as documented by a qualified expert, and the commissioner authorizes commencement of payment by modifying the agreement accordingly; and

(3) the amount of the monthly payment for a guardianship assistance agreement for a child, other than an at-risk child, who is under the age of six must be as specified in section 256N.26, subdivision 5.

(d) For adoption assistance agreements:

(1) for a child in foster care with the prospective adoptive parent immediately prior to adoptive placement, the initial amount of the monthly adoption assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets in section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to by the prospective adoptive parents and specified in that agreement, unless the child is identified as at-risk or the adoption assistance agreement is entered into when a child is under the age of six;

(2) an at-risk child must be assigned level A as outlined in section 256N.26 and receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly;

(3) the amount of the monthly payment for an adoption assistance agreement for a child under the age of six, other than an at-risk child, must be as specified in section 256N.26, subdivision 5;

(4) for a child who is in the guardianship assistance program immediately prior to adoptive placement, the initial amount of the adoption assistance payment must be equivalent to the guardianship assistance payment in effect at the time that the adoption assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive parent and specified in that agreement; and

(5) for a child who is not in foster care placement or the guardianship assistance program immediately prior to adoptive placement or negotiation of the adoption assistance agreement, the initial amount of the adoption assistance agreement must be determined using the assessment tool and process in this section and the corresponding payment amount outlined in section 256N.26.

Subd. 3. Renegotiation of agreement. (a) A relative custodian or adoptive parent of a child with a guardianship assistance or adoption assistance agreement may request renegotiation of the agreement when there is a change in the needs of the child or in the family's circumstances. When a relative custodian or adoptive parent requests renegotiation of the agreement, a reassessment of the child must be completed consistent with section 256N.24, subdivisions 9 and 10. If the reassessment indicates that the child's level has changed, the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner or the commissioner's designee, and the caregiver must renegotiate the agreement to include a payment with the level determined through the reassessment process. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(b) A relative custodian or adoptive parent of an at-risk child with a guardianship assistance or adoption assistance agreement may request renegotiation of the agreement to include a monthly payment higher than the special at-risk monthly payment under section 256N.26, subdivision 7, if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment of the child must be conducted as outlined in section 256N.24, subdivision 9. The reassessment must be used to renegotiate the agreement to include an appropriate monthly payment. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(c) Renegotiation of a guardianship assistance or adoption assistance agreement is required when one of the circumstances outlined in section 256N.26, subdivision 13, occurs.

Sec. 13. **[256N.26] BENEFITS AND PAYMENTS.**

Subdivision 1. **Benefits.** (a) There are three benefits under Northstar Care for Children: medical assistance, basic payment, and supplemental difficulty of care payment.

(b) A child is eligible for medical assistance under subdivision 2.

(c) A child is eligible for the basic payment under subdivision 3, except for a child assigned level A under section 256N.24, subdivision 1, because the child is determined to be an at-risk child receiving guardianship assistance or adoption assistance.

(d) A child, including a foster child age 18 to 21, is eligible for an additional supplemental difficulty of care payment under subdivision 4, as determined by the assessment under section 256N.24.

(e) An eligible child entering guardianship assistance or adoption assistance under the age of six receives a basic payment and supplemental difficulty of care payment as specified in subdivision 5.

(f) A child transitioning in from a pre-Northstar Care for Children program under section 256N.28, subdivision 7, shall receive basic and difficulty of care supplemental payments according to those provisions.

Subd. 2. **Medical assistance.** Eligibility for medical assistance under this chapter must be determined according to section 256B.055.

Subd. 3. **Basic monthly rate.** From January 1, 2015, to June 30, 2016, the basic monthly rate must be according to the following schedule:

<u>Ages 0-5</u>	<u>\$565 per month</u>
<u>Ages 6-12</u>	<u>\$670 per month</u>
<u>Ages 13 and older</u>	<u>\$790 per month</u>

Subd. 4. **Difficulty of care supplemental monthly rate.** From January 1, 2015, to June 30, 2016, the supplemental difficulty of care monthly rate is determined by the following schedule:

<u>Level A</u>	<u>none (special rate under subdivision 7 applies)</u>
<u>Level B</u>	<u>none (basic under subdivision 3 only)</u>
<u>Level C</u>	<u>\$100 per month</u>
<u>Level D</u>	<u>\$200 per month</u>
<u>Level E</u>	<u>\$300 per month</u>
<u>Level F</u>	<u>\$400 per month</u>
<u>Level G</u>	<u>\$500 per month</u>
<u>Level H</u>	<u>\$600 per month</u>
<u>Level I</u>	<u>\$700 per month</u>
<u>Level J</u>	<u>\$800 per month</u>
<u>Level K</u>	<u>\$900 per month</u>
<u>Level L</u>	<u>\$1,000 per month</u>
<u>Level M</u>	<u>\$1,100 per month</u>
<u>Level N</u>	<u>\$1,200 per month</u>
<u>Level O</u>	<u>\$1,300 per month</u>

<u>Level P</u>	<u>\$1,400 per month</u>
<u>Level Q</u>	<u>\$1,500 per month</u>

A child assigned level A is not eligible for either the basic or supplemental difficulty of care payment, while a child assigned level B is not eligible for the supplemental difficulty of care payment but is eligible for the basic monthly rate under subdivision 3.

Subd. 5. **Alternate rates for preschool entry and certain transitioned children.** A child who entered the guardianship assistance or adoption assistance components of Northstar Care for Children while under the age of six shall receive 50 percent of the amount the child would otherwise be entitled to under subdivisions 3 and 4. The commissioner may also use the 50 percent rate for a child who was transitioned into those components through declaration of the commissioner under section 256N.28, subdivision 7.

Subd. 6. **Emergency foster care rate for initial placement.** (a) A child who enters foster care due to immediate custody by a police officer or court order, consistent with section 260C.175, subdivisions 1 and 2, or equivalent provision under tribal code, shall receive the emergency foster care rate for up to 30 days. The emergency foster care rate cannot be extended beyond 30 days of the child's placement.

(b) For this payment rate to be applied, at least one of three conditions must apply:

(1) the child's initial placement must be in foster care in Minnesota;

(2) the child's previous placement was more than two years ago; or

(3) the child's previous placement was for fewer than 30 days and an assessment under section 256N.24 was not completed by an agency under section 256N.24.

(c) The emergency foster care rate consists of the appropriate basic monthly rate under subdivision 3 plus a difficulty of care supplemental monthly rate of level D under subdivision 4.

(d) The emergency foster care rate ends under any of three conditions:

(1) when an assessment under section 256N.24 is completed;

(2) when the placement ends; or

(3) after 30 days have elapsed.

(e) The financially responsible agency, in consultation with the legally responsible agency, if different, may replace the emergency foster care rate at any time by completing an initial assessment on which a revised difficulty of care supplemental monthly rate would be based. Consistent with section 256N.24, subdivision 9, the caregiver may request a reassessment in writing for an initial assessment to replace the emergency foster care rate. This written request would initiate an initial assessment under section 256N.24, subdivision 5. If the revised difficulty of care supplemental level based on the initial assessment is higher than level D, then the revised higher rate shall apply retroactively to the beginning of the placement. If the revised level is lower, the lower rate shall apply on the date the initial assessment was completed.

(f) If a child remains in foster care placement for more than 30 days, the emergency foster care rate ends after the 30th day of placement and an assessment under section 256N.26 must be completed.

Subd. 7. **Special at-risk monthly payment for at-risk children in guardianship assistance and adoption assistance.** A child eligible for guardianship assistance under section 256N.22 or adoption assistance under section 256N.23 who is determined to be an at-risk child shall receive a special at-risk monthly payment of \$1 per month basic, unless and until the potential disability manifests itself and the agreement is renegotiated to include reimbursement. Such an at-risk child shall receive neither a supplemental difficulty of care monthly rate under subdivision 4 nor home and vehicle modifications under subdivision 10, but must be considered for medical assistance under subdivision 2.

Subd. 8. **Daily rates.** (a) The commissioner shall establish prorated daily rates to the nearest cent for the monthly rates under subdivisions 3 to 7. Daily rates must be routinely used when a partial month is involved for foster care, guardianship assistance, or adoption assistance.

(b) A full month payment is permitted if a foster child is temporarily absent from the foster home if the brief absence does not exceed 14 days and the child's placement continues with the same caregiver.

Subd. 9. **Revision.** By April 1, 2016, for fiscal year 2017, and by each succeeding April 1 for the subsequent fiscal year, the commissioner shall review and revise the rates under subdivisions 3 to 7 based on the United States Department of Agriculture, 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 United States Department of Agriculture, Estimates of the Cost of Raising a Child, except that in no instance must the increase be more than three percent per annum. The monthly rates must be revised to the nearest dollar and the daily rates to the nearest cent.

Subd. 10. **Home and vehicle modifications.** (a) Except for a child assigned level A under section 256N.24, subdivision 1, paragraph (d), clause (1), a child who is eligible for an adoption assistance agreement may have reimbursement of home and vehicle modifications necessary to accommodate the child's special needs upon which eligibility for adoption assistance was based and included as part of the negotiation of the agreement under section 256N.25, subdivision 2. Reimbursement of home and vehicle modifications must not be available for a child who is assessed at level A under subdivision 1, unless and until the potential disability manifests itself and the agreement is renegotiated to include reimbursement.

(b) Application for and reimbursement of modifications must be completed according to a process specified by the commissioner. The type and cost of each modification must be preapproved by the commissioner. The type of home and vehicle modifications must be limited to those specified by the commissioner.

(c) Reimbursement for home modifications as outlined in this subdivision is limited to once every five years per child. Reimbursement for vehicle modifications as outlined in this subdivision is limited to once every five years per family.

Subd. 11. **Child income or income attributable to the child.** (a) A monthly guardianship assistance or adoption assistance payment must be considered as income and resources attributable to the child. Guardianship assistance and adoption assistance are exempt from garnishment, except as permissible under the laws of the state where the child resides.

(b) When a child is placed into foster care, any income and resources attributable to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as applicable to the child being placed.

(c) Consideration of income and resources attributable to the child must be part of the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances, the receipt of other income on behalf of the child may impact the amount of the monthly payment received by the relative custodian or adoptive parent on behalf of the child through Northstar Care for Children. Supplemental Security Income (SSI), retirement survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and black lung benefits are considered income and resources attributable to the child.

Subd. 12. **Treatment of Supplemental Security Income.** If a child placed in foster care receives benefits through Supplemental Security Income (SSI) at the time of foster care placement or subsequent to placement in foster care, the financially responsible agency may apply to be the payee for the child for the duration of the child's placement in foster care. If a child continues to be eligible for SSI after finalization of the adoption or transfer of permanent legal and physical custody and is determined to be eligible for a payment under Northstar Care for Children, a permanent caregiver may choose to receive payment from

both programs simultaneously. The permanent caregiver is responsible to report the amount of the payment to the Social Security Administration and the SSI payment will be reduced as required by the Social Security Administration.

Subd. 13. Treatment of retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, and black lung benefits. (a) If a child placed in foster care receives retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits at the time of foster care placement or subsequent to placement in foster care, the financially responsible agency may apply to be the payee for the child for the duration of the child's placement in foster care. If it is anticipated that a child will be eligible to receive retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after finalization of the adoption or assignment of permanent legal and physical custody, the permanent caregiver shall apply to be the payee of those benefits on the child's behalf. The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.

(b) If a child becomes eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to redetermine the payment under Northstar Care for Children. The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.

(c) If a child ceases to be eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to redetermine the payment under Northstar Care for Children. The monthly amount of the payment under Northstar Care for Children must be the amount the child was determined to be eligible for prior to consideration of any offset.

(d) If the monthly payment received on behalf of the child under retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits changes after the adoption assistance or guardianship assistance agreement is finalized, the permanent caregiver shall notify the commissioner as to the new monthly payment amount, regardless of the amount of the change in payment. If the monthly payment changes by \$75 or more, even if the change occurs incrementally over the duration of the term of the adoption assistance or guardianship assistance agreement, the monthly payment under Northstar Care for Children must be adjusted without further consent to reflect the amount of the increase or decrease in the offset amount. Any subsequent change to the payment must be reported and handled in the same manner. A change of monthly payments of less than \$75 is not a permissible reason to renegotiate the adoption assistance or guardianship assistance agreement under section 256N.25, subdivision 3. The commissioner shall review and revise the limit at which the adoption assistance or guardian assistance agreement must be renegotiated in accordance with subdivision 9.

Subd. 14. Treatment of child support and Minnesota family investment program. (a) If a child placed in foster care receives child support, the child support payment may be redirected to the financially responsible agency for the duration of the child's placement in foster care. In cases where the child qualifies for Northstar Care for Children by meeting the adoption assistance eligibility criteria or the guardianship assistance eligibility criteria, any court-ordered child support must not be considered income attributable to the child and must have no impact on the monthly payment.

(b) Consistent with section 256J.24, a child eligible for Northstar Care for Children whose caregiver receives a payment on the child's behalf is excluded from a Minnesota family investment program assistance unit.

Subd. 15. **Payments.** (a) Payments to caregivers under Northstar Care for Children must be made monthly. Consistent with section 256N.24, subdivision 12, the financially responsible agency must send the caregiver the required written notice within 15 days of a completed assessment or reassessment.

(b) Unless paragraph (c) or (d) applies, the financially responsible agency shall pay foster parents directly for eligible children in foster care.

(c) When the legally responsible agency is different than the financially responsible agency, the legally responsible agency may make the payments to the caregiver, provided payments are made on a timely basis. The financially responsible agency must pay the legally responsible agency on a timely basis. Caregivers must have access to the financially and legally responsible agencies' records of the transaction, consistent with the retention schedule for the payments.

(d) For eligible children in foster care, the financially responsible agency may pay the foster parent's payment for a licensed child-placing agency instead of paying the foster parents directly. The licensed child-placing agency must timely pay the foster parents and maintain records of the transaction. Caregivers must have access to the financially responsible agency's records of the transaction and the child-placing agency's records of the transaction, consistent with the retention schedule for the payments.

Subd. 16. **Effect of benefit on other aid.** Payments received under this section must not be considered as income for child care assistance under chapter 119B or any other financial benefit. Consistent with section 256J.24, a child receiving a maintenance payment under Northstar Care for Children is excluded from any Minnesota family investment program assistance unit.

Subd. 17. **Home and community-based services waiver for persons with disabilities.** A child in foster care may qualify for home and community-based waived services, consistent with section 256B.092 for developmental disabilities, or section 256B.49 for community alternative care, community alternatives for disabled individuals, or traumatic brain injury waivers. A waiver service must not be substituted for the foster care program. When the child is simultaneously eligible for waived services and for benefits under Northstar Care for Children, the financially responsible agency must assess and provide basic and supplemental difficulty of care rates as determined by the assessment according to section 256N.24. If it is determined that additional services are needed to meet the child's needs in the home that is not or cannot be met by the foster care program, the need would be referred to the local waived service program.

Subd. 18. **Overpayments.** The commissioner has the authority to collect any amount of foster care payment, adoption assistance, or guardianship assistance paid to a caregiver in excess of the payment due. Payments covered by this subdivision include basic maintenance needs payments, supplemental difficulty of care payments, and reimbursement of home and vehicle modifications under subdivision 10. Prior to any collection, the commissioner or the commissioner's designee shall notify the caregiver in writing, including:

- (1) the amount of the overpayment and an explanation of the cause of overpayment;
- (2) clarification of the corrected amount;
- (3) a statement of the legal authority for the decision;
- (4) information about how the caregiver can correct the overpayment;
- (5) if repayment is required, when the payment is due and a person to contact to review a repayment plan;
- (6) a statement that the caregiver has a right to a fair hearing review by the department; and
- (7) the procedure for seeking a fair hearing review by the department.

Subd. 19. **Payee.** For adoption assistance and guardianship assistance cases, the payment must only be made to the adoptive parent or relative custodian specified on the agreement. If there is more than one

adoptive parent or relative custodian, both parties will be listed as the payee unless otherwise specified in writing according to policies outlined by the commissioner. In the event of divorce or separation of the caregivers, a change of payee must be made in writing according to policies outlined by the commissioner. If both caregivers are in agreement as to the change, it may be made according to a process outlined by the commissioner. If there is not agreement as to the change, a court order indicating the party who is to receive the payment is needed before a change can be processed. If the change of payee is disputed, the commissioner may withhold the payment until agreement is reached. A noncustodial caregiver may request notice in writing of review, modification, or termination of the adoption assistance or guardianship assistance agreement. In the event of the death of a payee, a change of payee consistent with sections 256N.22 and 256N.23 may be made in writing according to policies outlined by the commissioner.

Subd. 20. **Notification of change.** (a) A caregiver who has an adoption assistance agreement or guardianship assistance agreement in place shall keep the agency administering the program informed of changes in status or circumstances which would make the child ineligible for the payments or eligible for payments in a different amount.

(b) For the duration of the agreement, the caregiver agrees to notify the agency administering the program in writing within 30 days of any of the following:

- (1) a change in the child's or caregiver's legal name;
- (2) a change in the family's address;
- (3) a change in the child's legal custody status;
- (4) the child's completion of high school, if this occurs after the child attains age 18;
- (5) the end of the caregiver's legal responsibility to support the child based on termination of parental rights of the caregiver, transfer of guardianship to another person, or transfer of permanent legal and physical custody to another person;
- (6) the end of the caregiver's financial support of the child;
- (7) the death of the child;
- (8) the death of the caregiver;
- (9) the child enlists in the military;
- (10) the child gets married;
- (11) the child becomes an emancipated minor through legal action;
- (12) the caregiver separates or divorces; and
- (13) the child is residing outside the caregiver's home for a period of more than 30 consecutive days.

Subd. 21. **Correct and true information.** The caregiver must be investigated for fraud if the caregiver reports information the caregiver knows is untrue, the caregiver fails to notify the commissioner of changes that may affect eligibility, or the agency administering the program receives relevant information that the caregiver did not report.

Subd. 22. **Termination notice for caregiver.** The agency that issues the maintenance payment shall provide the child's caregiver with written notice of termination of payment. Termination notices must be sent at least 15 days before the final payment or, in the case of an unplanned termination, the notice is sent within three days of the end of the payment. The written notice must minimally include the following:

- (1) the date payment will end;
- (2) the reason payments will end and the event that is the basis to terminate payment;

(3) a statement that the provider has a right to a fair hearing review by the department consistent with section 256.045, subdivision 3;

(4) the procedure to request a fair hearing; and

(5) the name, telephone number, and e-mail address of a contact person at the agency.

Sec. 14. **[256N.27] FEDERAL, STATE, AND LOCAL SHARES.**

Subdivision 1. **Federal share.** For the purposes of determining a child's eligibility under title IV-E of the Social Security Act for a child in foster care, the financially responsible agency shall use the eligibility requirements outlined in section 472 of the Social Security Act. For a child who qualifies for guardianship assistance or adoption assistance, the financially responsible agency and the commissioner shall use the eligibility requirements outlined in section 473 of the Social Security Act. In each case, the agency paying the maintenance payments must be reimbursed for the costs from the federal money available for this purpose.

Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance payments as determined under subdivision 4, and an identical share of the pre-Northstar Care foster care program under section 260C.4411, subdivision 1, the relative custody assistance program under section 257.85, and the pre-Northstar Care for Children adoption assistance program under chapter 259A. The commissioner may transfer funds into the account if a deficit occurs.

Subd. 3. **Local share.** (a) The financially responsible agency at the time of placement for foster care or finalization of the agreement for guardianship assistance or adoption assistance shall pay the local share of the maintenance payments as determined under subdivision 4, and an identical share of the pre-Northstar Care for Children foster care program under section 260C.4411, subdivision 1, the relative custody assistance program under section 257.85, and the pre-Northstar Care for Children adoption assistance program under chapter 259A.

(b) The financially responsible agency shall pay the entire cost of any initial clothing allowance, administrative payments to child caring agencies specified in section 317A.907, or other support services it authorizes, except as provided under other provisions of law.

(c) In cases of federally required adoption assistance where there is no financially responsible agency as provided in section 256N.24, subdivision 5, the commissioner shall pay the local share.

(d) When an Indian child being placed in Minnesota meets title IV-E eligibility defined in section 473(d) of the Social Security Act and is receiving guardianship assistance or adoption assistance, the agency or entity assuming responsibility for the child is responsible for the nonfederal share of the payment.

Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share of the maintenance payments, reduced by federal reimbursements under title IV-E of the Social Security Act, to be paid by the state and to be paid by the financially responsible agency.

(b) These state and local shares must initially be calculated based on the ratio of the average appropriate expenditures made by the state and all financially responsible agencies during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation, appropriate expenditures for the financially responsible agencies must include basic and difficulty of care payments for foster care reduced by federal reimbursements, but not including any initial clothing allowance, administrative payments to child care agencies specified in section 317A.907, child care, or other support or ancillary expenditures. For purposes of this calculation, appropriate expenditures for the state shall include adoption assistance and relative custody assistance, reduced by federal reimbursements.

(c) For each of the periods January 1, 2015, to June 30, 2016, and fiscal years 2017, 2018, and 2019, the commissioner shall adjust this initial percentage of state and local shares to reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and 2014, taking into account appropriations

for Northstar Care for Children and the turnover rates of the components. In making these adjustments, the commissioner's goal shall be to make these state and local expenditures other than the appropriations for Northstar Care for Children to be the same as they would have been had Northstar Care for Children not been implemented, or if that is not possible, proportionally higher or lower, as appropriate. The state and local share percentages for fiscal year 2019 must be used for all subsequent years.

Subd. 5. **Adjustments for proportionate shares among financially responsible agencies.** (a) The commissioner shall adjust the expenditures under subdivision 4 by each financially responsible agency so that its relative share is proportional to its foster care expenditures, with the goal of making the local share similar to what the county or tribe would have spent had Northstar Care for Children not been enacted.

(b) For the period January 1, 2015, to June 30, 2016, the relative shares must be as determined under subdivision 4 for calendar years 2011, 2012, 2013, and 2014 compared with similar costs of all financially responsible agencies.

(c) For subsequent fiscal years, the commissioner shall update the relative shares based on actual utilization of Northstar Care for Children by the financially responsible agencies during the previous period, so that those using relatively more than they did historically are adjusted upward and those using less are adjusted downward.

(d) The commissioner must ensure that the adjustments are not unduly influenced by onetime events, anomalies, small changes that appear large compared to a narrow historic base, or fluctuations that are the results of the transfer of responsibilities to tribal social service agencies authorized in section 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative.

Sec. 15. **[256N.28] ADMINISTRATION AND APPEALS.**

Subdivision 1. **Responsibilities.** (a) The financially responsible agency shall determine the eligibility for Northstar Care for Children for children in foster care under section 256N.21, and for those children determined eligible, shall further determine each child's eligibility for title IV-E of the Social Security Act, provided the agency has such authority under the state title IV-E plan.

(b) Subject to commissioner review and approval, the financially responsible agency shall prepare the eligibility determination for Northstar Care for Children for children in guardianship assistance under section 256N.22 and children in adoption assistance under section 256N.23. The AFDC relatedness determination, when necessary to determine a child's eligibility for title IV-E funding, shall be made only by an authorized agency according to policies and procedures prescribed by the commissioner.

(c) The financially responsible agency is responsible for the administration of Northstar Care for Children for children in foster care. The agency designated by the commissioner is responsible for assisting the commissioner with the administration of Northstar Care for Children for children in guardianship assistance and adoption assistance by conducting assessments, reassessments, negotiations, and other activities as specified by the commissioner under subdivision 2.

Subd. 2. **Procedures, requirements, and deadlines.** The commissioner shall specify procedures, requirements, and deadlines for the administration of Northstar Care for Children in accordance with sections 256N.001 to 256N.28, including for children transitioning into Northstar Care for Children under subdivision 7. The commissioner shall periodically review all procedures, requirements, and deadlines, including the assessment tool and process under section 256N.24, in consultation with counties, tribes, and representatives of caregivers, and may alter them as needed.

Subd. 3. **Administration of title IV-E programs.** The title IV-E foster care, guardianship assistance, and adoption assistance programs must operate within the statutes, rules, and policies set forth by the federal government in the Social Security Act.

Subd. 4. **Reporting.** The commissioner shall specify required fiscal and statistical reports under section 256.01, subdivision 2, paragraph (q), and other reports as necessary.

Subd. 5. **Promotion of programs.** Families who adopt a child under the commissioner's guardianship must be informed as to the adoption tax credit. The commissioner shall actively seek ways to promote the guardianship assistance and adoption assistance programs, including informing prospective caregivers of eligible children of the availability of guardianship assistance and adoption assistance.

Subd. 6. **Appeals and fair hearings.** (a) A caregiver has the right to appeal to the commissioner under section 256.045 when eligibility for Northstar Care for Children is denied, and when payment or the agreement for an eligible child is modified or terminated.

(b) A relative custodian or adoptive parent has additional rights to appeal to the commissioner pursuant to section 256.045. These rights include when the commissioner terminates or modifies the guardianship assistance or adoption assistance agreement or when the commissioner denies an application for guardianship assistance or adoption assistance. A prospective relative custodian or adoptive parent who disagrees with a decision by the commissioner before transfer of permanent legal and physical custody or finalization of the adoption may request review of the decision by the commissioner or may appeal the decision under section 256.045. A guardianship assistance or adoption assistance agreement must be signed and in effect before the court order that transfers permanent legal and physical custody or the adoption finalization; however, in some cases, there may be extenuating circumstances as to why an agreement was not entered into before finalization of permanency for the child. Caregivers who believe that extenuating circumstances exist in the case of their child may request a fair hearing. Caregivers have the responsibility of proving that extenuating circumstances exist. Caregivers must be required to provide written documentation of each eligibility criterion at the fair hearing. Examples of extenuating circumstances include: relevant facts regarding the child were known by the placing agency and not presented to the caregivers before transfer of permanent legal and physical custody or finalization of the adoption, or failure by the commissioner or a designee to advise potential caregivers about the availability of guardianship assistance or adoption assistance for children in the state foster care system. If an appeals judge finds through the fair hearing process that extenuating circumstances existed and that the child met all eligibility criteria at the time the transfer of permanent legal and physical custody was ordered or the adoption was finalized, the effective date and any associated federal financial participation shall be retroactive from the date of the request for a fair hearing.

Subd. 7. **Transitions from pre-Northstar Care for Children programs.** (a) A child in foster care who remains with the same caregiver shall continue to receive benefits under the pre-Northstar Care for Children foster care program under section 256.82. Transitions to Northstar Care for Children must occur as provided in section 256N.21, subdivision 6.

(b) The commissioner may seek to transition into Northstar Care for Children a child who is in pre-Northstar Care for Children relative custody assistance under section 257.85 or pre-Northstar Care for Children adoption assistance under chapter 259A, in accordance with these priorities, in order of priority:

- (1) financial and budgetary constraints;
- (2) complying with federal regulations;
- (3) converting pre-Northstar Care for Children relative custody assistance under section 257.85 to the guardianship assistance component of Northstar Care for Children;
- (4) improving permanency for a child or children;
- (5) maintaining permanency for a child or children;
- (6) accessing additional federal funds; and

(7) administrative simplification.

(c) Transitions shall be accomplished according to procedures, deadlines, and requirements specified by the commissioner under subdivision 2.

(d) The commissioner may accomplish a transition of a child from pre-Northstar Care for Children relative custody assistance under section 257.85 to the guardianship assistance component of Northstar Care for Children by declaration and appropriate notice to the caregiver, provided that the benefit for a child under this paragraph is not reduced.

(e) The commissioner may offer a transition of a child from pre-Northstar Care for Children adoption assistance under chapter 259A to the adoption assistance component of Northstar Care for Children by contacting the caregiver with an offer. The transition must be accomplished only when the caregiver agrees to the offer. The caregiver shall have a maximum of 90 days to review and accept the commissioner's offer. If the commissioner's offer is not accepted within 90 days, the pre-Northstar Care for Children adoption assistance agreement remains in effect until it terminates or a subsequent offer is made by the commissioner.

(f) For a child transitioning into Northstar Care for Children, the commissioner shall assign an equivalent assessment level based on the most recently completed supplemental difficulty of care level assessment, unless the commissioner determines that arranging for a new assessment under section 256N.24 would be more appropriate based on the priorities specified in paragraph (b).

(g) For a child transitioning into Northstar Care for Children, regardless of the age of the child, the commissioner shall use the rates under section 256N.26, subdivision 5, unless the rates under section 256N.26, subdivisions 3 and 4, are more appropriate based on the priorities specified in paragraph (b), as determined by the commissioner.

Subd. 8. **Purchase of child-specific adoption services.** The commissioner may reimburse the placing agency for appropriate adoption services for children eligible under section 259A.75.

Sec. 16. Minnesota Statutes 2012, section 257.85, subdivision 2, is amended to read:

Subd. 2. **Scope.** The provisions of this section apply to those situations in which the legal and physical custody of a child is established with a relative or important friend with whom the child has resided or had significant contact according to section 260C.515, subdivision 4, by a district court order issued on or after July 1, 1997, but on or before November 26, 2014, or a tribal court order issued on or after July 1, 2005, but on or before November 26, 2014, when the child has been removed from the care of the parent by previous district or tribal court order.

Sec. 17. Minnesota Statutes 2012, section 257.85, subdivision 5, is amended to read:

Subd. 5. **Relative custody assistance agreement.** (a) A relative custody assistance agreement will not be effective, unless it is signed by the local agency and the relative custodian no later than 30 days after the date of the order establishing permanent legal and physical custody, and on or before November 26, 2014, except that a local agency may enter into a relative custody assistance agreement with a relative custodian more than 30 days after the date of the order if it certifies that the delay in entering the agreement was through no fault of the relative custodian and the agreement is signed and in effect on or before November 26, 2014. There must be a separate agreement for each child for whom the relative custodian is receiving relative custody assistance.

(b) Regardless of when the relative custody assistance agreement is signed by the local agency and relative custodian, the effective date of the agreement shall be the date of the order establishing permanent legal and physical custody.

(c) If MFIP is not the applicable program for a child at the time that a relative custody assistance agreement is entered on behalf of the child, when MFIP becomes the applicable program, if the relative custodian had been receiving custody assistance payments calculated based upon a different program, the amount of relative custody assistance payment under subdivision 7 shall be recalculated under the Minnesota family investment program.

(d) The relative custody assistance agreement shall be in a form specified by the commissioner and shall include provisions relating to the following:

- (1) the responsibilities of all parties to the agreement;
- (2) the payment terms, including the financial circumstances of the relative custodian, the needs of the child, the amount and calculation of the relative custody assistance payments, and that the amount of the payments shall be reevaluated annually;
- (3) the effective date of the agreement, which shall also be the anniversary date for the purpose of submitting the annual affidavit under subdivision 8;
- (4) that failure to submit the affidavit as required by subdivision 8 will be grounds for terminating the agreement;
- (5) the agreement's expected duration, which shall not extend beyond the child's eighteenth birthday;
- (6) any specific known circumstances that could cause the agreement or payments to be modified, reduced, or terminated and the relative custodian's appeal rights under subdivision 9;
- (7) that the relative custodian must notify the local agency within 30 days of any of the following:
 - (i) a change in the child's status;
 - (ii) a change in the relationship between the relative custodian and the child;
 - (iii) a change in composition or level of income of the relative custodian's family;
 - (iv) a change in eligibility or receipt of benefits under MFIP, or other assistance program; and
 - (v) any other change that could affect eligibility for or amount of relative custody assistance;
- (8) that failure to provide notice of a change as required by clause (7) will be grounds for terminating the agreement;
- (9) that the amount of relative custody assistance is subject to the availability of state funds to reimburse the local agency making the payments;
- (10) that the relative custodian may choose to temporarily stop receiving payments under the agreement at any time by providing 30 days' notice to the local agency and may choose to begin receiving payments again by providing the same notice but any payments the relative custodian chooses not to receive are forfeit; and
- (11) that the local agency will continue to be responsible for making relative custody assistance payments under the agreement regardless of the relative custodian's place of residence.

Sec. 18. Minnesota Statutes 2012, section 257.85, subdivision 6, is amended to read:

Subd. 6. **Eligibility criteria.** (a) A local agency shall enter into a relative custody assistance agreement under subdivision 5 if it certifies that the following criteria are met:

- (1) the juvenile court has determined or is expected to determine that the child, under the former or current custody of the local agency, cannot return to the home of the child's parents;

(2) the court, upon determining that it is in the child's best interests, has issued or is expected to issue an order transferring permanent legal and physical custody of the child; and

(3) the child either:

(i) is a member of a sibling group to be placed together; or

(ii) has a physical, mental, emotional, or behavioral disability that will require financial support.

When the local agency bases its certification that the criteria in clause (1) or (2) are met upon the expectation that the juvenile court will take a certain action, the relative custody assistance agreement does not become effective until and unless the court acts as expected.

(b) After November 26, 2014, new relative custody assistance agreements must not be executed. Agreements that were signed by all parties on or before November 26, 2014, and were not in effect because the proposed transfer of permanent legal and physical custody of the child did not occur on or before November 26, 2014, must be renegotiated under the terms of Northstar Care for Children in chapter 256N.

Sec. 19. [259A.12] NO NEW EXECUTION OF ADOPTION ASSISTANCE AGREEMENTS.

After November 26, 2014, new adoption assistance agreements must not be executed under this section. Agreements that were signed on or before November 26, 2014, and were not in effect because the adoption finalization of the child did not occur on or before November 26, 2014, must be renegotiated according to the terms of Northstar Care for Children under chapter 256N. Agreements signed and in effect on or before November 26, 2014, must continue according to the terms of this section and applicable rules for the duration of the agreement, unless the commissioner and the adoptive parents choose to renegotiate the agreements under Northstar Care for Children consistent with section 256N.28, subdivision 7. After November 26, 2014, this section and associated rules must be referred to as the pre-Northstar Care for Children adoption assistance program and shall apply to children whose adoption assistance agreements were in effect on or before November 26, 2014, and whose adoptive parents have not renegotiated their agreements according to the terms of Northstar Care for Children.

Sec. 20. [260C.4411] PRE-NORTHSTAR CARE FOR CHILDREN FOSTER CARE PROGRAM.

Subdivision 1. **Pre-Northstar Care for Children foster care program.** (a) For a child placed in family foster care on or before December 31, 2014, the county of financial responsibility under section 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, shall pay the local share under section 256N.27, subdivision 3, for foster care maintenance including any difficulty of care as defined in Minnesota Rules, part 9560.0521, subparts 7 and 10. Family foster care includes:

(1) emergency relative placement under section 245A.035;

(2) licensed foster family settings, foster residence settings, or treatment foster care settings, licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and served by a public or private child care agency authorized by Minnesota Rules, parts 9545.0755 to 9545.0845;

(3) family foster care homes approved by a tribal agency; and

(4) unlicensed supervised settings for foster youth ages 18 to 21.

(b) The county of financial responsibility under section 256G.02 or tribal social services agency authorized in section 256.01, subdivision 14b, shall pay the entire cost of any initial clothing allowance, administrative payments to child care agencies specified in section 317A.907, or any other support services it authorizes, except as otherwise provided by law.

(c) The rates for the pre-Northstar Care for Children foster care program remain those in effect on January 1, 2013, continuing the preexisting rate structure for foster children who remain with the same caregivers and do not transition into Northstar Care for Children under section 256N.21, subdivision 6.

(d) Difficulty of care payments must be maintained consistent with Minnesota Rules, parts 9560.0652 and 9560.0653, using the established reassessment tool in Minnesota Rules, part 9560.0654. The preexisting rate structure for the pre-Northstar Care for Children foster care program must be maintained, provided that when the number of foster children in the program is less than ten percent of the population in 2012, the commissioner may apply the same assessment tool to both the pre-Northstar Care for Children foster care program and Northstar Care for Children under the authority granted in section 256N.24, subdivision 2.

(e) The county of financial responsibility under section 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, shall document the determined pre-Northstar Care for Children foster care rate in the case record, including a description of each condition on which the difficulty of care assessment is based. The difficulty of care rate is reassessed:

- (1) every 12 months;
- (2) at the request of the foster parent; or
- (3) if the child's level of need changes in the current foster home.

(f) The pre-Northstar Care for Children foster care program must maintain the following existing program features:

- (1) monthly payments must be made to the family foster home provider;
- (2) notice and appeal procedures must be consistent with Minnesota Rules, part 9560.0665; and
- (3) medical assistance eligibility for foster children must continue to be determined according to section 256B.055.

(g) The county of financial responsibility under section 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, may continue existing program features, including:

- (1) establishing a local fund of county money through which the agency may reimburse foster parents for the cost of repairing damage done to the home and contents by the foster child and the additional care insurance premium cost of a child who possesses a permit or license to drive a car; and
- (2) paying a fee for specific services provided by the foster parent, based on the parent's skills, experience, or training. This fee must not be considered foster care maintenance.

(h) The following events end the child's enrollment in the pre-Northstar Care for Children foster care program:

- (1) reunification with parent or other relative;
- (2) adoption or transfer of permanent legal and physical custody;
- (3) removal from the current foster home to a different foster home;
- (4) another event that ends the current placement episode; or
- (5) attaining the age of 21.

Subd. 2. **Consideration of other programs.** (a) When a child in foster care is eligible to receive a grant of Retirement Survivors Disability Insurance (RSDI) or Supplemental Security Income for the aged, blind, and disabled, or a foster care maintenance payment under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, the child's needs must be met through these programs. Every

effort must be made to establish a child's eligibility for a title IV-E grant to reimburse the county or tribe from the federal funds available for this purpose.

(b) When a child in foster care qualifies for home and community-based waived services under section 256B.49 for community alternative care (CAC), community alternatives for disabled individuals (CADI), or traumatic brain injury (TBI) waivers, this service does not substitute for the child foster care program. When a foster child is receiving waived services benefits, the county of financial responsibility under section 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, assesses and provides foster care maintenance including difficulty of care using the established tool in Minnesota Rules, part 9560.0654. If it is determined that additional services are needed to meet the child's needs in the home that are not or cannot be met by the foster care program, the needs must be referred to the waived service program.

Sec. 21. [260C.4412] PAYMENT FOR RESIDENTIAL PLACEMENTS.

When a child is placed in a foster care group residential setting under Minnesota Rules, parts 2960.0020 to 2960.0710, foster care maintenance payments must be made on behalf of the child to cover the cost of providing food, clothing, shelter, daily supervision, school supplies, child's personal incidentals and supports, reasonable travel for visitation, or other transportation needs associated with the items listed. Daily supervision in the group residential setting includes routine day-to-day direction and arrangements to ensure the well-being and safety of the child. It may also include reasonable costs of administration and operation of the facility.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 22. [260C.4413] INITIAL CLOTHING ALLOWANCE.

(a) An initial clothing allowance must be available to a child eligible for:

(1) the pre-Northstar Care for Children foster care program under section 260C.4411, subdivision 1;
and

(2) the Northstar Care for Children benefits under section 256N.21.

(b) An initial clothing allowance must also be available for a foster child in a group residential setting based on the child's individual needs during the first 60 days of the child's initial placement. The agency must consider the parent's ability to provide for a child's clothing needs and the residential facility contracts.

(c) The county of financial responsibility under section 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, shall approve an initial clothing allowance consistent with the child's needs. The amount of the initial clothing allowance must not exceed the monthly basic rate for the child's age group under section 256N.26, subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 23. Minnesota Statutes 2012, section 260C.446, is amended to read:

260C.446 DISTRIBUTION OF FUNDS RECOVERED FOR ASSISTANCE FURNISHED.

When any amount shall be recovered from any source for assistance furnished under the provisions of sections 260C.001 to 260C.421 ~~and 260C.441~~, there shall be paid into the treasury of the state or county in the proportion in which they have respectively contributed toward the total assistance paid.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 24. **REPEALER.**

(a) Minnesota Statutes 2012, sections 256.82, subdivision 4; and 260C.441, are repealed effective January 1, 2015.

(b) Minnesota Rules, parts 9560.0650, subparts 1, 3, and 6; 9560.0651; and 9560.0655, are repealed effective January 1, 2015.

Presented to the governor May 22, 2013

Signed by the governor May 23, 2013, 11:25 a.m.