SENATE
STATE OF MINNESOTA
EIGHTY-EIGHTH SESSION

S.F. No. 1568

(SENATE AUTHORS: SHERAN)

DATE	D-PG	OFFICIAL STATUS
04/08/2013	1687	Introduction and first reading Referred to Judiciary
04/16/2013	1848a	Comm report: To pass as amended Joint rule 2.03, referred to Rules and Administration Withdrawn Joint rule 3.02, returned to Judiciary See HF1233, Art. 2, Sec. 41-43; Art. 5, Sec. 2-5; Art. 8, Sec. 25-27, 34, 35; Art. 11, Sec. 3-6, 10-29; Art. 12, Sec. 16-29, 774-75, 95, 97-99

A bill for an act

human services; establishing community first services and supports and Northstar Care for Children; modifying provisions relating to vital records, reporting suspected maltreatment, child custody, data practices, background studies, and fraud investigations; licensing home care providers; establishing penalties; establishing an advisory council; amending Minnesota Statutes 2012, sections 144.051, by adding subdivisions; 144.212; 144.213; 144.215, subdivisions 3, 4; 144.216, subdivision 1; 144.217, subdivision 2; 144.218, subdivision 5; 144.225; 144.226; 243.166, subdivision 7; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245C.33, subdivision 1; 245D.05; 245D.06; 245D.10; 257.75, subdivision 7; 260C.635, subdivision 1; 517.001; 626.557, subdivisions 4, 9, 9e; proposing coding for new law in Minnesota Statutes, chapters 144; 144A; 149A; 245D; 256B; proposing coding for new law as Minnesota Statutes, chapters 245E; 256N.

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

ARTICLE 1

REDESIGNING HOME AND COMMUNITY-BASED SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) include people chosen by the participant;

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

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

(4) reflect cultural considerations of the participant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) include individually identified goals and desired outcomes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) transition costs, including:

(i) deposits for rent and utilities;

(ii) first month's rent and utilities;

(iii) bedding;

(iv) basic kitchen supplies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) medical supplies and equipment;

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

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

(11) experimental treatments;

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

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

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

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

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

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

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

(2) comply with medical assistance provider enrollment requirements;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) participants directly employ support workers;

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

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

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

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

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

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

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

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

(1) information and consultation about CFSS;

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

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

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

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

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

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

(e) The FMS contractor shall:

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

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

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

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

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

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

(f) The commissioner of human services shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) full name of the participant;

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

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

(6) personal signature of the support worker;

(7) any shared care provided, if applicable;

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

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

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

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

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

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

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

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

(4) not be a participant of CFSS;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the time and date of the report;

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

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

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

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

(6) a description of the suspected maltreatment;

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

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

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

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

(11) whether law enforcement has been notified;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 2

SAFE AND HEALTHY DEVELOPMENT OF CHILDREN

Section 1. 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;

(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, a transfer of permanent legal and physical custody under section 260C.515, 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.

Sec. 2. Minnesota Statutes 2012, section 245C.33, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by commissioner.** (a) Before placement of a child for purposes of adoption, the commissioner shall conduct a background study on individuals listed in section 259.41, subdivision 3, for county agencies and private agencies licensed to place children for adoption.

(b) Before placement of a child for the purposes of a transfer of permanent legal and physical custody to a relative under section 260C.515, the commissioner shall conduct a background study on each person over the age of 13 living in the home. New background studies do not need to be completed if the proposed relative custodian has a valid foster care license, and background studies according to section 245C.08, subdivision 1, were completed as part of the licensure process.

Sec. 3. **[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 of 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 in the following circumstances when a child's status within Northstar Care is shifted from a pre-Northstar Care program into Northstar Care for Children 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. 4. **[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. 5. **[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. 6. **[256N.22] GUARDIANSHIP ASSISTANCE ELIGIBILITY.**

Subdivision 1. **General eligibility requirements.** (a) To be eligible for the 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; and

(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) death of the relative custodian under subdivision 9;

(3) child enlists in the military;

(4) child gets married; or

(5) 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. 7. **[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. 8. **[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;

(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. **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. 5. **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. 6. **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. 7. **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. 8. **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. 9. **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. 10. **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. 11. **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. 12. **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. 13. **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. 9. **[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 a 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. 10. **[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:

Ages 0-5	$565 per month
Ages 6-12	$670 per month
Ages 13 and older	$790 per month

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:

Level A	none (special rate under subdivision 7 applies)
Level B	none (basic under subdivision 3 only)
Level C	$100 per month
Level D	$200 per month
Level E	$300 per month
Level F	$400 per month
Level G	$500 per month
Level H	$600 per month
Level I	$700 per month
Level J	$800 per month
Level K	$900 per month
Level L	$1,000 per month

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 (b), 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 resource 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 Social Security.

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 on 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 waivered 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 waivered 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 waivered 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 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) name, telephone number, and email address of a contact person at the agency.

Sec. 11. **[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, 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 to be the same as they would have been had Northstar Care 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. 12. **[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 the 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) improving permanency for a child or children;

(2) maintaining permanency for a child or children;

(3) administrative simplification;

(4) accessing additional federal funds;

(5) converting pre-Northstar Care for Children relative custody assistance under section 257.85 to the guardianship assistance component of Northstar Care for Children;

(6) complying with federal regulations; and

(7) financial and budgetary constraints.

(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.

ARTICLE 3

DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. **[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 persons 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) In addition to section 256.98, 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) 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 date the record is created. 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, 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 Office of Inspector General, Financial Fraud and Abuse 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's Office of Inspector General, Financial Fraud and Abuse Division, 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.

ARTICLE 4

WAIVER PROVIDER STANDARDS

Section 1. Minnesota Statutes 2012, section 245D.05, is amended to read:

245D.05 HEALTH SERVICES.

Subdivision 1. **Health needs.** (a) The license holder is responsible for ~~providing~~ meeting health ~~services~~ service needs assigned in the coordinated service and support plan ~~and~~ or the coordinated service and support plan addendum, consistent with the person's health needs. The license holder is responsible for promptly notifying ~~the person or~~ the person's legal representative, if any, and the case manager of changes in a person's physical and mental health needs affecting ~~assigned~~ health ~~services~~ service needs assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, when discovered by the license holder, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

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

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

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

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

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

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

Subd. 1b. **Medication assistance.** If responsibility for medication assistance is assigned to the license holder in the coordinated service and support plan or the

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

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

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

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

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

(1) checking the person's medication record;

(2) preparing the medication as necessary;

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

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

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

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

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

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

~~(3) The medication or treatment will be administered under administration procedures established for the person in consultation with a licensed health professional. written instruction from the person's physician may constitute the medication administration procedures. A prescription label or the prescriber's order for the prescription is sufficient to constitute written instructions from the prescriber. A licensed health professional may delegate medication administration procedures.~~

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

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

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

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

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

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

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

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

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

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

~~(c) The license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed with the person or the person's legal representative and the staff administering the medication to identify medication administration issues or errors. At a minimum, the review must be conducted every three months or more often if requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct medication administration issues or errors. If issues or concerns are identified related to the medication itself, the license holder must report those as required under subdivision 4.~~

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. **[245D.051] PSYCHOTROPIC MEDICATION USE AND MONITORING.**

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

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

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

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

(2) documentation methods the license holder will use to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medication if required by the prescriber. The license holder must collect and report on medication and symptom-related data as instructed by the prescriber. The license holder must provide

the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

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

(d) If a person is prescribed a psychotropic medication, monitoring the use of the psychotropic medication must be assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum. The assigned license holder must monitor the psychotropic medication as required by this section.

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

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

Sec. 3. Minnesota Statutes 2012, section 245D.06, is amended to read:

245D.06 PROTECTION STANDARDS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(b) The license holder is prohibited from using restraints or seclusion under any circumstance, unless the commissioner has approved a variance request from the license~~

~~holder that allows for the emergency use of restraints and seclusion according to terms and conditions approved in the variance. Applicants and license holders who have reason to believe they may be serving an individual who will need emergency use of restraints or seclusion may request a variance on the application or reapplication, and the commissioner shall automatically review the request for a variance as part of the application or reapplication process. License holders may also request the variance any time after issuance of a license. In the event a license holder uses restraint or seclusion for any reason without first obtaining a variance as required, the license holder must report the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the occurrence and request the required variance.~~

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

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

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

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

Sec. 4. **[245D.095] RECORD REQUIREMENTS.**

Subdivision 1. **Record-keeping systems.** The license holder must ensure that the content and format of service recipient, personnel, and program records are uniform and legible according to the requirements of this chapter.

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

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

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

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

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

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

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

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

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

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

(iii) medication administration procedures;

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

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

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

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

(6) a record of other service providers serving the person when the person's coordinated service and support plan or coordinated service and support plan addendum identifies the need for coordination between the service providers, that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds, according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports involving the person, required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3, progress review reports as required under section 245D.071, subdivision 5, progress or daily log notes that are recorded by the program, and reports received from other agencies involved in providing services or care to the person; and

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

Subd. 4. **Access to service recipient records.** The license holder must ensure that the following people have access to the information in subdivision 1 in accordance with applicable state and federal law, regulation, or rule:

(1) the person, the person's legal representative, and anyone properly authorized by the person;

(2) the person's case manager;

(3) staff providing services to the person unless the information is not relevant to carrying out the coordinated service and support plan or coordinated service and support plan addendum; and

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

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

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

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

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

(b) For employees hired after January 1, 2014, the license holder must maintain documentation in the personnel record or elsewhere, sufficient to determine the date of the employee's first supervised direct contact with a person served by the program, and the date of first unsupervised direct contact with a person served by the program.

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

Sec. 5. Minnesota Statutes 2012, section 245D.10, is amended to read:

245D.10 POLICIES AND PROCEDURES.

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) includes the results of the complaint review;

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

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

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

(b) The policy must include the following requirements:

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

(2) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before

the proposed termination is to become effective when a license holder is providing ~~independent living skills training, structured day, prevocational or supported employment services to the person~~ intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The license holder must provide a written notice at least 30 days before implementing any ~~revised policies and procedures~~ procedural revisions to policies

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

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

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

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

ARTICLE 5

HOME CARE PROVIDERS

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

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

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

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

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

(4) Social Security numbers; and

(5) health record data.

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

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

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

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

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

(4) final enforcement actions pursuant to chapter 14;

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

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

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

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

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

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

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

Subdivision 1. **License required.** A home care provider may not open, operate, manage, conduct, maintain, or advertise itself as a home care provider or provide home

care services in Minnesota without a temporary or current home care provider license issued by the commissioner of health.

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

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

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

(3) establishes the charges;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) providing standby assistance;

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

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

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

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

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

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

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

(3) medication management services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) a physician licensed under chapter 147;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) conducting and handling background studies on employees;

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

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

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

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

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

(viii) infection control practices;

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

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

(15) other information required by the department.

Subd. 2. **Comprehensive home care license applications.** In addition to the information and fee required in subdivision 1, applicants applying for a comprehensive

home care license must also provide verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures in this subdivision and keep them current:

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

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

(3) medication and treatment management;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$6,625
greater than $1,275,000 and no more than $1,500,000	$5,797
greater than $1,100,000 and no more than $1,275,000	$4,969
greater than $950,000 and no more than $1,100,000	$4,141
greater than $850,000 and no more than $950,000	$3,727
greater than $750,000 and no more than $850,000	$3,313

greater than $650,000 and no more than $750,000	$2,898
greater than $550,000 and no more than $650,000	$2,485
greater than $450,000 and no more than $550,000	$2,070
greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242
greater than $100,000 and no more than $250,000	$828
greater than $25,000 and no more than $100,000	$414
no more than $25,000	$166

(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) 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.

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

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

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

(b) Within 14 calendar days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete.

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

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

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

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

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

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

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

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

(b) If the temporary licensee whose basic or comprehensive license has been denied disagrees with the conclusions of the commissioner, then the licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration

request process will be conducted internally by the commissioner or commissioner's designee, and chapter 14 does not apply.

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

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

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

Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home care provider. 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. **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. 3. **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. 4. **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. 5. **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. 6. **Complaint investigations.** Upon receiving information alleging that a home care provider has violated or is currently violating a requirement of sections 144A.43 to 144A.482, 626.556, and 626.557, the commissioner shall investigate the complaint according to sections 144A.51 to 144A.54.

Subd. 7. **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 controlling person, or an employee of the provider is not in compliance with

sections 144A.43 to 144A.482, 626.556, or 626.557. The correction order shall cite the specific rule or statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail copies of any correction order 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. 8. **Reconsideration of survey findings.** (a) If the applicant or licensee believes that the contents of the commissioner's order for correction are in error, the applicant or license holder may ask the commissioner to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be made in writing and must be postmarked and sent to the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

(b) A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 9. **Fines.** (a) The commissioner may assess fines according to this subdivision.

(b) In addition to any enforcement action authorized under this chapter, the commissioner may assess a licensed home care provider a fine from $1,000 to $10,000 for any of the following violations:

(1) failure to report maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557;

(2) failure to establish and implement procedures for reporting suspected maltreatment under section 144A.479, subdivision 6, paragraph (a);

(3) failure to complete and implement an abuse prevention plan under section 144.479, subdivision 6, paragraph (b);

(4) an act, omission, or practice that results in a client's illness, injury, or death or places the client at imminent risk including physical abuse, sexual abuse, questionable or wrongful death, serious unexplained injuries, or serious medical emergency;

(5) failure to obtain background check clearance or exemption for direct care staff prior to provision of services;

(6) willful violation of state licensing laws and regulations; and

(7) violation of employee health status guidance relating to control of infectious diseases such as tuberculosis.

(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 identified in a survey or complaint investigation that were specified in the correction order or conditional license, 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) Fines under this subdivision may be assessed according to paragraph (b), or the commissioner may assess a fine other than those identified in paragraph (b) from $500 to $2,000 per violation when the provider has failed to correct an order relating to violation of state licensing laws.

(e) 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. 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.

(f) A license holder shall promptly notify the commissioner in writing, including by e-mail, 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 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.

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

(h) 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 personally liable for payment of the fine. In the case of a corporation, each controlling individual is personally and jointly liable for payment of the fine.

(i) 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.

(j) 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 regulations as recommended by the advisory council established in section 144A.4799.

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

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

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

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

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

(4) obtains the license by fraud or misrepresentation;

(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

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

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

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

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

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

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

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

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

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

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

Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the provider. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the home care provider's practices and submit reports to the commissioner at the cost of the home care provider;

(2) requiring supervision of the home care provider or staff practices at the cost of the home care provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the home care provider or employees to obtain training at the cost of the home care provider;

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

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

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

Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 90 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided:

(1) advance notice is given to the home care provider;

(2) after notice, the home care provider fails to correct the problem;

(3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and

(4) there is an opportunity for a contested case hearing within the 90 days.

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

Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the home care provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation or suspension notice issued by the commissioner.

Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The owner and managerial officials of a home care provider whose Minnesota license has not been renewed or that has been revoked because of noncompliance with applicable laws or rules shall not be eligible to apply for nor will be granted a home care license, including other licenses under this chapter, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659 for five years following the effective date of the nonrenewal or revocation. If the owner and managerial officials already have enrollment status, their enrollment will be terminated by the Department of Human Services.

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

(c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend or revoke, the license of any home care provider that includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.

(d) The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of the notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well-being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials with the home care provider poses to client health, safety, and well-being;

(2) the compliance history of the home care provider; and

(3) the appropriateness of any limits suggested by the home care provider.

If the commissioner grants the stay, the order shall include any restrictions or limitation on the provider's license. The failure of the provider to comply with any restrictions or limitations shall result in the immediate removal of the stay and the commissioner shall take immediate action to suspend, revoke, or not renew the license.

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

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

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

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

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

Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a home care provider or an employee of the home care provider from illegally engaging in activities regulated by sections 144A.43 to 144A.482. The commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which a home care provider is providing services. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a home care provider, or by an employee of the home care provider, would create an imminent risk of harm to a recipient of home care services.

Subd. 10. **Subpoena.** In matters pending before the commissioner under sections 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district, and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner of health may administer oaths to witnesses or take their affirmation. Depositions may be taken in or outside the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served on a named person anywhere in the state by an officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for a process issued out of a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

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

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No

person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.056 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to 144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

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

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

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

Subdivision 1. **Medicare-certified providers; coordination of surveys.** If feasible, the commissioner shall survey licensees to determine compliance with this chapter at the same time as surveys for certification for Medicare if Medicare certification is based on compliance with the federal conditions of participation and on survey and enforcement by the Department of Health as agent for the United States Department of Health and Human Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subdivision 1. **Definition.** For purposes of this section, "innovation variance" means a specified alternative to a requirement of this chapter. An innovation variance may be granted to allow a home care provider to offer home care services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the clients, and is likely to improve the services provided. The innovative variance cannot change any of the client's rights under section 144A.44, home care bill of rights.

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

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

Subd. 4. **Applications; innovation variance.** An application for innovation variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following:

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

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

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

(4) the reasons for the request; and

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

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

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

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

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

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

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

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

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

Sec. 13. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES; BUSINESS OPERATION.**

Subdivision 1. **Display of license.** The original current license must be displayed in the home care providers' principal business office and copies must be displayed in any branch office. The home care provider must provide a copy of the license to any person who requests it.

Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this section, advertising includes any verbal, written, or electronic means of communicating to potential clients about the availability, nature, or terms of home care services.

Subd. 3. **Quality management.** The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government.

(b) A home care provider or staff cannot accept powers-of-attorney from clients for any purpose, and may not accept appointments as guardians or conservators of clients.

(c) A home care provider cannot serve as a client's representative.

Subd. 5. **Handling of client's finances and property.** (a) A home care provider may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A home care provider must provide a client with receipts for all transactions and purchases paid with the clients' funds. When receipts are not available, the transaction or purchase must be documented. A home care provider must maintain records of all such transactions.

(b) A home care provider or staff may not borrow a client's funds or personal or real property, nor in any way convert a client's property to the home care provider's or staff's possession.

(c) Nothing in this section precludes a home care provider or staff from accepting gifts of minimal value, or precludes the acceptance of donations or bequests made to a home care provider that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

Subd. 6. **Reporting maltreatment of vulnerable adults and minors.** (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Home care providers must report suspected maltreatment of minors and vulnerable adults to the common entry point. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.

(b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.

Subd. 7. **Employee records.** The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute, or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;

(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;

(5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.

Sec. 14. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH RESPECT TO CLIENTS.**

Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 in a language that the client or the client's representative can understand before the initiation of services to that client. If a written version is not available, the home care bill of rights must be communicated to the client or client's representative in a language they can understand.

(b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices.

"If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

The statement should include the telephone number, Web site address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint.

(c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record.

Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related disorders.** The home care provider that provides services to clients with dementia shall

provide in written or electronic form, to clients and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements in section 325F.72, subdivision 2, clause (4).

Subd. 3. **Statement of home care services.** Prior to the initiation of services, a home care provider must provide to the client or the client's representative a written statement which identifies if they have a basic or comprehensive home care license, the services they are authorized to provide, and which services they cannot provide under the scope of their license. The home care provider shall obtain written acknowledgment from the clients that they have provided the statement or must document why they could not obtain the acknowledgment.

Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice.

Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in need of another medical or health service, including a licensed health professional, or social service provider, the home care provider shall:

(1) determine the client's preferences with respect to obtaining the service; and

(2) inform the client of resources available, if known, to assist the client in obtaining services.

Subd. 6. **Initiation of services.** When a provider initiates services and the individualized review or assessment required in subdivisions 7 and 8 has not been completed, the provider must complete a temporary plan and agreement with the client for services.

Subd. 7. **Basic individualized client review and monitoring.** (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the initiation of the home care services.

(b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in-person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services.

(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services.

(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service plan.

(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and

(5) a contingency plan that includes:

(i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

(ii) information and method for a client or client's representative to contact the home care provider;

(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a list of known licensed home care providers in the client's immediate geographic area;

(4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

(5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

(6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and the ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Subd. 11. **Client complaint and investigative process.** (a) The home care provider must have a written policy and system for receiving, investigating, reporting, and attempting to resolve complaints from its clients or clients' representatives. The policy should clearly identify the process by which clients may file a complaint or concern about home care services and an explicit statement that the home care provider will not

discriminate or retaliate against a client for expressing concerns or complaints. A home care provider must have a process in place to conduct investigations of complaints made by the client or the client's representative about the services in the client's plan that are or are not being provided or other items covered in the client's home care bill of rights. This complaint system must provide reasonable accommodations for any special needs of the client or client's representative if requested.

(b) The home care provider must document the complaint, name of the client, investigation, and resolution of each complaint filed. The home care provider must maintain a record of all activities regarding complaints received, including the date the complaint was received, and the home care provider's investigation and resolution of the complaint. This complaint record must be kept for each event for at least two years after the date of entry and must be available to the commissioner for review.

(c) The required complaint system must provide for written notice to each client or client's representative that includes:

(1) the client's right to complain to the home care provider about the services received;

(2) the name or title of the person or persons with the home care provider to contact with complaints;

(3) the method of submitting a complaint to the home care provider; and

(4) a statement that the provider is prohibited against retaliation according to paragraph (d).

(d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative.

Subd. 12. **Disaster planning and emergency preparedness plan.** The home care provider must have a written plan of action to facilitate the management of the client's care and services in response to a natural disaster, such as flood and storms, or other emergencies that may disrupt the home care provider's ability to provide care or services. The licensee must provide adequate orientation and training of staff on emergency preparedness.

Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a client, family member, or other caregiver of the client requests that an employee or other agent of the home care provider discontinue a life-sustaining treatment, the employee or agent receiving the request:

(1) shall take no action to discontinue the treatment; and

(2) shall promptly inform their supervisor or other agent of the home care provider of the client's request.

(b) Upon being informed of a request for termination of treatment, the home care provider shall promptly:

(1) inform the client that the request will be made known to the physician who ordered the client's treatment;

(2) inform the physician of the client's request; and

(3) work with the client and the client's physician to comply with the provisions of the Health Care Directive Act in chapter 145C.

(c) This section does not require the home care provider to discontinue treatment, except as may be required by law or court order.

(d) This section does not diminish the rights of clients to control their treatments, refuse services, or terminate their relationships with the home care provider.

(e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by clients under those chapters.

Sec. 15. **[144A.4792] MEDICATION MANAGEMENT.**

Subdivision 1. **Medication management services; comprehensive home care license.** (a) This subdivision applies only to home care providers with a comprehensive home care license that provides medication management services to clients. Medication management services may not be provided by a home care provider that has a basic home care license.

(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22.

Subd. 2. **Provision of medication management services.** (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what mediation management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications. Diversion of medications means the misuse, theft, or illegal or improper disposition of medications.

Subd. 3. **Individualized medication monitoring and reassessment.** The comprehensive home care provider must monitor and reassess the client's medication management services as needed under subdivision 14 when the client presents with symptoms or other issues that may be medication-related and, at a minimum, annually.

Subd. 4. **Client refusal.** The home care provider must document in the client's record any refusal for an assessment for medication management by the client. The provider must discuss with the client the possible consequences of the client's refusal and document the discussion in the client's record.

Subd. 5. **Individualized medication management plan.** For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written medication management plan. The written plan must be updated when changes are made to the plan. The plan must contain at least the following provisions:

(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) procedures for documenting medications that clients are taking;

(4) procedures for verifying all prescription drugs are administered as prescribed;

(5) procedures for monitoring medication use to prevent possible complications or adverse reactions;

(6) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(7) identification of medication management tasks that may be delegated to unlicensed personnel; and

(8) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services.

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 with respect to each client, and the unlicensed personnel has demonstrated ability to competently follow the procedures;

(2) specified, in writing, specific instructions for each client and documented those instructions in the client's records; and

(3) communicated with the unlicensed personnel about the individual needs of the client.

Subd. 8. **Documentation of administration of medications.** Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan.

Subd. 9. **Documentation of medication set up.** Documentation of dates of medication set up, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication set up must be done at time of set up.

Subd. 10. **Medications when client is away from home.** (a) A home care provider providing medication management services must develop a policy and procedures for the issuance of medications to clients for planned and unplanned times the client will be away from home and need to have their medications with them which complies with the following:

(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 nurse standards of practice; and

(2) for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse in a timely manner, the provider may allow an unlicensed personnel to set up the medications.

(b) The task of medication set up may be done by an unlicensed personnel who is trained and has been determined competent according to subdivisions 6 and 7. Prior to providing the medications to the client, the unlicensed personnel must speak with the registered nurse to ensure that all appropriate precautions are taken. The unlicensed personnel may provide the client or the client's representative up to a 72-hour supply of the client's medications.

(c) When preparing the medications, the medications must be taken from the original containers prepared by the pharmacist and then placed in a suitable container. The container must be labeled with the client's name; the medication name, strength, dose, and route of administration; and the dates and times the medications are to be taken by the client and any other information that the client should know regarding the medications. For those medications which cannot be prepared in advance, the client must be given the original container and complete directions and information for the administration of that medication.

(d) The client or client's representative must also be provided in writing with the home care provider's name and contact information for the home care provider's registered nurse.

The unlicensed personnel must document in the client's record the date the medications were provided to the client; the name of medication; the medication's strength, dose, and routes and administration times; the amounts of medications that were provided to the client and to whom the medications were given. The registered nurse must review the set up of medication and documentation to ensure that the issuance of medications by the unlicensed personnel was handled appropriately.

Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home care provider must determine whether it will require a prescription for all medications it manages. The comprehensive home care provider must inform the client or the client's representative whether the comprehensive home care provider requires a prescription for all over-the-counter and dietary supplements before the comprehensive home care provider will agree to manage those medications.

Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.** A comprehensive home care provider providing medication management services for

over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The provider must verify that the medications are up-to-date and stored as appropriate.

Subd. 13. **Prescriptions.** There must be a current written or electronically recorded prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed medications that the comprehensive home care provider is managing for the client.

Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.

Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an authorized prescriber must be received by a nurse or pharmacist. The order must be handled according to Minnesota Rules, part 6800.6200.

Subd. 16. **Written or electronic prescription.** When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the client's record.

Subd. 17. **Records confidential.** A prescription or order received verbally, in writing, or electronically must be kept confidential according to sections 144.291 to 144.298 and 144A.44.

Subd. 18. **Medications provided by client or family members.** When the comprehensive home care provider is aware of any medications or dietary supplements that are being used by the client and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the client's record.

Subd. 19. **Storage of drugs.** A comprehensive home care provider providing storage of medications outside of the client's private living space must store all prescription drugs in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.

Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.

Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or saved for use by anyone other than the client.

Subd. 22. **Disposition of drugs.** (a) Any current medications being managed by the comprehensive home care provider must be given to the client or the client's representative when the client's service plan ends or medication management services are no longer part

of the service plan. Medications that have been stored in the client's private living space for a client that is deceased or that have been discontinued or that have expired may be given to the client or the client's representative for disposal.

(b) The comprehensive home care provider will dispose of any medications remaining with the comprehensive home care provider that are discontinued or expired or upon the termination of the service contract or the client's death according to state and federal regulations for disposition of drugs and controlled substances.

(c) Upon disposition, the comprehensive home care provider must document in the client's record the disposition of the medications including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the client's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations.

(b) The procedures must require the comprehensive home care provider of medication management to investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records.

Sec. 16. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT SERVICES.**

Subdivision 1. **Providers with a comprehensive home care license.** This section applies only to home care providers with a comprehensive home care license that provide treatment or therapy management services to clients. Treatment or therapy management services cannot be provided by a home care provider that has a basic home care license.

Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.

(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting of treatment or therapy activities, educating and communicating with clients about treatments or therapy they are receiving, monitoring and evaluating the treatment and therapy, and communicating with the prescriber.

Subd. 3. **Individualized treatment or therapy management plan.** For each client receiving management of ordered or prescribed treatments or therapy services, the comprehensive home care provider must include in the service plan a written management plan which contains at least the following provisions:

(1) a statement of the type of services that will be provided;

(2) procedures for documenting treatments or therapies the client is receiving;

(3) procedures for monitoring treatments or therapy to prevent possible complications or adverse reactions;

(4) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and

(5) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services.

Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has:

(1) instructed the unlicensed personnel in the proper methods with respect to each client and has demonstrated their ability to competently follow the procedures;

(2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and

(3) communicated with the unlicensed personnel about the individual needs of the client.

Subd. 5. **Documentation of administration of treatments and therapies.** Each treatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or

prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs.

Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or electronically recorded order or prescription for all treatments and therapies. The order must contain the name of the client, description of the treatment or therapy to be provided, and the frequency and other information needed to administer the treatment or therapy.

Sec. 17. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

Subdivision 1. **Client record.** (a) The home care provider must maintain records for each client for whom it is providing services. Entries in the client records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

(b) Client records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The home care provider shall establish and implement written procedures to control use, storage, and security of client's records and establish criteria for release of client information.

(c) The home care provider may not disclose to any other person any personal, financial, medical, or other information about the client, except:

(1) as may be required by law;

(2) to employees or contractors of the home care provider, another home care provider, other health care practitioner or provider, or inpatient facility needing information in order to provide services to the client, but only such information that is necessary for the provision of services;

(3) to persons authorized in writing by the client or the client's representative to receive the information, including third-party payers; and

(4) to representatives of the commissioner authorized to survey or investigate home care providers under this chapter or federal laws.

Subd. 2. **Access to records.** The home care provider must ensure that the appropriate records are readily available to employees or contractors authorized to access the records. Client records must be maintained in a manner that allows for timely access, printing, or transmission of the records.

Subd. 3. **Contents of client record.** Contents of a client record include the following for each client:

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

(2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified;

(3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known;

(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;

(5) client's advance directives, if any;

(6) the home care provider's current and previous assessments and service plans;

(7) all records of communications pertinent to the client's home care services;

(8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(10) documentation that services have been provided as identified in the service plan;

(11) documentation that the client has received and reviewed the home care bill of rights;

(12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3;

(13) documentation of complaints received and resolution;

(14) discharge summary, including service termination notice and related documentation, when applicable; and

(15) other documentation required under this chapter and relevant to the client's services or status.

Subd. 4. **Transfer of client records.** If a client transfers to another home care provider or other health care practitioner or provider, or is admitted to an inpatient facility, the home care provider, upon request of the client or the client's representative, shall take steps to ensure a coordinated transfer including sending a copy or summary of the client's record to the new home care provider, facility, or the client, as appropriate.

Subd. 5. **Record retention.** Following the client's discharge or termination of services, a home care provider must retain a client's record for at least five years, or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of client records if the home care provider ceases business.

Sec. 18. **[144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**

Subdivision 1. **Qualifications, training, and competency.** All staff providing home care services must be trained and competent in the provision of home care services consistent with current practice standards appropriate to the client's needs.

Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health professionals and nurses providing home care services as an employee of a licensed home care provider must possess current Minnesota license or registration to practice.

(b) Licensed health professionals and registered nurses must be competent in assessing client needs, planning appropriate home care services to meet client needs, implementing services, and supervising staff if assigned.

(c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law.

Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home care services must have:

(1) successfully completed a training and competency evaluation appropriate to the services provided by the home care provider and the topics listed in subdivision 7, paragraph (b); or

(2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and in the topics listed in subdivision 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7, paragraph (b), clauses (5), (7), and (8), by a practical skills test.

Unlicensed personnel providing home care services for a basic home care provider may not perform delegated nursing or therapy tasks.

(b) Unlicensed personnel performing delegated nursing tasks for a comprehensive home care provider must have:

(1) successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; or

(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or section 484.36; or

(3) before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.

(c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks in subdivision 4 and any other training or competency requirements within the licensed health professional scope of practice relating to delegation or assignment of tasks to unlicensed personnel.

Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health professional may delegate tasks only to staff that are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota Practice Act. The comprehensive home care provider must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual client needs and preferences.

Subd. 5. **Individual contractors.** When a home care provider contracts with an individual contractor excluded from licensure under section 144A.471 to provide home care services, the contractor must meet the same requirements required by this section for personnel employed by the home care provider.

Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary staffing agency excluded from licensure under section 144A.471, those individuals must meet the same requirements required by this section for personnel employed by the home care provider and shall be treated as if they are staff of the home care provider.

Subd. 7. **Requirements for instructors, training content, and competency evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must meet the following requirements:

(1) training and competency evaluations of unlicensed personnel providing basic home care services must be conducted by individuals with work experience and training in providing home care services listed in section 144A.471, subdivisions 6 and 7; and

(2) training and competency evaluations of unlicensed personnel providing comprehensive home care services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. If the home care provider is providing services by licensed health professionals only, then that specific training and competency evaluation may be conducted by the licensed health professionals as appropriate.

(b) Training and competency evaluations for all unlicensed personnel must include the following:

(1) documentation requirements for all services provided;

(2) reports of changes in the client's condition to the supervisor designated by the home care provider;

(3) basic infection control, including blood-borne pathogens;

(4) maintenance of a clean and safe environment;

(5) appropriate and safe techniques in personal hygiene and grooming, including:

(i) hair care and bathing;

(ii) care of teeth, gums, and oral prosthetic devices;

(iii) care and use of hearing aids; and

(iv) dressing and assisting with toileting;

(6) training on the prevention of falls for providers working with the elderly or individuals at risk of falls;

(7) standby assistance techniques and how to perform them;

(8) medication, exercise, and treatment reminders;

(9) basic nutrition, meal preparation, food safety, and assistance with eating;

(10) preparation of modified diets as ordered by a licensed health professional;

(11) communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family;

(12) awareness of confidentiality and privacy;

(13) understanding appropriate boundaries between staff and clients and the client's family;

(14) procedures to utilize in handling various emergency situations; and

(15) awareness of commonly used health technology equipment and assistive devices.

(c) In addition to paragraph (b), training and competency evaluation for unlicensed personnel providing comprehensive home care services must include:

(1) observation, reporting, and documenting of client status;

(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;

(3) reading and recording temperature, pulse, and respirations of the client;

(4) recognizing physical, emotional, cognitive, and developmental needs of the client;

(5) safe transfer techniques and ambulation;

(6) range of motioning and positioning; and

(7) administering medications or treatments as required.

(d) When the registered nurse or licensed health professional delegates tasks, they must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed

personnel has not regularly performed the delegated home care task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the client's record.

Sec. 19. **[144A.4796] ORIENTATION AND ANNUAL TRAINING REQUIREMENTS.**

Subdivision 1. **Orientation of staff and supervisors to home care.** All staff providing and supervising direct home care services must complete an orientation to home care licensing requirements and regulations before providing home care services to clients. The orientation may be incorporated into the training required under subdivision 6. The orientation need only be completed once for each staff person and is not transferable to another home care provider.

Subd. 2. **Content.** The orientation must contain the following topics:

(1) an overview of sections 144A.43 to 144A.4798;

(2) introduction and review of all the provider's policies and procedures related to the provision of home care services;

(3) handling of emergencies and use of emergency services;

(4) compliance with and reporting 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 market, promote, or provide services for persons with Alzheimer's or related disorders, all direct care staff and their supervisors must receive training that includes a current explanation of Alzheimer's disease and related disorders, how to assist clients with activities of daily living, effective approaches to use to problem solve when working with a client's challenging behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

Subd. 6. **Required annual training.** All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include:

(1) training on reporting of maltreatment of minors under section 626.556 and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided;

(2) review of the home care bill of rights in section 144A.44;

(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of communicable diseases; and

(4) review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures.

Subd. 7. **Documentation.** A home care provider must retain documentation in the employee records of the staff that have satisfied the orientation and training requirements of this section.

Sec. 20. **[144A.4797] PROVISION OF SERVICES.**

Subdivision 1. **Availability of contact person to staff.** (a) A home care provider with a basic home care license must have a person available to staff for consultation on items relating to the provision of services or about the client.

(b) A home care provider with a comprehensive home care license must have a registered nurse available for consultation to staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.

(c) The appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services.

Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform basic home care services must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the home care provider having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff.

(b) Supervision includes direct observation of unlicensed personnel while they are providing the services and may also include indirect methods of gaining input such as gathering feedback from the client. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance.

(c) For an individual who is licensed as a home care provider, this section does not apply.

Subd. 3. **Supervision of staff providing delegated nursing or therapy home care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Subd. 4. **Documentation.** A home care provider must retain documentation of supervision activities in the personnel records.

Subd. 5. **Exemption.** This section does not apply to an individual licensed under sections 144A.43 to 144A.4799.

Sec. 21. **[144A.4798] EMPLOYEE HEALTH STATUS.**

Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider must establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's Web site.

Subd. 2. **Communicable diseases.** A home care provider must follow current federal or state guidelines for prevention, control, and reporting of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other communicable diseases as defined in Minnesota Rules, part 4605.7040.

Sec. 22. **[144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE PROVIDER ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care provider advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be either persons who are currently receiving home care services or have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; and

(4) one member representing the ombudsman for long-term care.

Subd. 2. **Organizations and meetings.** The advisory council shall be organized and administered under section 15.059 with per diems and costs paid within the limits of available appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees may be developed as necessary by the commissioner. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter such as:

(1) advice to the commissioner regarding community standards for home care practices;

(2) advice to the commissioner on enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) advice to the commissioner about ways of distributing information to licensees and consumers of home care;

(4) advice to the commissioner about training standards;

(5) identify emerging issues and opportunities in the home care field, including the use of technology in home and telehealth capabilities; and

(6) perform other duties as directed by the commissioner.

Sec. 23. **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

Subdivision 1. **Initial home care licenses and changes of ownership.** (a) Beginning October 1, 2013, all initial license applicants must apply for either a temporary basic or comprehensive home care license.

(b) Initial home care temporary licenses or licenses issued beginning October 1, 2013, will be issued according to the provisions in sections 144A.43 to 144A.4799 and fees in section 144A.472 and will be required to comply with this chapter.

(c) No initial temporary licenses or initial licenses will be accepted or issued between July 1, 2013, and October 1, 2013.

(d) Beginning July 1, 2013, changes in ownership applications will require payment of the new fees listed in section 144A.472.

Subd. 2. **Current home care licensees with licenses on July 1, 2013.** (a) Beginning October 1, 2013, department licensed home care providers who are licensed on July 1, 2013, must apply for either the basic or comprehensive home care license on their regularly scheduled renewal date.

(b) By September 30, 2014, all home care providers must either have a basic or comprehensive home care license or temporary license.

Sec. 24. **[144A.4811] APPLICATION OF HOME CARE LICENSURE DURING TRANSITION PERIOD.**

Renewal of home care licenses issued beginning October 1, 2013, will be issued according to sections 144A.43 to 144A.4799 and, upon license renewal, providers must comply with sections 144A.43 to 144A.4799. Prior to renewal, providers must comply with the home care licensure law in effect on June 30, 2013.

Sec. 25. **[144A.482] REGISTRATION OF HOME MANAGEMENT PROVIDERS.**

(a) For purposes of this section, a home management provider is an individual or organization that provides at least two of the following services: housekeeping, meal preparation, and shopping, to a person who is unable to perform these activities due to illness, disability, or physical condition.

(b) A person or organization that provides only home management services may not operate in the state without a current certificate of registration issued by the commissioner of health. To obtain a certificate of registration, the person or organization must annually submit to the commissioner the name, mailing and physical address, e-mail address, and telephone number of the individual or organization and a signed statement declaring that the individual or organization is aware that the home care bill of rights applies to their clients and that the person or organization will comply with the home care bill of rights provisions contained in section 144A.44. An individual or organization applying for a certificate must also provide the name, business address, and telephone number of each of the individuals responsible for the management or direction of the organization.

(c) The commissioner shall charge an annual registration fee of $20 for individuals and $50 for organizations. The registration fee shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) A home care provider that provides home management services and other home care services must be licensed, but licensure requirements other than the home care bill of rights do not apply to those employees or volunteers who provide only home management services to clients who do not receive any other home care services from the provider. A licensed home care provider need not be registered as a home management service provider, but must provide an orientation on the home care bill of rights to its employees or volunteers who provide home management services.

(e) An individual who provides home management services under this section must, within 120 days after beginning to provide services, attend an orientation session approved by the commissioner that provides training on the home care bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons.

(f) The commissioner may suspend or revoke a provider's certificate of registration or assess fines for violation of the home care bill of rights. Any fine assessed for a violation of the home care bill of rights by a provider registered under this section shall be in the amount established in the licensure rules for home care providers. As a condition of registration, a provider must cooperate fully with any investigation conducted by the commissioner, including providing specific information requested by the commissioner on

clients served and the employees and volunteers who provide services. Fines collected under this paragraph shall be deposited in the state treasury and credited to the fund specified in the statute or rule in which the penalty was established.

(g) The commissioner may use any of the powers granted in sections 144A.43 to 144A.4799 to administer the registration system and enforce the home care bill of rights under this section.

ARTICLE 6

HEALTH DEPARTMENT

Section 1. 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 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, the 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. 2. 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. 3. **[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. 4. 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. 5. 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~~ confidential 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. 6. 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. 7. 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. 8. 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. 9. **[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. 10. Minnesota Statutes 2012, section 144.225, is amended to read:

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

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.

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of ~~a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record~~ an individual, are confidential data. ~~At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate demographic data pertaining to the birth as public.~~ Notwithstanding the designation of the data as confidential,

~~it may~~ upon the proper completion of an attestation provided by the commissioner and payment of the required fee, demographic birth data by certified record shall be disclosed:

(1) to a parent ~~or guardian~~ of the ~~child~~ individual;

(2) to the ~~child~~ individual when the ~~child~~ individual is 16 years of age or older;

(3) under paragraph (b) or (e); or

(4) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order~~.~~;

(5) to the legal custodian, guardian or conservator, or health care agent of the individual;

(6) to adoption agencies in order to complete confidential postadoption searches as required by section 259.83;

(7) 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; or

(8) to a representative authorized by a person under clauses (1) to (7).

(b) Unless the ~~child~~ individual is adopted, data pertaining to the birth of ~~a child~~ an individual that are not accessible to the public become public data if ~~100~~ 125 years have elapsed since the birth of the ~~child~~ individual who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance, general assistance medical care, and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

(f) The fact of birth consisting of the name of the individual, date of birth, county of birth, and state file number are public data.

Subd. 2a. **Health data associated with birth registration.** Information from which an identification of risk for disease, disability, or developmental delay in a mother or child can be made, that is collected in conjunction with birth registration or fetal death reporting, is ~~private~~ confidential data ~~as defined in section 13.02, subdivision 12~~. The commissioner may disclose to a local board of health, as defined in section 145A.02, subdivision 2,

health data associated with birth registration which identifies a mother or child at high risk for serious disease, disability, or developmental delay in order to assure access to appropriate health, social, or educational services. Notwithstanding the designation of the ~~private~~ confidential data, the commissioner of human services shall have access to health data associated with birth registration for:

(1) purposes of administering medical assistance, general assistance medical care, and the MinnesotaCare program; and

(2) for other public health purposes as determined by the commissioner of health.

Subd. 2b. **Commissioner of health; duties.** Notwithstanding the designation of certain of this data as confidential under subdivision 2 or ~~private under subdivision~~ 2a, the commissioner shall give the commissioner of human services access to birth record data and data contained in recognitions of parentage prepared according to section 257.75 necessary to enable the commissioner of human services to identify a child who is subject to threatened injury, as defined in section 626.556, subdivision 2, paragraph (l), by a person responsible for the child's care, as defined in section 626.556, subdivision 2, paragraph (b), clause (1). The commissioner shall be given access to all data included on official birth records.

Subd. 3. **Laws and rules for preparing vital records.** No person shall prepare or issue any vital record which purports to be an original, certified copy, or copy of a vital record except as authorized in sections 144.211 to 144.227 or the rules of the commissioner.

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.

Subd. 5. **Residents of other states.** When a resident of another state is born or dies in this state, the state registrar shall send a report of the birth or death to the state of residence.

Subd. 6. **Group purchaser identity; nonpublic data; disclosure.** (a) Except as otherwise provided in this subdivision, the named identity of a group purchaser as defined in section 62J.03, subdivision 6, collected in association with birth registration is nonpublic data as defined in section 13.02.

(b) The commissioner may publish, or by other means release to the public, the named identity of a group purchaser as part of an analysis of information collected from the birth registration process. Analysis means the identification of trends in prenatal care and birth outcomes associated with group purchasers. The commissioner may not reveal the named identity of the group purchaser until the group purchaser has had 21 days after receipt of the analysis to review the analysis and comment on it. In releasing data

under this subdivision, the commissioner shall include comments received from the group purchaser related to the scientific soundness and statistical validity of the methods used in the analysis. This subdivision does not authorize the commissioner to make public any individual identifying data except as permitted by law.

(c) A group purchaser may contest whether an analysis made public under paragraph (b) is based on scientifically sound and statistically valid methods in a contested case proceeding under sections 14.57 to 14.62, subject to appeal under sections 14.63 to 14.68. To obtain a contested case hearing, the group purchaser must present a written request to the commissioner before the end of the time period for review and comment. Within ten days of the assignment of an administrative law judge, the group purchaser must demonstrate by clear and convincing evidence the group purchaser's likelihood of succeeding on the merits. If the judge determines that the group purchaser has made this demonstration, the data may not be released during the contested case proceeding and through appeal. If the judge finds that the group purchaser has not made this demonstration, the commissioner may immediately publish, or otherwise make public, the nonpublic group purchaser data, with comments received as set forth in paragraph (b).

(d) The contested case proceeding and subsequent appeal is not an exclusive remedy and any person may seek a remedy pursuant to section 13.08, subdivisions 1 to 4, or as otherwise authorized by law.

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)~~ (i) a child of the ~~subject~~ decedent;

~~(iii)~~ (ii) the spouse of the ~~subject~~ decedent;

~~(iv)~~ (iii) a parent of the ~~subject~~ decedent;

~~(v)~~ (iv) the grandparent or grandchild of the ~~subject~~ decedent;

~~(vi) if the requested record is a death record,~~ (v) a sibling of the ~~subject~~ decedent;

~~(vii)~~ (vi) the party responsible for filing the vital record;

~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the ~~subject~~ decedent;

~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(x)~~ (ix) a successor of the ~~subject~~ decedent, 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,~~ (x) a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust; or

~~(xii)~~ (xi) 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.

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. 11. 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 a certified vital record, a search for a vital record that cannot be issued, 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 reviewing and processing 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 reviewing and processing 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 reviewing and processing 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 reviewing and processing 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. 12. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS FACILITY.**

Subdivision 1. **License requirement.** Except as provided in section 149A.01, subdivision 3, a place or premise shall not be maintained, managed, or operated which is devoted to or used in the holding and alkaline hydrolysis of a dead human body without possessing a valid license to operate an alkaline hydrolysis facility issued by the commissioner of health.

Subd. 2. **Requirements for an alkaline hydrolysis facility.** (a) An alkaline hydrolysis facility licensed under this section must consist of:

(1) a building or structure that complies with applicable local and state building codes, zoning laws and ordinances, wastewater management and environmental standards,

containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead human bodies;

(2) a method approved by the commissioner of health to dry the hydrolyzed remains and which is located within the licensed facility;

(3) a means approved by the commissioner of health for refrigeration of dead human bodies awaiting alkaline hydrolysis;

(4) an appropriate means of processing hydrolyzed remains to a granulated appearance appropriate for final disposition; and

(5) an appropriate holding facility for dead human bodies awaiting alkaline hydrolysis.

(b) An alkaline hydrolysis facility licensed under this section may also contain a display room for funeral goods.

Subd. 3. **Application procedure; documentation; initial inspection.** An application to license and operate an alkaline hydrolysis facility shall be submitted to the commissioner of health. A completed application includes:

(1) a completed application form, as provided by the commissioner;

(2) proof of business form and ownership;

(3) proof of liability insurance coverage or other financial documentation, as determined by the commissioner, that demonstrates the applicant's ability to respond in damages for liability arising from the ownership, maintenance management, or operation of an alkaline hydrolysis facility; and

(4) copies of wastewater and other environmental regulatory permits and environmental regulatory licenses necessary to conduct operations.

Upon receipt of the application and appropriate fee, the commissioner shall review and verify all information. Upon completion of the verification process and resolution of any deficiencies in the application information, the commissioner shall conduct an initial inspection of the premises to be licensed. After the inspection and resolution of any deficiencies found and any reinspections as may be necessary, the commissioner shall make a determination, based on all the information available, to grant or deny licensure. If the commissioner's determination is to grant the license, the applicant shall be notified and the license shall issue and remain valid for a period prescribed on the license, but not to exceed one calendar year from the date of issuance of the license. If the commissioner's determination is to deny the license, the commissioner must notify the applicant in writing of the denial and provide the specific reason for denial.

Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis facility is not assignable or transferable and shall not be valid for any entity other than the

one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the location identified on the license. A 50 percent or more change in ownership or location of the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall be required of two or more persons or other legal entities operating from the same location.

Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis facility must be conspicuously displayed in the alkaline hydrolysis facility at all times. Conspicuous display means in a location where a member of the general public within the alkaline hydrolysis facility will be able to observe and read the license.

Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility issued by the commissioner are valid for a period of one calendar year beginning on July 1 and ending on June 30, regardless of the date of issuance.

Subd. 7. **Reporting changes in license information.** Any change of license information must be reported to the commissioner, on forms provided by the commissioner, no later than 30 calendar days after the change occurs. Failure to report changes is grounds for disciplinary action.

Subd. 8. **Notification to the commissioner.** If the licensee is operating under a wastewater or an environmental permit or license that is subsequently revoked, denied, or terminated, the licensee shall notify the commissioner.

Subd. 9. **Application information.** All information submitted to the commissioner for a license to operate an alkaline hydrolysis facility is classified as licensing data under section 13.41, subdivision 5.

Sec. 13. **[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. 14. **[149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE HYDROLYSIS.**

Subdivision 1. **License required.** A dead human body may only be hydrolyzed in this state at an alkaline hydrolysis facility licensed by the commissioner of health.

Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis facility must comply with all applicable local and state building codes, zoning laws and ordinances, wastewater management regulations, and environmental statutes, rules, and standards. An alkaline hydrolysis facility must have, on site, a purpose built human alkaline hydrolysis system approved by the commissioner of health, a system approved by the commissioner of health for drying the hydrolyzed remains, a motorized mechanical device approved by the commissioner of health for processing hydrolyzed remains and must have in the building a holding facility approved by the commissioner of health for the retention of dead human bodies awaiting alkaline hydrolysis. The holding facility must be secure from access by anyone except the authorized personnel of the alkaline hydrolysis facility, preserve the dignity of the remains, and protect the health and safety of the alkaline hydrolysis facility personnel.

Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall be properly lit and ventilated with an exhaust fan that provides at least 12 air changes per hour.

Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines, plumbing vents, and waste drains shall be properly vented and connected pursuant to the Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a functional sink with hot and cold running water.

Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall have nonporous flooring, so that a sanitary condition is provided. The walls and ceiling of the room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall run from floor to ceiling and be covered with tile, or by plaster or sheetrock painted with washable paint or other appropriate material so that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be constructed to prevent odors from entering any other part of the building. All windows or other openings to the outside must be screened and all windows must be treated in a

manner that prevents viewing into the room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place. A viewing window for authorized family members or their designees is not a violation of this subdivision.

Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a functional emergency eye wash and quick drench shower.

Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place must be private and have no general passageway through it. The room shall, at all times, be secure from the entrance of unauthorized persons. Authorized persons are:

(1) licensed morticians;

(2) registered interns or students as described in section 149A.91, subdivision 6;

(3) public officials or representatives in the discharge of their official duties;

(4) trained alkaline hydrolysis facility operators; and

(5) the person(s) with the right to control the dead human body as defined in section 149A.80, subdivision 2, and their designees.

(b) Each door allowing ingress or egress shall carry a sign that indicates that the room is private and access is limited. All authorized persons who are present in or enter the room where the alkaline hydrolysis vessel is located while a body is being prepared for final disposition must be attired according to all applicable state and federal regulations regarding the control of infectious disease and occupational and workplace health and safety.

Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place and all fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies stored or used in the room must be maintained in a clean and sanitary condition at all times.

Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline hydrolysis vessel for its operation, all state and local regulations for that boiler must be followed.

Subd. 10. **Occupational and workplace safety.** All applicable provisions of state and federal regulations regarding exposure to workplace hazards and accidents shall be followed in order to protect the health and safety of all authorized persons at the alkaline hydrolysis facility.

Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body. It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for

compliance with this chapter and other applicable state and federal regulations regarding occupational and workplace health and safety.

Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part without receiving written authorization to do so from the person or persons who have the legal right to control disposition as described in section 149A.80 or the person's legal designee. The written authorization must include:

(1) the name of the deceased and the date of death of the deceased;

(2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;

(3) the name, address, telephone number, relationship to the deceased, and signature of the person or persons with legal right to control final disposition or a legal designee;

(4) directions for the disposition of any nonhydrolyzed materials or items recovered from the alkaline hydrolysis vessel;

(5) acknowledgment that the hydrolyzed remains will be dried and mechanically reduced to a granulated appearance and placed in an appropriate container and authorization to place any hydrolyzed remains that a selected urn or container will not accommodate into a temporary container;

(6) acknowledgment that, even with the exercise of reasonable care, it is not possible to recover all particles of the hydrolyzed remains and that some particles may inadvertently become commingled with particles of other hydrolyzed remains that remain in the alkaline hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;

(7) directions for the ultimate disposition of the hydrolyzed remains; and

(8) a statement that includes, but is not limited to, the following information: "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an alkaline solution is used to chemically break down the human tissue and the hydrolyzable alkaline hydrolysis container. After the process is complete, the liquid effluent solution contains the chemical by-products of the alkaline hydrolysis process except for the deceased's bone fragments. The solution is cooled and released according to local environmental regulations. A water rinse is applied to the hydrolyzed remains which are then dried and processed to facilitate inurnment or scattering."

Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis facility.

Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be accepted for final disposition by alkaline hydrolysis unless:

(1) encased in an appropriate alkaline hydrolysis container;

(2) accompanied by a disposition permit issued pursuant to section 149A.93, subdivision 3, including a photocopy of the completed death record or a signed release authorizing alkaline hydrolysis of the body received from the coroner or medical examiner; and

(3) accompanied by an alkaline hydrolysis authorization that complies with subdivision 12.

(b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline hydrolysis container where there is:

(1) evidence of leakage of fluids from the alkaline hydrolysis container;

(2) a known dispute concerning hydrolysis of the body delivered;

(3) a reasonable basis for questioning any of the representations made on the written authorization to hydrolyze; or

(4) any other lawful reason.

Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of the body.

Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.** All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for dead human bodies shall use universal precautions and otherwise exercise all reasonable precautions to minimize the risk of transmitting any communicable disease from the body. No dead human body shall be removed from the container in which it is delivered.

Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall develop, implement, and maintain an identification procedure whereby dead human bodes can be identified from the time the alkaline hydrolysis facility accepts delivery of the remains until the hydrolyzed remains are released to an authorized party. After hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the hydrolyzed remains container before the hydrolyzed remains are released from the alkaline hydrolysis facility. Each identification disk, tab, or label shall have a number that shall be recorded on all paperwork regarding the decedent. This procedure shall be designed to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the inability to individually identify the hydrolyzed remains is a violation of this subdivision.

Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for infectious disease control.

Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is written authorization from the person with the legal right to control the disposition, only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains prohibited.** Except with the express written permission of the person with the legal right to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze a dead human body and other human remains at the same time and in the same alkaline hydrolysis vessel. This section does not apply where commingling of human remains during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is not a violation of this subdivision.

Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed human remains and dispose of these materials in a lawful manner, by the alkaline hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate container to be transported to the processing area.

Subd. 22. **Drying device or mechanical processor procedures; commingling of hydrolyzed remains prohibited.** Except with the express written permission of the person with the legal right to control the final disposition or otherwise provided by law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed human remains of more than one body at a time in the same drying device or mechanical processor, or introduce the hydrolyzed human remains of a second body into a drying

device or mechanical processor until processing of any preceding hydrolyzed human remains has been terminated and reasonable efforts have been employed to remove all fragments of the preceding hydrolyzed remains. The fact that there is incidental and unavoidable residue in the drying device, the mechanical processor, or any container used in a prior alkaline hydrolysis process, is not a violation of this provision.

Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The hydrolyzed human remains shall be dried and then reduced by a motorized mechanical device to a granulated appearance appropriate for final disposition and placed in an alkaline hydrolysis remains container along with the appropriate identifying disk, tab, or permanent label. Processing must take place within the licensed alkaline hydrolysis facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they can be identified, may be removed prior to processing the hydrolyzed remains, only by staff licensed or registered by the commissioner of health; however, any dental gold and silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains container unless otherwise directed by the person or persons having the right to control the final disposition. Every person who removes or possesses dental gold or silver, jewelry, or mementos from any hydrolyzed remains without specific written permission of the person or persons having the right to control those remains is guilty of a misdemeanor. The fact that residue and any unavoidable dental gold or dental silver, or other precious metals remain in the alkaline hydrolysis vessel or other equipment or any container used in a prior hydrolysis is not a violation of this section.

Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.** If a hydrolyzed remains container is of insufficient capacity to accommodate all hydrolyzed remains of a given dead human body, subject to directives provided in the written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the second container, in a manner so as not to be easily detached through incidental contact, to the primary alkaline hydrolysis remains container. The secondary container shall contain a duplicate of the identification disk, tab, or permanent label that was placed in the primary container and all paperwork regarding the given body shall include a notation that the hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature hydrolyzed remains containers are not subject to the requirements of this subdivision.

Subd. 25. **Disposition procedures; commingling of hydrolyzed remains prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in a location where the hydrolyzed remains are commingled with those of another person without the express written permission of the person with the legal right to control

disposition or as otherwise provided by law. This subdivision does not apply to the scattering or burial of hydrolyzed remains at sea or in a body of water from individual containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to the disposal in a dedicated cemetery of accumulated residue removed from an alkaline hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members of the same family in a common container designed for the hydrolyzed remains of more than one body, or to the inurnment in a container or interment in a space that has been previously designated, at the time of sale or purchase, as being intended for the inurnment or interment of the hydrolyzed remains of more than one person.

Subd. 26. **Alkaline hydrolysis procedures; disposition of accumulated residue.** Every alkaline hydrolysis facility shall provide for the removal and disposition in a dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel, drying device, mechanical processor, container, or other equipment used in alkaline hydrolysis. Disposition of accumulated residue shall be according to the regulations of the dedicated cemetery and any applicable local ordinances.

Subd. 27. **Alkaline hydrolysis procedures; release of hydrolyzed remains.** Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be released according to the instructions given on the written authorization to hydrolyze. If the hydrolyzed remains are to be shipped, they must be securely packaged and transported by a method which has an internal tracing system available and which provides for a receipt signed by the person accepting delivery. Where there is a dispute over release or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit the hydrolyzed remains with a court of competent jurisdiction pending resolution of the dispute or retain the hydrolyzed remains until the person with the legal right to control disposition presents satisfactory indication that the dispute is resolved.

Subd. 28. **Unclaimed hydrolyzed remains.** If, after 30 calendar days following the inurnment, the hydrolyzed remains are not claimed or disposed of according to the written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment may give written notice, by certified mail, to the person with the legal right to control the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and requesting further release directions. Should the hydrolyzed remains be unclaimed 120 calendar days following the mailing of the written notification, the alkaline hydrolysis facility or funeral establishment may dispose of the hydrolyzed remains in any lawful manner deemed appropriate.

Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and maintain on its premises or other business location in Minnesota an accurate record of

every hydrolyzation provided. The record shall include all of the following information for each hydrolyzation:

(1) the name of the person or funeral establishment delivering the body for alkaline hydrolysis;

(2) the name of the deceased and the identification number assigned to the body;

(3) the date of acceptance of delivery;

(4) the names of the alkaline hydrolysis vessel, drying device, and mechanical processor operator;

(5) the time and date that the body was placed in and removed from the alkaline hydrolysis vessel;

(6) the time and date that processing and inurnment of the hydrolyzed remains was completed;

(7) the time, date, and manner of release of the hydrolyzed remains;

(8) the name and address of the person who signed the authorization to hydrolyze;

(9) all supporting documentation, including any transit or disposition permits, a photocopy of the death record, and the authorization to hydrolyze; and

(10) the type of alkaline hydrolysis container.

Subd. 30. **Retention of records.** Records required under subdivision 29 shall be maintained for a period of three calendar years after the release of the hydrolyzed remains. Following this period and subject to any other laws requiring retention of records, the alkaline hydrolysis facility may then place the records in storage or reduce them to microfilm, microfiche, laser disc, or any other method that can produce an accurate reproduction of the original record, for retention for a period of ten calendar years from the date of release of the hydrolyzed remains. At the end of this period and subject to any other laws requiring retention of records, the alkaline hydrolysis facility may destroy the records by shredding, incineration, or any other manner that protects the privacy of the individuals identified.

Sec. 15. 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. 16. 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. 17. 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.

APPENDIX
Article locations in 13-2938