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State of Minnesota
HOUSE OF REPRESENTATIVES
EIGHTY-EIGHTH SESSION
H. F. No. 1233

03/04/2013 Authored by Huntley and Moran
The bill was read for the first time and referred to the Committee on Rules and Legislative Administration
03/11/2013 Adoption of Report: Pass and re-referred to the Committee on Health and Human Services Finance

1.1 A bill for an act
1.2 relating to state government; establishing the health and human services budget;
1.3 modifying provisions related to health care, continuing care, nursing facility
1.4 admission, children and family services, human services licensing, chemical and
1.5 mental health, program integrity, managed care organizations, waiver provider
1.6 standards, home care, and the Department of Health; redesigning home and
1.7 community-based services; establishing community first services and supports
1.8 and Northstar Care for Children; providing for fraud investigations in the
1.9 child care assistance program; establishing autism early intensive intervention
1.10 benefits; creating a human services performance council; making technical
1.11 changes; requiring a study; requiring reports; appropriating money; repealing
1.12 MinnesotaCare; amending Minnesota Statutes 2012, sections 16C.10, subdivision
1.13 5; 16C.155, subdivision 1; 103I.005, by adding a subdivision; 103I.521;
1.14 119B.011, by adding a subdivision; 119B.02, by adding a subdivision; 119B.025,
1.15 subdivision 1; 119B.03, subdivision 4; 119B.05, subdivision 1; 119B.13,
1.16 subdivisions 1, 1a, 6, by adding subdivisions; 144.051, by adding subdivisions;
1.17 144.0724, subdivision 4; 144.123, subdivision 1; 144.125, subdivision 1; 144.98,
1.18 subdivisions 3, 5, by adding subdivisions; 144.99, subdivision 4; 144A.351;
1.19 144A.43; 144A.44; 144A.45; 144D.01, subdivision 4; 145.986; 145C.01,
1.20 subdivision 7; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5,
1.21 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding
1.22 subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;
1.23 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions
1.24 1, 2, 4; 149A.74; 149A.90, subdivision 8; 149A.91, subdivision 9; 149A.92,
1.25 subdivision 1; 149A.93, subdivisions 3, 6; 149A.94; 149A.96, subdivision
1.26 9; 174.30, subdivision 1; 243.166, subdivisions 4b, 7; 245.4682, subdivision
1.27 2; 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 9; 245A.04,
1.28 subdivision 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08,
1.29 subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435;
1.30 245A.144; 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5;
1.31 245A.50; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245C.33,
1.32 subdivision 1; 245D.02; 245D.03; 245D.04; 245D.05; 245D.06; 245D.07;
1.33 245D.09; 245D.10; 246.18, subdivision 8, by adding a subdivision; 246.54;
1.34 254B.04, subdivision 1; 256.01, subdivisions 2, 24, 34, by adding subdivisions;
1.35 256.0112, by adding a subdivision; 256.82, subdivisions 2, 3; 256.969,
1.36 subdivision 3a; 256.975, subdivision 7, by adding subdivisions; 256.9754,
1.37 subdivision 5, by adding subdivisions; 256.98, subdivision 8; 256B.02, by
1.38 adding subdivisions; 256B.021, by adding subdivisions; 256B.04, subdivisions
1.39 18, 21, by adding a subdivision; 256B.055, subdivisions 3a, 6, 10, 15, by adding

2.1 subdivisions; 256B.056, subdivisions 1, 1a, 1c, 3, 3c, 4, 5c, 10, by adding a
2.2 subdivision; 256B.057, subdivisions 1, 8, 10, by adding a subdivision; 256B.059,
2.3 subdivision 1; 256B.06, subdivision 4; 256B.0625, subdivisions 13e, 17a, 19c,
2.4 58, by adding subdivisions; 256B.0659, subdivision 21; 256B.0911, subdivisions
2.5 1, 1a, 3a, 4d, 6, 7, by adding a subdivision; 256B.0913, subdivision 4, by adding a
2.6 subdivision; 256B.0915, subdivisions 3a, 5, by adding a subdivision; 256B.0916,
2.7 by adding a subdivision; 256B.0917, subdivisions 6, 13, by adding subdivisions;
2.8 256B.092, subdivisions 11, 12, by adding subdivisions; 256B.434, subdivision
2.9 4; 256B.437, subdivision 6; 256B.439, subdivisions 1, 2, 3, 4, by adding a
2.10 subdivision; 256B.441, subdivisions 13, 53, by adding subdivisions; 256B.49,
2.11 subdivisions 11a, 12, 14, 15, by adding subdivisions; 256B.4912, subdivisions 1,
2.12 7, by adding subdivisions; 256B.493, subdivision 2; 256B.5011, subdivision 2;
2.13 256B.69, subdivisions 5c, 31; 256B.76, subdivisions 1, 2; 256B.761; 256B.766;
2.14 256I.05, by adding a subdivision; 256J.08, subdivision 24; 256J.21, subdivisions
2.15 2, 3; 256J.24, subdivisions 3, 7; 256J.621; 256J.626, subdivision 7; 257.85,
2.16 subdivisions 2, 5, 6; 260C.446; 402A.10; 402A.18; 471.59, subdivision 1;
2.17 626.556, subdivisions 2, 3, 10d; 626.557, subdivisions 4, 9, 9a, 9e; 626.5572,
2.18 subdivision 13; Laws 1998, chapter 407, article 6, section 116; proposing coding
2.19 for new law in Minnesota Statutes, chapters 144; 144A; 149A; 245; 245A;
2.20 245D; 256; 256B; 256J; 259A; 260C; 402A; proposing coding for new law
2.21 as Minnesota Statutes, chapters 245E; 256N; repealing Minnesota Statutes
2.22 2012, sections 103I.005, subdivision 20; 144.123, subdivision 2; 144A.46;
2.23 144A.461; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40,
2.24 subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6; 149A.51,
2.25 subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9; 245A.655;
2.26 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2, 3,
2.27 5, 6, 7; 245B.055; 245B.06; 245B.07; 245B.08; 245D.08; 256.82, subdivision
2.28 4; 256B.055, subdivisions 3, 5, 10b; 256B.056, subdivision 5b; 256B.057,
2.29 subdivisions 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917, subdivisions
2.30 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.092, subdivision 11; 256B.49,
2.31 subdivisions 16a, 22; 256J.24, subdivision 10; 256L.01, subdivisions 1, 1a, 2, 3,
2.32 3a, 4a, 5; 256L.02, subdivisions 1, 2, 3; 256L.03, subdivisions 1, 1a, 1b, 2, 3,
2.33 3a, 3b, 4, 5, 6; 256L.031; 256L.04, subdivisions 1, 1a, 1b, 2, 2a, 7, 7a, 7b, 8, 9,
2.34 10, 10a, 12, 13; 256L.05; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2,
2.35 3, 4, 5, 8, 9; 256L.09, subdivisions 1, 2, 4, 5, 6, 7; 256L.10; 256L.11; 256L.12;
2.36 256L.15, subdivisions 1, 1a, 1b, 2; 256L.17, subdivisions 1, 2, 3, 4, 5; 256L.18;
2.37 256L.22; 256L.24; 256L.26; 256L.28; 260C.441; 485.14; Minnesota Rules, parts
2.38 3400.0130, subpart 8; 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012;
2.39 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040;
2.40 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080;
2.41 4668.0100; 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150;
2.42 4668.0160; 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218;
2.43 4668.0220; 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810;
2.44 4668.0815; 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840;
2.45 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001;
2.46 4669.0010; 4669.0020; 4669.0030; 4669.0040; 4669.0050; 9502.0355, subpart
2.47 4; 9560.0650, subparts 1, 3, 6; 9560.0651; 9560.0655.

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

2.49 **ARTICLE 1**

2.50 **AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH**
2.51 **CARE FOR MORE MINNESOTANS**

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

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

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

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

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

Sec. 2. **[256.0131] FEDERAL APPROVAL OF HEALTH CARE COVERAGE WAIVER.**

4.1 (a) The commissioner of human services shall pursue federal funding to provide
4.2 health care coverage to certain individuals with incomes above 133 percent of the federal
4.3 poverty guidelines effective January 1, 2014. The waiver request shall specify that
4.4 reimbursement is requested for providing health care coverage to:
4.5 (1) parents and caretaker relatives of children ages birth up to a child's 19th birthday,
4.6 children who are 19 years old or older and up to the child's 21st birthday, and adults without
4.7 children with household incomes above 133 percent of federal poverty guidelines, and at
4.8 or below the lowest income standard for the advance premium tax credit program offered
4.9 by the Minnesota Insurance Marketplace, who meet all other eligibility requirements; and
4.10 (2) lawfully present noncitizens ineligible for Medicaid by reason of immigration
4.11 status with income at or below the lowest income standard for the advance premium
4.12 tax credit program offered by the Minnesota Insurance Marketplace who meet all other
4.13 eligibility requirements.
4.14 (b) The commissioner shall request that federal funding for health care coverage
4.15 as described in paragraph (a) continue until Minnesota receives federal approval for, and
4.16 implements, a Basic Health Plan option as described in section 1331 of the Affordable
4.17 Care Act (Public Law 111-148).
4.18 (c) The waiver request must be consistent with provisions of the Affordable Care
4.19 Act so that it will operate in conjunction with other insurance affordability programs
4.20 defined in that law.

4.21 Sec. 3. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
4.22 to read:
4.23 Subd. 17. **Affordable Care Act or ACA.** "Affordable Care Act" or "ACA" means
4.24 Public Law 111-148, as amended by the federal Health Care and Education Reconciliation
4.25 Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance
4.26 issued under, those acts.

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

4.28 Sec. 4. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
4.29 to read:
4.30 Subd. 18. **Caretaker relative.** "Caretaker relative" means a relative, by blood,
4.31 adoption, or marriage, of a child under age 19 with whom the child is living and who
4.32 assumes primary responsibility for the child's care.

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

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

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

5.5 (1) medical assistance under this chapter;

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

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

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

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

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

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

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

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

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

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

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

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

6.4 Sec. 8. Minnesota Statutes 2012, section 256B.055, subdivision 6, is amended to read:
6.5 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid
6.6 for a pregnant woman who ~~has written verification of a positive pregnancy test from a~~
6.7 ~~physician or licensed registered nurse, who~~ meets the other eligibility criteria of this
6.8 section and whose unborn child would be eligible as a needy child under subdivision 10 if
6.9 born and living with the woman. In accordance with Code of Federal Regulations, title
6.10 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless
6.11 the agency has information that is not reasonably compatible with such attestation. For
6.12 purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

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

6.14 Sec. 9. Minnesota Statutes 2012, section 256B.055, subdivision 10, is amended to read:
6.15 Subd. 10. **Infants.** Medical assistance may be paid for an infant less than one year
6.16 of age, whose mother was eligible for and receiving medical assistance at the time of birth
6.17 or who is less than two years of age and is in a family with countable income that is equal
6.18 to or less than the income standard established under section 256B.057, subdivision 1.

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

6.22 Sec. 10. Minnesota Statutes 2012, section 256B.055, subdivision 15, is amended to read:
6.23 Subd. 15. **Adults without children.** Medical assistance may be paid for a person
6.24 who is:
6.25 (1) at least age 21 and under age 65;
6.26 (2) not pregnant;
6.27 (3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII
6.28 of the Social Security Act;
6.29 (4) ~~not an adult in a family with children as defined in section 256L.01, subdivision~~
6.30 ~~3a; and~~ not otherwise eligible under subdivision 7 as a person who meets the categorical
6.31 eligibility requirements of the supplemental security income program;

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

7.4 ~~(5)~~ (6) not described in another subdivision of this section.

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

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

7.8 Subd. 16. **Children ages 19 and 20.** Medical assistance may be paid for children
7.9 who are 19 to 20 years of age.

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

7.11 Sec. 12. Minnesota Statutes 2012, section 256B.055, is amended by adding a
7.12 subdivision to read:

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

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

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

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

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

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

7.26 Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by
7.27 state law or rule or federal law or regulation, the methodologies used in counting income
7.28 and assets to determine eligibility for medical assistance for persons whose eligibility
7.29 category is based on blindness, disability, or age of 65 or more years, the methodologies

8.1 for the supplemental security income program shall be used, except as provided under
8.2 subdivision 3, paragraph (a), clause (6).

8.3 (2) Increases in benefits under title II of the Social Security Act shall not be counted
8.4 as income for purposes of this subdivision until July 1 of each year. Effective upon federal
8.5 approval, for children eligible under section 256B.055, subdivision 12, or for home and
8.6 community-based waiver services whose eligibility for medical assistance is determined
8.7 without regard to parental income, child support payments, including any payments
8.8 made by an obligor in satisfaction of or in addition to a temporary or permanent order
8.9 for child support, and Social Security payments are not counted as income. ~~For families~~
8.10 ~~and children, which includes all other eligibility categories, the methodologies under the~~
8.11 ~~state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility~~
8.12 ~~and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193,~~
8.13 ~~shall be used, except that effective October 1, 2003, the earned income disregards and~~
8.14 ~~deductions are limited to those in subdivision 1c.~~

8.15 (b)(1) The modified adjusted gross income methodology as defined in the Affordable
8.16 Care Act shall be used for eligibility categories based on:

8.17 (i) children under age 19 and their parents and relative caretakers as defined in
8.18 section 256B.055, subdivision 3a;

8.19 (ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

8.20 (iii) pregnant women as defined in section 256B.055, subdivision 6;

8.21 (iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057,
8.22 subdivision 8; and

8.23 (v) adults without children as defined in section 256B.055, subdivision 15.

8.24 For these purposes, a "methodology" does not include an asset or income standard,
8.25 or accounting method, or method of determining effective dates.

8.26 (2) For individuals whose income eligibility is determined using the modified
8.27 adjusted gross income methodology in clause (1), the commissioner shall subtract from
8.28 the individual's modified adjusted gross income an amount equivalent to five percent
8.29 of the federal poverty guidelines.

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

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

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

8.34 (2) For applications processed within one calendar month prior to July 1, 2003,
8.35 eligibility shall be determined by applying the income standards and methodologies in

9.1 effect prior to July 1, 2003, for any months in the six-month budget period before July
9.2 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any
9.3 months in the six-month budget period on or after that date. The income standards for
9.4 each month shall be added together and compared to the applicant's total countable income
9.5 for the six-month budget period to determine eligibility.

9.6 (3) For children ages one through 18 ~~whose eligibility is determined under section~~
9.7 ~~256B.057, subdivision 2~~, the following deductions shall be applied to income counted
9.8 toward the child's eligibility as allowed under the state's AFDC plan in effect as of July
9.9 16, 1996: $90 work expense, dependent care, and child support paid under court order.
9.10 This clause is effective October 1, 2003.

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

9.17 (c) If the four-month disregard in paragraph (b) has been applied to the wage
9.18 earner's income for four months, the disregard shall not be applied again until the wage
9.19 earner's income has not been considered in determining medical assistance eligibility for
9.20 12 consecutive months.

9.21 (d) The commissioner shall adjust the income standards under this section each July
9.22 1 by the annual update of the federal poverty guidelines following publication by the
9.23 United States Department of Health and Human Services except that the income standards
9.24 shall not go below those in effect on July 1, 2009.

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

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

9.29 Subd. 3. **Asset limitations for <u>certain</u> individuals ~~and families~~.** ~~(a)~~ To be
9.30 eligible for medical assistance, a person must not individually own more than $3,000 in
9.31 assets, or if a member of a household with two family members, husband and wife, or
9.32 parent and child, the household must not own more than $6,000 in assets, plus $200 for
9.33 each additional legal dependent. In addition to these maximum amounts, an eligible
9.34 individual or family may accrue interest on these amounts, but they must be reduced to the
9.35 maximum at the time of an eligibility redetermination. The accumulation of the clothing

10.1 and personal needs allowance according to section 256B.35 must also be reduced to the
10.2 maximum at the time of the eligibility redetermination. The value of assets that are not
10.3 considered in determining eligibility for medical assistance is the value of those assets
10.4 excluded under the supplemental security income program for aged, blind, and disabled
10.5 persons, with the following exceptions:

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

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

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

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

10.15 (5) for a person who no longer qualifies as an employed person with a disability due
10.16 to loss of earnings, assets allowed while eligible for medical assistance under section
10.17 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
10.18 of ineligibility as an employed person with a disability, to the extent that the person's total
10.19 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

10.20 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
10.21 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
10.22 before the person's 65th birthday, the assets owned by the person and the person's spouse
10.23 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
10.24 when determining eligibility for medical assistance under section 256B.055, subdivision
10.25 7. The income of a spouse of a person enrolled in medical assistance under section
10.26 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
10.27 65th birthday must be disregarded when determining eligibility for medical assistance
10.28 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
10.29 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
10.30 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
10.31 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65; and

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

11.1 ~~(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision~~
11.2 ~~15.~~

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

11.4 Sec. 17. Minnesota Statutes 2012, section 256B.056, subdivision 3c, is amended to read:
11.5 Subd. 3c. **Asset limitations for families and children.** (a) A household of two or
11.6 more persons must not own more than $20,000 in total net assets, and a household of one
11.7 person must not own more than $10,000 in total net assets. In addition to these maximum
11.8 amounts, an eligible individual or family may accrue interest on these amounts, but they
11.9 must be reduced to the maximum at the time of an eligibility redetermination. The value of
11.10 assets that are not considered in determining eligibility for medical assistance for families
11.11 and children is the value of those assets excluded under the AFDC state plan as of July 16,
11.12 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
11.13 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:
11.14 (1) household goods and personal effects are not considered;
11.15 (2) capital and operating assets of a trade or business up to $200,000 are not
11.16 considered, except that a bank account that contains personal income or assets, or is used to
11.17 pay personal expenses, is not considered a capital or operating asset of a trade or business;
11.18 (3) one motor vehicle is excluded for each person of legal driving age who is
11.19 employed or seeking employment;
11.20 (4) assets designated as burial expenses are excluded to the same extent they are
11.21 excluded by the Supplemental Security Income program;
11.22 (5) court-ordered settlements up to $10,000 are not considered;
11.23 (6) individual retirement accounts and funds are not considered;
11.24 (7) assets owned by children are not considered; and
11.25 (8) effective July 1, 2009, certain assets owned by American Indians are excluded as
11.26 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
11.27 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
11.28 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

11.29 The assets specified in clause (2) must be disclosed to the local agency at the time of
11.30 application and at the time of an eligibility redetermination, and must be verified upon
11.31 request of the local agency.
11.32 (b) Beginning January 1, 2014, this subdivision applies only to parents and caretaker
11.33 relatives who qualify for medical assistance under subdivision 5.

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

12.1 Sec. 18. Minnesota Statutes 2012, section 256B.056, subdivision 4, is amended to read:

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

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

12.11 (c) Effective July 1, 2002 January 1, 2014, to be eligible for medical assistance,
12.12 families and children under section 256B.055, subdivision 3a, a parent or caretaker
12.13 relative may have an income up to 100 133 percent of the federal poverty guidelines for
12.14 the family household size.

12.15 (d) To be eligible for medical assistance under section 256B.055, subdivision 15,
12.16 a person may have an income up to 75 133 percent of federal poverty guidelines for
12.17 the family household size.

12.18 (e) In computing income to determine eligibility of persons under paragraphs (a) to
12.19 (d) who are not residents of long-term care facilities, the commissioner shall disregard
12.20 increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509.
12.21 Veterans aid and attendance benefits and Veterans Administration unusual medical
12.22 expense payments are considered income to the recipient To be eligible for medical
12.23 assistance under section 256B.055, subdivision 16, a child may have an income up to 133
12.24 percent of the federal poverty guidelines for the household size.

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

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

12.31 Sec. 19. Minnesota Statutes 2012, section 256B.056, subdivision 5c, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2012, section 256B.056, subdivision 10, is amended to read:

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

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

14.1 (c) The commissioner shall verify assets and income for all applicants, and for all
14.2 recipients upon renewal.
14.3 (d) The commissioner shall utilize information obtained through the electronic
14.4 service established by the secretary of the United States Department of Health and Human
14.5 Services and other available electronic data sources in Code of Federal Regulations, title
14.6 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner
14.7 shall establish standards to define when information obtained electronically is reasonably
14.8 compatible with information provided by applicants and enrollees, including use of
14.9 self-attestation, to accomplish real-time eligibility determinations and maintain program
14.10 integrity.

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

14.12 Sec. 22. Minnesota Statutes 2012, section 256B.057, subdivision 1, is amended to read:
14.13 Subdivision 1. **Infants and pregnant women.** (a)~~(1)~~ An infant less than ~~one year~~
14.14 two years of age or a pregnant woman ~~who has written verification of a positive pregnancy~~
14.15 ~~test from a physician or licensed registered nurse~~ is eligible for medical assistance if the
14.16 individual's countable ~~family~~ household income is equal to or less than 275 percent of the
14.17 federal poverty guideline for the same ~~family~~ household size or an equivalent standard
14.18 when converted using modified adjusted gross income methodology as required under
14.19 the Affordable Care Act. ~~For purposes of this subdivision, "countable family income"~~
14.20 ~~means the amount of income considered available using the methodology of the AFDC~~
14.21 ~~program under the state's AFDC plan as of July 16, 1996, as required by the Personal~~
14.22 ~~Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public~~
14.23 ~~Law 104-193, except for the earned income disregard and employment deductions.~~
14.24 ~~(2) For applications processed within one calendar month prior to the effective date,~~
14.25 ~~eligibility shall be determined by applying the income standards and methodologies in~~
14.26 ~~effect prior to the effective date for any months in the six-month budget period before~~
14.27 ~~that date and the income standards and methodologies in effect on the effective date for~~
14.28 ~~any months in the six-month budget period on or after that date. The income standards~~
14.29 ~~for each month shall be added together and compared to the applicant's total countable~~
14.30 ~~income for the six-month budget period to determine eligibility.~~
14.31 ~~(b)(1) [Expired, 1Sp2003 c 14 art 12 s 19]~~
14.32 ~~(2) For applications processed within one calendar month prior to July 1, 2003,~~
14.33 ~~eligibility shall be determined by applying the income standards and methodologies in~~
14.34 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July 1,~~
14.35 ~~2003, and the income standards and methodologies in effect on the expiration date for any~~

15.1 ~~months in the six-month budget period on or after July 1, 2003. The income standards~~
15.2 ~~for each month shall be added together and compared to the applicant's total countable~~
15.3 ~~income for the six-month budget period to determine eligibility.~~
15.4 ~~(3) An amount equal to the amount of earned income exceeding 275 percent of~~
15.5 ~~the federal poverty guideline, up to a maximum of the amount by which the combined~~
15.6 ~~total of 185 percent of the federal poverty guideline plus the earned income disregards~~
15.7 ~~and deductions allowed under the state's AFDC plan as of July 16, 1996, as required~~
15.8 ~~by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public~~
15.9 ~~Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for~~
15.10 ~~pregnant women and infants less than one year of age.~~
15.11 ~~(c) Dependent care and child support paid under court order shall be deducted from~~
15.12 ~~the countable income of pregnant women.~~
15.13 ~~(d)~~ (b) An infant born to a woman who was eligible for and receiving medical
15.14 assistance on the date of the child's birth shall continue to be eligible for medical assistance
15.15 without redetermination until the child's first birthday.

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

15.17 Sec. 23. Minnesota Statutes 2012, section 256B.057, subdivision 8, is amended to read:
15.18 Subd. 8. **Children under age two.** Medical assistance may be paid for a child under
15.19 two years of age whose countable family income is above 275 percent of the federal poverty
15.20 guidelines for the same size family but less than or equal to 280 percent of the federal
15.21 poverty guidelines for the same size family or an equivalent standard when converted using
15.22 modified adjusted gross income methodology as required under the Affordable Care Act.

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

15.24 Sec. 24. Minnesota Statutes 2012, section 256B.057, subdivision 10, is amended to read:
15.25 Subd. 10. **Certain persons needing treatment for breast or cervical cancer.** (a)
15.26 Medical assistance may be paid for a person who:
15.27 (1) has been screened for breast or cervical cancer by the Minnesota breast and
15.28 cervical cancer control program, and program funds have been used to pay for the person's
15.29 screening;
15.30 (2) according to the person's treating health professional, needs treatment, including
15.31 diagnostic services necessary to determine the extent and proper course of treatment, for
15.32 breast or cervical cancer, including precancerous conditions and early stage cancer;

16.1 (3) meets the income eligibility guidelines for the Minnesota breast and cervical
16.2 cancer control program;
16.3 (4) is under age 65;
16.4 (5) is not otherwise eligible for medical assistance under United States Code, title
16.5 42, section 1396a(a)(10)(A)(i); and
16.6 (6) is not otherwise covered under creditable coverage, as defined under United
16.7 States Code, title 42, section 1396a(aa).
16.8 (b) Medical assistance provided for an eligible person under this subdivision shall
16.9 be limited to services provided during the period that the person receives treatment for
16.10 breast or cervical cancer.
16.11 (c) A person meeting the criteria in paragraph (a) is eligible for medical assistance
16.12 without meeting the eligibility criteria relating to income and assets in section 256B.056,
16.13 subdivisions 1a to ~~5b~~ 5a.

16.14 Sec. 25. Minnesota Statutes 2012, section 256B.057, is amended by adding a
16.15 subdivision to read:
16.16 Subd. 12. **Presumptive eligibility determinations made by qualified hospitals.**
16.17 The commissioner shall establish a process to qualify hospitals that are participating
16.18 providers under the medical assistance program to determine presumptive eligibility for
16.19 medical assistance for applicants who may have a basis of eligibility using the modified
16.20 adjusted gross income methodology as defined in section 256B.056, subdivision 1a,
16.21 paragraph (b), clause (1).

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

16.23 Sec. 26. Minnesota Statutes 2012, section 256B.059, subdivision 1, is amended to read:
16.24 Subdivision 1. **Definitions.** (a) For purposes of this section and sections 256B.058
16.25 and 256B.0595, the terms defined in this subdivision have the meanings given them.
16.26 (b) "Community spouse" means the spouse of an institutionalized spouse.
16.27 (c) "Spousal share" means one-half of the total value of all assets, to the extent that
16.28 either the institutionalized spouse or the community spouse had an ownership interest at
16.29 the time of the first continuous period of institutionalization.
16.30 (d) "Assets otherwise available to the community spouse" means assets individually
16.31 or jointly owned by the community spouse, other than assets excluded by subdivision 5,
16.32 paragraph (c).
16.33 (e) "Community spouse asset allowance" is the value of assets that can be transferred
16.34 under subdivision 3.

17.1 (f) "Institutionalized spouse" means a person who is:
17.2 (1) in a hospital, nursing facility, or intermediate care facility for persons with
17.3 developmental disabilities, or receiving home and community-based services under section
17.4 256B.0915, 256B.092, or 256B.49 and is expected to remain in the facility or institution
17.5 or receive the home and community-based services for at least 30 consecutive days; and
17.6 (2) married to a person who is not in a hospital, nursing facility, or intermediate
17.7 care facility for persons with developmental disabilities, and is not receiving home and
17.8 community-based services under section 256B.0915, 256B.092, or 256B.49.
17.9 (g) "For the sole benefit of" means no other individual or entity can benefit in any
17.10 way from the assets or income at the time of a transfer or at any time in the future.
17.11 (h) "Continuous period of institutionalization" means a 30-consecutive-day period
17.12 of time in which a person is expected to stay in a medical or long-term care facility, or
17.13 receive home and community-based services that would qualify for coverage under ~~the~~
17.14 ~~elderly waiver (EW) or alternative care (AC) programs~~ section 256B.0913, 256B.0915,
17.15 256B.092, or 256B.49. For a stay in a facility, the 30-consecutive-day period begins
17.16 on the date of entry into a medical or long-term care facility. For receipt of home and
17.17 community-based services, the 30-consecutive-day period begins on the date that the
17.18 following conditions are met:
17.19 (1) the person is receiving services that meet the nursing facility level of care
17.20 determined by a long-term care consultation;
17.21 (2) the person has received the long-term care consultation within the past 60 days;
17.22 (3) the services are paid ~~by the EW program~~ under section ~~256B.0915 or the AC~~
17.23 ~~program under section~~ 256B.0913, 256B.0915, 256B.092, or 256B.49 or would qualify
17.24 for payment under ~~the EW or AC programs~~ those sections if the person were otherwise
17.25 eligible for either program, and but for the receipt of such services the person would have
17.26 resided in a nursing facility; and
17.27 (4) the services are provided by a licensed provider qualified to provide home and
17.28 community-based services.

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

17.30 Sec. 27. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:
17.31 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
17.32 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
17.33 other persons residing lawfully in the United States. Citizens or nationals of the United
17.34 States must cooperate in obtaining satisfactory documentary evidence of citizenship or

18.1 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
18.2 Public Law 109-171.

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

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

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

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

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

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

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

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

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

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

18.24 (c) All qualified noncitizens who were residing in the United States before August
18.25 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
18.26 medical assistance with federal financial participation.

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

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

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

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

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

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

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

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

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

19.20 (g) For purposes of this subdivision, the term "emergency medical condition" means
19.21 a medical condition that meets the requirements of United States Code, title 42, section
19.22 1396b(v).

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

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

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

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

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

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

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

20.1 (iii) services for routine prenatal care;
20.2 (iv) continuing care, including long-term care, nursing facility services, home health
20.3 care, adult day care, day training, or supportive living services;
20.4 (v) elective surgery;
20.5 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
20.6 part of an emergency room visit;
20.7 (vii) preventative health care and family planning services;
20.8 (viii) dialysis;
20.9 (ix) chemotherapy or therapeutic radiation services;
20.10 (x) rehabilitation services;
20.11 (xi) physical, occupational, or speech therapy;
20.12 (xii) transportation services;
20.13 (xiii) case management;
20.14 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
20.15 (xv) dental services;
20.16 (xvi) hospice care;
20.17 (xvii) audiology services and hearing aids;
20.18 (xviii) podiatry services;
20.19 (xix) chiropractic services;
20.20 (xx) immunizations;
20.21 (xxi) vision services and eyeglasses;
20.22 (xxii) waiver services;
20.23 (xxiii) individualized education programs; or
20.24 (xxiv) chemical dependency treatment.
20.25 (i) ~~Beginning July 1, 2009,~~ Pregnant noncitizens who are ~~undocumented,~~
20.26 ~~nonimmigrants, or lawfully present in the United States as defined in Code of Federal~~
20.27 ~~Regulations, title 8, section 103.12,~~ ineligible for federally funded medical assistance
20.28 are not covered by a group health plan or health insurance coverage according to Code
20.29 of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility
20.30 requirements of this chapter, are eligible for medical assistance through the period of
20.31 pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal
20.32 funds are available under title XXI of the Social Security Act, and the state children's
20.33 health insurance program.
20.34 (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation
20.35 services from a nonprofit center established to serve victims of torture and are otherwise
20.36 ineligible for medical assistance under this chapter are eligible for medical assistance

21.1 without federal financial participation. These individuals are eligible only for the period
21.2 during which they are receiving services from the center. Individuals eligible under this
21.3 paragraph shall not be required to participate in prepaid medical assistance.
21.4 (k) Noncitizens who are lawfully present in the United States as defined in Code
21.5 of Federal Regulations, title 8, section 103.12, who are not children or pregnant women
21.6 as defined in paragraph (d), and who otherwise meet the eligibility requirements of this
21.7 chapter, are eligible for medical assistance without federal financial participation. These
21.8 individuals must cooperate with the United States Citizenship and Immigration Services to
21.9 pursue any applicable immigration status, including citizenship, that would qualify them
21.10 for medical assistance with federal financial participation.

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

21.12 Sec. 28. **REPEALER.**
21.13 Subdivision 1. **Repeal; certain health care provisions.** Minnesota Statutes 2012,
21.14 sections 256B.055, subdivisions 3, 5, and 10b; 256B.056, subdivision 5b; and 256B.057,
21.15 subdivisions 1c and 2, are repealed.
21.16 Subd. 2. **Repeal of MinnesotaCare.** Minnesota Statutes 2012, sections 256L.01,
21.17 subdivisions 1, 1a, 2, 3, 3a, 4a, and 5; 256L.02, subdivisions 1, 2, and 3; 256L.03,
21.18 subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 5, and 6; 256L.031; 256L.04, subdivisions 1, 1a,
21.19 1b, 2, 2a, 7, 7a, 7b, 8, 9, 10, 10a, 12, and 13; 256L.05; 256L.06, subdivision 3; 256L.07,
21.20 subdivisions 1, 2, 3, 4, 5, 8, and 9; 256L.09, subdivisions 1, 2, 4, 5, 6, and 7; 256L.10;
21.21 256L.11; 256L.12; 256L.15, subdivisions 1, 1a, 1b, and 2; 256L.17, subdivisions 1, 2,
21.22 3, 4, and 5; 256L.18; 256L.22; 256L.24; 256L.26; and 256L.28, are repealed effective
21.23 January 1, 2014.

21.24 **ARTICLE 2**

21.25 **REFORM 2020; REDESIGNING HOME AND COMMUNITY-BASED SERVICES**

21.26 Section 1. Minnesota Statutes 2012, section 144.0724, subdivision 4, is amended to read:
21.27 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
21.28 electronically submit to the commissioner of health case mix assessments that conform
21.29 with the assessment schedule defined by Code of Federal Regulations, title 42, section
21.30 483.20, and published by the United States Department of Health and Human Services,
21.31 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
21.32 Instrument User's Manual, version 3.0, and subsequent updates when issued by the
21.33 Centers for Medicare and Medicaid Services. The commissioner of health may substitute

22.1 successor manuals or question and answer documents published by the United States
22.2 Department of Health and Human Services, Centers for Medicare and Medicaid Services,
22.3 to replace or supplement the current version of the manual or document.
22.4 (b) The assessments used to determine a case mix classification for reimbursement
22.5 include the following:
22.6 (1) a new admission assessment must be completed by day 14 following admission;
22.7 (2) an annual assessment which must have an assessment reference date (ARD)
22.8 within 366 days of the ARD of the last comprehensive assessment;
22.9 (3) a significant change assessment must be completed within 14 days of the
22.10 identification of a significant change; and
22.11 (4) all quarterly assessments must have an assessment reference date (ARD) within
22.12 92 days of the ARD of the previous assessment.
22.13 (c) In addition to the assessments listed in paragraph (b), the assessments used to
22.14 determine nursing facility level of care include the following:
22.15 (1) preadmission screening completed under section ~~256B.0911, subdivision 4a, by a~~
22.16 ~~county, tribe, or managed care organization under contract with the Department of Human~~
22.17 ~~Services~~ 256.975, subdivision 7a, by the Senior LinkAge Line or Disability Linkage Line
22.18 or other organization under contract with the Minnesota Board on Aging; and
22.19 (2) a nursing facility level of care determination as provided for under section
22.20 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment
22.21 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
22.22 managed care organization under contract with the Department of Human Services.

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

22.24 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
22.25 **REPORT AND STUDY REQUIRED.**

22.26 Subdivision 1. **Report requirements.** The commissioners of health and human
22.27 services, with the cooperation of counties and in consultation with stakeholders, including
22.28 persons who need or are using long-term care services and supports, lead agencies,
22.29 regional entities, senior, disability, and mental health organization representatives, service
22.30 providers, and community members shall prepare a report to the legislature by August 15,
22.31 2013, and biennially thereafter, regarding the status of the full range of long-term care
22.32 services and supports for the elderly and children and adults with disabilities and mental
22.33 illnesses in Minnesota. The report shall address:
22.34 (1) demographics and need for long-term care services and supports in Minnesota;

23.1 (2) summary of county and regional reports on long-term care gaps, surpluses,
23.2 imbalances, and corrective action plans;
23.3 (3) status of long-term care services and related mental health services, housing
23.4 options, and supports by county and region including:
23.5 (i) changes in availability of the range of long-term care services and housing options;
23.6 (ii) access problems, including access to the least restrictive and most integrated
23.7 services and settings, regarding long-term care services; and
23.8 (iii) comparative measures of long-term care services availability, including serving
23.9 people in their home areas near family, and changes over time; and
23.10 (4) recommendations regarding goals for the future of long-term care services and
23.11 supports, policy and fiscal changes, and resource development and transition needs.
23.12 Subd. 2. **Critical access study.** The commissioner shall conduct a onetime study
23.13 to assess local capacity and availability of home and community-based services for
23.14 older adults and people with disabilities. The study must assess critical access at the
23.15 community level and identify potential strategies to build home and community-based
23.16 service capacity in critical access areas.

23.17 Sec. 3. Minnesota Statutes 2012, section 148E.065, subdivision 4a, is amended to read:
23.18 Subd. 4a. **City, county, and state social workers.** (a) Beginning July 1, 2016, the
23.19 licensure of city, county, and state agency social workers is voluntary, except an individual
23.20 who is newly employed by a city or state agency after July 1, 2016, must be licensed
23.21 if the individual who provides social work services, as those services are defined in
23.22 section 148E.010, subdivision 11, paragraph (b), is presented to the public by any title
23.23 incorporating the words "social work" or "social worker."
23.24 (b) City, county, and state agencies employing social workers and staff who are
23.25 designated to perform mandated duties under sections 256.975, subdivisions 7 to 7c and
23.26 256.01, subdivision 24, are not required to employ licensed social workers.

23.27 Sec. 4. Minnesota Statutes 2012, section 256.01, subdivision 2, is amended to read:
23.28 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision
23.29 2, the commissioner of human services shall carry out the specific duties in paragraphs (a)
23.30 through ~~(cc)~~ (dd):
23.31 (a) Administer and supervise all forms of public assistance provided for by state law
23.32 and other welfare activities or services as are vested in the commissioner. Administration
23.33 and supervision of human services activities or services includes, but is not limited to,
23.34 assuring timely and accurate distribution of benefits, completeness of service, and quality

24.1 program management. In addition to administering and supervising human services
24.2 activities vested by law in the department, the commissioner shall have the authority to:
24.3 (1) require county agency participation in training and technical assistance programs
24.4 to promote compliance with statutes, rules, federal laws, regulations, and policies
24.5 governing human services;
24.6 (2) monitor, on an ongoing basis, the performance of county agencies in the
24.7 operation and administration of human services, enforce compliance with statutes, rules,
24.8 federal laws, regulations, and policies governing welfare services and promote excellence
24.9 of administration and program operation;
24.10 (3) develop a quality control program or other monitoring program to review county
24.11 performance and accuracy of benefit determinations;
24.12 (4) require county agencies to make an adjustment to the public assistance benefits
24.13 issued to any individual consistent with federal law and regulation and state law and rule
24.14 and to issue or recover benefits as appropriate;
24.15 (5) delay or deny payment of all or part of the state and federal share of benefits and
24.16 administrative reimbursement according to the procedures set forth in section 256.017;
24.17 (6) make contracts with and grants to public and private agencies and organizations,
24.18 both profit and nonprofit, and individuals, using appropriated funds; and
24.19 (7) enter into contractual agreements with federally recognized Indian tribes with
24.20 a reservation in Minnesota to the extent necessary for the tribe to operate a federally
24.21 approved family assistance program or any other program under the supervision of the
24.22 commissioner. The commissioner shall consult with the affected county or counties in
24.23 the contractual agreement negotiations, if the county or counties wish to be included,
24.24 in order to avoid the duplication of county and tribal assistance program services. The
24.25 commissioner may establish necessary accounts for the purposes of receiving and
24.26 disbursing funds as necessary for the operation of the programs.
24.27 (b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law,
24.28 regulation, and policy necessary to county agency administration of the programs.
24.29 (c) Administer and supervise all child welfare activities; promote the enforcement of
24.30 laws protecting disabled, dependent, neglected and delinquent children, and children born
24.31 to mothers who were not married to the children's fathers at the times of the conception
24.32 nor at the births of the children; license and supervise child-caring and child-placing
24.33 agencies and institutions; supervise the care of children in boarding and foster homes or
24.34 in private institutions; and generally perform all functions relating to the field of child
24.35 welfare now vested in the State Board of Control.

25.1 (d) Administer and supervise all noninstitutional service to disabled persons,
25.2 including those who are visually impaired, hearing impaired, or physically impaired
25.3 or otherwise disabled. The commissioner may provide and contract for the care and
25.4 treatment of qualified indigent children in facilities other than those located and available
25.5 at state hospitals when it is not feasible to provide the service in state hospitals.
25.6 (e) Assist and actively cooperate with other departments, agencies and institutions,
25.7 local, state, and federal, by performing services in conformity with the purposes of Laws
25.8 1939, chapter 431.
25.9 (f) Act as the agent of and cooperate with the federal government in matters of
25.10 mutual concern relative to and in conformity with the provisions of Laws 1939, chapter
25.11 431, including the administration of any federal funds granted to the state to aid in the
25.12 performance of any functions of the commissioner as specified in Laws 1939, chapter 431,
25.13 and including the promulgation of rules making uniformly available medical care benefits
25.14 to all recipients of public assistance, at such times as the federal government increases its
25.15 participation in assistance expenditures for medical care to recipients of public assistance,
25.16 the cost thereof to be borne in the same proportion as are grants of aid to said recipients.
25.17 (g) Establish and maintain any administrative units reasonably necessary for the
25.18 performance of administrative functions common to all divisions of the department.
25.19 (h) Act as designated guardian of both the estate and the person of all the wards of
25.20 the state of Minnesota, whether by operation of law or by an order of court, without any
25.21 further act or proceeding whatever, except as to persons committed as developmentally
25.22 disabled. For children under the guardianship of the commissioner or a tribe in Minnesota
25.23 recognized by the Secretary of the Interior whose interests would be best served by
25.24 adoptive placement, the commissioner may contract with a licensed child-placing agency
25.25 or a Minnesota tribal social services agency to provide adoption services. A contract
25.26 with a licensed child-placing agency must be designed to supplement existing county
25.27 efforts and may not replace existing county programs or tribal social services, unless the
25.28 replacement is agreed to by the county board and the appropriate exclusive bargaining
25.29 representative, tribal governing body, or the commissioner has evidence that child
25.30 placements of the county continue to be substantially below that of other counties. Funds
25.31 encumbered and obligated under an agreement for a specific child shall remain available
25.32 until the terms of the agreement are fulfilled or the agreement is terminated.
25.33 (i) Act as coordinating referral and informational center on requests for service for
25.34 newly arrived immigrants coming to Minnesota.
25.35 (j) The specific enumeration of powers and duties as hereinabove set forth shall in no
25.36 way be construed to be a limitation upon the general transfer of powers herein contained.

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

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

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

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

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

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

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

27.1 same proportion as that county's value of food stamp benefits issued are to the total of
27.2 all benefits issued for all counties. Each county shall pay its share of the disallowance
27.3 to the state of Minnesota. When a county fails to pay the amount due hereunder, the
27.4 commissioner may deduct the amount from reimbursement otherwise due the county, or
27.5 the attorney general, upon the request of the commissioner, may institute civil action
27.6 to recover the amount due; and

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

27.13 (o) Develop and implement special projects that maximize reimbursements and
27.14 result in the recovery of money to the state. For the purpose of recovering state money,
27.15 the commissioner may enter into contracts with third parties. Any recoveries that result
27.16 from projects or contracts entered into under this paragraph shall be deposited in the
27.17 state treasury and credited to a special account until the balance in the account reaches
27.18 $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be
27.19 transferred and credited to the general fund. All money in the account is appropriated to
27.20 the commissioner for the purposes of this paragraph.

27.21 (p) Have the authority to make direct payments to facilities providing shelter
27.22 to women and their children according to section 256D.05, subdivision 3. Upon
27.23 the written request of a shelter facility that has been denied payments under section
27.24 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make
27.25 a determination within 30 days of the request for review regarding issuance of direct
27.26 payments to the shelter facility. Failure to act within 30 days shall be considered a
27.27 determination not to issue direct payments.

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

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

27.35 (2) the county board shall submit monthly or quarterly reports to the department
27.36 as required by the commissioner. Monthly reports are due no later than 15 working days

28.1 after the end of the month. Quarterly reports are due no later than 30 calendar days after
28.2 the end of the quarter, unless the commissioner determines that the deadline must be
28.3 shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines
28.4 or risking a loss of federal funding. Only reports that are complete, legible, and in the
28.5 required format shall be accepted by the commissioner;

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

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

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

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

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

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

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

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

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

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

29.31 (w) Have the authority to administer a supplemental drug rebate program for drugs
29.32 purchased under the medical assistance program. The commissioner may enter into
29.33 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
29.34 authorization for drugs that are from manufacturers that have not signed a supplemental
29.35 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
29.36 256B.0625, subdivision 13.

30.1 (x) Operate the department's communication systems account established in Laws
30.2 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
30.3 communication costs necessary for the operation of the programs the commissioner
30.4 supervises. A communications account may also be established for each regional
30.5 treatment center which operates communications systems. Each account must be used
30.6 to manage shared communication costs necessary for the operations of the programs the
30.7 commissioner supervises. The commissioner may distribute the costs of operating and
30.8 maintaining communication systems to participants in a manner that reflects actual usage.
30.9 Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and
30.10 other costs as determined by the commissioner. Nonprofit organizations and state, county,
30.11 and local government agencies involved in the operation of programs the commissioner
30.12 supervises may participate in the use of the department's communications technology and
30.13 share in the cost of operation. The commissioner may accept on behalf of the state any
30.14 gift, bequest, devise or personal property of any kind, or money tendered to the state for
30.15 any lawful purpose pertaining to the communication activities of the department. Any
30.16 money received for this purpose must be deposited in the department's communication
30.17 systems accounts. Money collected by the commissioner for the use of communication
30.18 systems must be deposited in the state communication systems account and is appropriated
30.19 to the commissioner for purposes of this section.

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

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

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

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

31.8 (cc) Have the authority to administer a drug rebate program for drugs purchased for
31.9 persons eligible for general assistance medical care under section 256D.03, subdivision 3.
31.10 For manufacturers that agree to participate in the general assistance medical care rebate
31.11 program, the commissioner shall enter into a rebate agreement for covered drugs as
31.12 defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the
31.13 rebate shall be equal to the rebate as defined for purposes of the federal rebate program in
31.14 United States Code, title 42, section 1396r-8. The manufacturers must provide payment
31.15 within the terms and conditions used for the federal rebate program established under
31.16 section 1927 of title XIX of the Social Security Act. The rebate program shall utilize
31.17 the terms and conditions used for the federal rebate program established under section
31.18 1927 of title XIX of the Social Security Act.

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

31.21 (1) are covered under the medical assistance program as described in section
31.22 256B.0625, subdivisions 13 and 13d; and

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

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

31.30 (dd) Designate the agencies that operate the Senior LinkAge Line under section
31.31 256.975, subdivision 7, and the Disability Linkage Line under subdivision 24 as the state
31.32 of Minnesota Aging and the Disability Resource Centers under United States Code, title
31.33 42, section 3001, the Older Americans Act Amendments of 2006 and incorporate cost
31.34 reimbursement claims from the designated centers into the federal cost reimbursement
31.35 claiming processes of the department according to federal law, rule, and regulations. Any
31.36 reimbursement must be appropriated to the commissioner and all Aging and Disability

32.1 Resource Center designated agencies shall receive payments of grant funding that supports
32.2 the activity and generates the federal financial participation according to Board on Aging
32.3 administrative granting mechanisms.

32.4 Sec. 5. Minnesota Statutes 2012, section 256.01, subdivision 24, is amended to read:
32.5 Subd. 24. **Disability Linkage Line.** The commissioner shall establish the Disability
32.6 Linkage Line, to who shall serve people with disabilities as the designated Aging and
32.7 Disability Resource Center under United States Code, title 42, section 3001, the Older
32.8 Americans Act Amendments of 2006 in partnership with the Senior LinkAge Line and
32.9 shall serve as Minnesota's neutral access point for statewide disability information and
32.10 assistance and must be available during business hours through a statewide toll-free
32.11 number and the internet. The Disability Linkage Line shall:
32.12 (1) deliver information and assistance based on national and state standards;
32.13 (2) provide information about state and federal eligibility requirements, benefits,
32.14 and service options;
32.15 (3) provide benefits and options counseling;
32.16 (4) make referrals to appropriate support entities;
32.17 (5) educate people on their options so they can make well-informed choices and link
32.18 them to quality profiles;
32.19 (6) help support the timely resolution of service access and benefit issues;
32.20 (7) inform people of their long-term community services and supports;
32.21 (8) provide necessary resources and supports that can lead to employment and
32.22 increased economic stability of people with disabilities; and
32.23 (9) serve as the technical assistance and help center for the Web-based tool,
32.24 Minnesota's Disability Benefits 101.org.; and
32.25 (10) provide preadmission screening for individuals under 60 years of age who are
32.26 admitted to a nursing facility from a hospital using the procedures as defined in section
32.27 256.975, subdivisions 7a to 7c, and 256B.0911, subdivision 4d.

32.28 Sec. 6. Minnesota Statutes 2012, section 256.975, subdivision 7, is amended to read:
32.29 Subd. 7. **Consumer information and assistance and long-term care options**
32.30 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
32.31 statewide service to aid older Minnesotans and their families in making informed choices
32.32 about long-term care options and health care benefits. Language services to persons
32.33 with limited English language skills may be made available. The service, known as
32.34 Senior LinkAge Line, shall serve older adults as the designated Aging and Disability

33.1 Resource Center under United States Code, title 42, section 3001, the Older Americans
33.2 Act Amendments of 2006 in partnership with the Disability LinkAge Line under section
33.3 256.01, subdivision 24, and must be available during business hours through a statewide
33.4 toll-free number and ~~must also be available through~~ the Internet. The Minnesota Board
33.5 on Aging shall consult with, and when appropriate work through, the area agencies on
33.6 aging to provide and maintain the telephony infrastructure and related support for the
33.7 Aging and Disability Resource Center partners which agree by memorandum to access
33.8 the infrastructure, including the designated providers of the Senior LinkAge Line and the
33.9 Disability Linkage Line.

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

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

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

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

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

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

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

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

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

33.31 (9) incorporate information about the availability of housing options, as well as
33.32 registered housing with services and consumer rights within the MinnesotaHelp.info
33.33 network long-term care database to facilitate consumer comparison of services and costs
33.34 among housing with services establishments and with other in-home services and to
33.35 support financial self-sufficiency as long as possible. Housing with services establishments
33.36 and their arranged home care providers shall provide information that will facilitate price

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

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

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

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

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

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

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

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

35.1 (ii) designated care coordinators of contracted entities under section 256B.035 for
35.2 persons who are enrolled in a managed care plan; or
35.3 (iii) the long-term care consultation team for those who are ~~appropriate~~ eligible
35.4 for relocation service coordination due to high-risk factors or psychological or physical
35.5 disability; and
35.6 (12) develop referral protocols and processes that will assist certified health care
35.7 homes and hospitals to identify at-risk older adults and determine when to refer these
35.8 individuals to the Senior LinkAge Line for long-term care options counseling under this
35.9 section. The commissioner is directed to work with the commissioner of health to develop
35.10 protocols that would comply with the health care home designation criteria and protocols
35.11 available at the time of hospital discharge. The commissioner shall keep a record of the
35.12 number of people who choose long-term care options counseling as a result of this section.

35.13 Sec. 7. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
35.14 to read:
35.15 Subd. 7a. **Preadmission screening activities related to nursing facility**
35.16 **admissions.** (a) All individuals seeking admission to Medicaid certified nursing facilities,
35.17 including certified boarding care facilities, must be screened prior to admission regardless
35.18 of income, assets, or funding sources for nursing facility care, except as described in
35.19 subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the
35.20 need for nursing facility level of care as described in section 256B.0911, subdivision
35.21 4e, and to complete activities required under federal law related to mental illness and
35.22 developmental disability as outlined in paragraph (b).
35.23 (b) A person who has a diagnosis or possible diagnosis of mental illness or
35.24 developmental disability must receive a preadmission screening before admission
35.25 regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify
35.26 the need for further evaluation and specialized services, unless the admission prior to
35.27 screening is authorized by the local mental health authority or the local developmental
35.28 disabilities case manager, or unless authorized by the county agency according to Public
35.29 Law 101-508.
35.30 (c) The following criteria apply to the preadmission screening:
35.31 (1) requests for preadmission screenings must be submitted via an online form
35.32 developed by the commissioner;
35.33 (2) the Senior LinkAge Line must use forms and criteria developed by the
35.34 commissioner to identify persons who require referral for further evaluation and
35.35 determination of the need for specialized services; and

36.1 (3) the evaluation and determination of the need for specialized services must be
36.2 done by:
36.3 (i) a qualified independent mental health professional, for persons with a primary or
36.4 secondary diagnosis of a serious mental illness; or
36.5 (ii) a qualified developmental disability professional, for persons with a primary or
36.6 secondary diagnosis of developmental disability. For purposes of this requirement, a
36.7 qualified developmental disability professional must meet the standards for a qualified
36.8 developmental disability professional under Code of Federal Regulations, title 42, section
36.9 483.430.
36.10 (d) The local county mental health authority or the state developmental disability
36.11 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
36.12 nursing facility if the individual does not meet the nursing facility level of care criteria or
36.13 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
36.14 purposes of this section, "specialized services" for a person with developmental disability
36.15 means active treatment as that term is defined under Code of Federal Regulations, title
36.16 42, section 483.440(a)(1).
36.17 (e) In assessing a person's needs, the screener shall:
36.18 (1) use an automated system designated by the commissioner;
36.19 (2) consult with care transitions coordinators or physician; and
36.20 (3) consider the assessment of the individual's physician.
36.21 Other personnel may be included in the level of care determination as deemed
36.22 necessary by the screener.

36.23 Sec. 8. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
36.24 to read:
36.25 Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal
36.26 screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:
36.27 (1) a person who, having entered an acute care facility from a certified nursing
36.28 facility, is returning to a certified nursing facility; or
36.29 (2) a person transferring from one certified nursing facility in Minnesota to another
36.30 certified nursing facility in Minnesota.
36.31 (b) Persons who are exempt from preadmission screening for purposes of level of
36.32 care determination include:
36.33 (1) persons described in paragraph (a);
36.34 (2) an individual who has a contractual right to have nursing facility care paid for
36.35 indefinitely by the Veterans' Administration;

37.1 (3) an individual enrolled in a demonstration project under section 256B.69,
37.2 subdivision 8, at the time of application to a nursing facility; and
37.3 (4) an individual currently being served under the alternative care program or under
37.4 a home and community-based services waiver authorized under section 1915(c) of the
37.5 federal Social Security Act.
37.6 (c) Persons admitted to a Medicaid-certified nursing facility from the community
37.7 on an emergency basis as described in paragraph (d) or from an acute care facility on a
37.8 nonworking day must be screened the first working day after admission.
37.9 (d) Emergency admission to a nursing facility prior to screening is permitted when
37.10 all of the following conditions are met:
37.11 (1) a person is admitted from the community to a certified nursing or certified
37.12 boarding care facility during Senior LinkAge Line nonworking hours for ages 60 and
37.13 older and Disability Linkage Line nonworking hours for under age 60;
37.14 (2) a physician has determined that delaying admission until preadmission screening
37.15 is completed would adversely affect the person's health and safety;
37.16 (3) there is a recent precipitating event that precludes the client from living safely in
37.17 the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's
37.18 inability to continue to provide care;
37.19 (4) the attending physician has authorized the emergency placement and has
37.20 documented the reason that the emergency placement is recommended; and
37.21 (5) the Senior LinkAge Line or Disability Linkage Line is contacted on the first
37.22 working day following the emergency admission.
37.23 Transfer of a patient from an acute care hospital to a nursing facility is not considered
37.24 an emergency except for a person who has received hospital services in the following
37.25 situations: hospital admission for observation, care in an emergency room without hospital
37.26 admission, or following hospital 24-hour bed care and from whom admission is being
37.27 sought on a nonworking day.
37.28 (e) A nursing facility must provide written information to all persons admitted
37.29 regarding the person's right to request and receive long-term care consultation services as
37.30 defined in section 256B.0911, subdivision 1a. The information must be provided prior to
37.31 the person's discharge from the facility and in a format specified by the commissioner.

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

38.1 Subd. 7c. **Screening requirements.** (a) A person may be screened for nursing
38.2 facility admission by telephone or in a face-to-face screening interview. The Senior
38.3 LinkAge Line shall identify each individual's needs using the following categories:
38.4 (1) the person needs no face-to-face long-term care consultation assessment
38.5 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
38.6 managed care organization under contract with the Department of Human Services to
38.7 determine the need for nursing facility level of care based on information obtained from
38.8 other health care professionals;
38.9 (2) the person needs an immediate face-to-face long-term care consultation
38.10 assessment completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county,
38.11 tribe, or managed care organization under contract with the Department of Human
38.12 Services to determine the need for nursing facility level of care and complete activities
38.13 required under subdivision 7a; or
38.14 (3) the person may be exempt from screening requirements as outlined in subdivision
38.15 7b, but will need transitional assistance after admission or in-person follow-along after
38.16 a return home.
38.17 (b) Individuals between the ages of 60 and 64 who are admitted to nursing facilities
38.18 with only a telephone screening must receive a face-to-face assessment from the long-term
38.19 care consultation team member of the county in which the facility is located or from the
38.20 recipient's county case manager within 40 calendar days of admission as described in
38.21 section 256B.0911, subdivision 4d, paragraph (c).
38.22 (c) Persons admitted on a nonemergency basis to a Medicaid-certified nursing
38.23 facility must be screened prior to admission.
38.24 (d) Screenings provided by the Senior LinkAge Line must include processes
38.25 to identify persons who may require transition assistance described in subdivision 7,
38.26 paragraph (b), clause (12), and section 256B.0911, subdivision 3b.

38.27 Sec. 10. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
38.28 to read:
38.29 Subd. 7d. **Payment for preadmission screening.** Funding for preadmission
38.30 screening shall be provided to the Minnesota Board on Aging for the population 60
38.31 years of age and older by the Department of Human Services to cover screener salaries
38.32 and expenses to provide the services described in subdivisions 7a to 7c. The Minnesota
38.33 Board on Aging shall employ, or contract with other agencies to employ, within the limits
38.34 of available funding, sufficient personnel to provide preadmission screening and level of

39.1 care determination services and shall seek to maximize federal funding for the service as
39.2 provided under section 256.01, subdivision 2, paragraph (dd).

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

39.5 Subd. 3a. **Priority for other grants.** The commissioner of health shall give
39.6 priority to a grantee selected under subdivision 3 when awarding technology-related
39.7 grants, if the grantee is using technology as a part of a proposal. The commissioner
39.8 of transportation shall give priority to a grantee selected under subdivision 3 when
39.9 distributing transportation-related funds to create transportation options for older adults.

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

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

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

39.16 Subd. 5. **Grant preference.** The commissioner of human services shall give
39.17 preference when awarding grants under this section to areas where nursing facility
39.18 closures have occurred or are occurring or areas with service needs identified by section
39.19 144A.351. The commissioner may award grants to the extent grant funds are available
39.20 and to the extent applications are approved by the commissioner. Denial of approval of an
39.21 application in one year does not preclude submission of an application in a subsequent
39.22 year. The maximum grant amount is limited to $750,000.

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

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

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

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

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

40.1 Sec. 15. Minnesota Statutes 2012, section 256B.021, is amended by adding a
40.2 subdivision to read:
40.3 Subd. 6. **Work, empower, and encourage independence.** As provided under
40.4 subdivision 4, paragraph (e), upon federal approval, the commissioner shall establish a
40.5 demonstration project to provide navigation, employment supports, and benefits planning
40.6 services to a targeted group of federally funded Medicaid recipients to begin July 1, 2014.
40.7 This demonstration shall promote economic stability, increase independence, and reduce
40.8 applications for disability benefits while providing a positive impact on the health and
40.9 future of participants.

40.10 Sec. 16. Minnesota Statutes 2012, section 256B.021, is amended by adding a
40.11 subdivision to read:
40.12 Subd. 7. **Housing stabilization.** As provided under subdivision 4, paragraph (e),
40.13 upon federal approval, the commissioner shall establish a demonstration project to provide
40.14 service coordination, outreach, in-reach, tenancy support, and community living assistance
40.15 to a targeted group of federally funded Medicaid recipients to begin January 1, 2014. This
40.16 demonstration shall promote housing stability, reduce costly medical interventions, and
40.17 increase opportunities for independent community living.

40.18 Sec. 17. Minnesota Statutes 2012, section 256B.0911, subdivision 1, is amended to read:
40.19 Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation
40.20 services is to assist persons with long-term or chronic care needs in making care
40.21 decisions and selecting support and service options that meet their needs and reflect
40.22 their preferences. The availability of, and access to, information and other types of
40.23 assistance, including assessment and support planning, is also intended to prevent or delay
40.24 institutional placements and to provide access to transition assistance after admission.
40.25 Further, the goal of these services is to contain costs associated with unnecessary
40.26 institutional admissions. Long-term consultation services must be available to any person
40.27 regardless of public program eligibility. The commissioner of human services shall seek
40.28 to maximize use of available federal and state funds and establish the broadest program
40.29 possible within the funding available.
40.30 (b) These services must be coordinated with long-term care options counseling
40.31 provided under subdivision 4d, section 256.975, ~~subdivision~~ subdivisions 7 to 7c, and
40.32 section 256.01, subdivision 24. The lead agency providing long-term care consultation
40.33 services shall encourage the use of volunteers from families, religious organizations, social
40.34 clubs, and similar civic and service organizations to provide community-based services.

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

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

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

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

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

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

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

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

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

41.18 ~~(7)~~ (6) determination of home and community-based waiver and other service
41.19 eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level
41.20 of care determination for individuals who need an institutional level of care as determined
41.21 under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, based on assessment and
41.22 community support plan development, appropriate referrals to obtain necessary diagnostic
41.23 information, and including an eligibility determination for consumer-directed community
41.24 supports;

41.25 ~~(8)~~ (7) providing recommendations for institutional placement when there are no
41.26 cost-effective community services available;

41.27 ~~(9)~~ (8) providing access to assistance to transition people back to community settings
41.28 after institutional admission; and

41.29 ~~(10)~~ (9) providing information about competitive employment, with or without
41.30 supports, for school-age youth and working-age adults and referrals to the Disability
41.31 Linkage Line and Disability Benefits 101 to ensure that an informed choice about
41.32 competitive employment can be made. For the purposes of this subdivision, "competitive
41.33 employment" means work in the competitive labor market that is performed on a full-time
41.34 or part-time basis in an integrated setting, and for which an individual is compensated at or
41.35 above the minimum wage, but not less than the customary wage and level of benefits paid
41.36 by the employer for the same or similar work performed by individuals without disabilities.

42.1 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
42.2 2c, and 3a, "long-term care consultation services" also means:
42.3 (1) service eligibility determination for state plan home care services identified in:
42.4 (i) section 256B.0625, subdivisions 7, 19a, and 19c;
42.5 (ii) section 256B.0657; or
42.6 (iii) consumer support grants under section 256.476;
42.7 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
42.8 determination of eligibility for case management services available under sections
42.9 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
42.10 9525.0016;
42.11 (3) determination of institutional level of care, home and community-based service
42.12 waiver, and other service eligibility as required under section 256B.092, determination
42.13 of eligibility for family support grants under section 252.32, semi-independent living
42.14 services under section 252.275, and day training and habilitation services under section
42.15 256B.092; and
42.16 (4) obtaining necessary diagnostic information to determine eligibility under clauses
42.17 (2) and (3).
42.18 (c) "Long-term care options counseling" means the services provided by the linkage
42.19 lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and
42.20 also includes telephone assistance and follow up once a long-term care consultation
42.21 assessment has been completed.
42.22 (d) "Minnesota health care programs" means the medical assistance program under
42.23 chapter 256B and the alternative care program under section 256B.0913.
42.24 (e) "Lead agencies" means counties administering or tribes and health plans under
42.25 contract with the commissioner to administer long-term care consultation assessment and
42.26 support planning services.

42.27 Sec. 19. Minnesota Statutes 2012, section 256B.0911, subdivision 3a, is amended to
42.28 read:
42.29 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
42.30 services planning, or other assistance intended to support community-based living,
42.31 including persons who need assessment in order to determine waiver or alternative care
42.32 program eligibility, must be visited by a long-term care consultation team within 20
42.33 calendar days after the date on which an assessment was requested or recommended.
42.34 Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also
42.35 applies to an assessment of a person requesting personal care assistance services and

43.1 private duty nursing. The commissioner shall provide at least a 90-day notice to lead
43.2 agencies prior to the effective date of this requirement. Face-to-face assessments must be
43.3 conducted according to paragraphs (b) to (i).

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

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

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

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

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

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

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

43.36 (4) referral information; and

44.1 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

44.24 (3) the need for and purpose of preadmission screening conducted by long-term
44.25 care options counselors according to section 256.975, subdivisions 7a to 7c, and section
44.26 256.01, subdivision 24, if the person selects nursing facility placement. If the individual
44.27 selects nursing facility placement, the lead agency shall forward information needed to
44.28 complete the level of care determinations and screening for developmental disability and
44.29 mental illness collected during the assessment to the long-term care options counselor
44.30 using forms provided by the commissioner;

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

44.35 (5) information about Minnesota health care programs;

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

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

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

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

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

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

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

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

(b) Individuals under ~~65~~ 60 years of age who are admitted to a nursing facility from a hospital must be screened prior to admission ~~as outlined in subdivisions 4a through 4c~~ according to the requirements outlined in section 256.975, subdivisions 7a

46.1 to 7c. This shall be provided by the Disability Linkage Line as required under section
46.2 256.01, subdivision 24.
46.3 (c) Individuals under 65 years of age who are admitted to nursing facilities with
46.4 only a telephone screening must receive a face-to-face assessment from the long-term
46.5 care consultation team member of the county in which the facility is located or from the
46.6 recipient's county case manager within 40 calendar days of admission.
46.7 ~~(d) Individuals under 65 years of age who are admitted to a nursing facility~~
46.8 ~~without preadmission screening according to the exemption described in subdivision 4b,~~
46.9 ~~paragraph (a), clause (3), and who remain in the facility longer than 30 days must receive~~
46.10 ~~a face-to-face assessment within 40 days of admission.~~
46.11 ~~(e)~~ (d) At the face-to-face assessment, the long-term care consultation team member
46.12 or county case manager must perform the activities required under subdivision 3b.
46.13 ~~(f)~~ (e) For individuals under 21 years of age, a screening interview which
46.14 recommends nursing facility admission must be face-to-face and approved by the
46.15 commissioner before the individual is admitted to the nursing facility.
46.16 ~~(g)~~ (f) In the event that an individual under ~~65~~ 60 years of age is admitted to a
46.17 nursing facility on an emergency basis, the ~~county~~ Disability Linkage Line must be
46.18 notified of the admission on the next working day, and a face-to-face assessment as
46.19 described in paragraph (c) must be conducted within 40 calendar days of admission.
46.20 ~~(h)~~ (g) At the face-to-face assessment, the long-term care consultation team member
46.21 or the case manager must present information about home and community-based options,
46.22 including consumer-directed options, so the individual can make informed choices. If the
46.23 individual chooses home and community-based services, the long-term care consultation
46.24 team member or case manager must complete a written relocation plan within 20 working
46.25 days of the visit. The plan shall describe the services needed to move out of the facility
46.26 and a time line for the move which is designed to ensure a smooth transition to the
46.27 individual's home and community.
46.28 ~~(i)~~ (h) An individual under 65 years of age residing in a nursing facility shall receive
46.29 a face-to-face assessment at least every 12 months to review the person's service choices
46.30 and available alternatives unless the individual indicates, in writing, that annual visits are
46.31 not desired. In this case, the individual must receive a face-to-face assessment at least
46.32 once every 36 months for the same purposes.
46.33 ~~(j)~~ (i) Notwithstanding the provisions of subdivision 6, the commissioner may pay
46.34 county agencies directly for face-to-face assessments for individuals under 65 years of age
46.35 who are being considered for placement or residing in a nursing facility.

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

47.8 Sec. 21. Minnesota Statutes 2012, section 256B.0911, is amended by adding a
47.9 subdivision to read:
47.10 Subd. 4e. **Determination of institutional level of care.** The determination of the
47.11 need for nursing facility, hospital, and intermediate care facility levels of care must be
47.12 made according to criteria developed by the commissioner, and in section 256B.092,
47.13 using forms developed by the commissioner. Effective January 1, 2014, for individuals
47.14 age 21 and older, the determination of need for nursing facility level of care shall be
47.15 based on criteria in section 144.0724, subdivision 11. For individuals under age 21, the
47.16 determination of the need for nursing facility level of care must be made according to
47.17 criteria developed by the commissioner until criteria in section 144.0724, subdivision 11,
47.18 becomes effective on or after October 1, 2019.

47.19 Sec. 22. Minnesota Statutes 2012, section 256B.0911, subdivision 7, is amended to read:
47.20 Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance
47.21 reimbursement for nursing facilities shall be authorized for a medical assistance recipient
47.22 only if a preadmission screening has been conducted prior to admission or the county has
47.23 authorized an exemption. Medical assistance reimbursement for nursing facilities shall
47.24 not be provided for any recipient who the local screener has determined does not meet the
47.25 level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or,
47.26 if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus
47.27 Budget Reconciliation Act of 1987 completed unless an admission for a recipient with
47.28 mental illness is approved by the local mental health authority or an admission for a
47.29 recipient with developmental disability is approved by the state developmental disability
47.30 authority.
47.31 (b) The nursing facility must not bill a person who is not a medical assistance
47.32 recipient for resident days that preceded the date of completion of screening activities
47.33 as required under section 256.975, subdivisions ~~4a, 4b, and 4c~~ 7a to 7c. The nursing

48.1 facility must include unreimbursed resident days in the nursing facility resident day totals
48.2 reported to the commissioner.

48.3 Sec. 23. Minnesota Statutes 2012, section 256B.0913, subdivision 4, is amended to read:
48.4 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**
48.5 (a) Funding for services under the alternative care program is available to persons who
48.6 meet the following criteria:
48.7 (1) the person has been determined by a community assessment under section
48.8 256B.0911 to be a person who would require the level of care provided in a nursing
48.9 facility, as determined under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, but for
48.10 the provision of services under the alternative care program;
48.11 (2) the person is age 65 or older;
48.12 (3) the person would be eligible for medical assistance within 135 days of admission
48.13 to a nursing facility;
48.14 (4) the person is not ineligible for the payment of long-term care services by the
48.15 medical assistance program due to an asset transfer penalty under section 256B.0595 or
48.16 equity interest in the home exceeding $500,000 as stated in section 256B.056;
48.17 (5) the person needs long-term care services that are not funded through other
48.18 state or federal funding, or other health insurance or other third-party insurance such as
48.19 long-term care insurance;
48.20 (6) except for individuals described in clause (7), the monthly cost of the alternative
48.21 care services funded by the program for this person does not exceed 75 percent of the
48.22 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
48.23 does not prohibit the alternative care client from payment for additional services, but in no
48.24 case may the cost of additional services purchased under this section exceed the difference
48.25 between the client's monthly service limit defined under section 256B.0915, subdivision
48.26 3, and the alternative care program monthly service limit defined in this paragraph. If
48.27 care-related supplies and equipment or environmental modifications and adaptations are or
48.28 will be purchased for an alternative care services recipient, the costs may be prorated on a
48.29 monthly basis for up to 12 consecutive months beginning with the month of purchase.
48.30 If the monthly cost of a recipient's other alternative care services exceeds the monthly
48.31 limit established in this paragraph, the annual cost of the alternative care services shall be
48.32 determined. In this event, the annual cost of alternative care services shall not exceed 12
48.33 times the monthly limit described in this paragraph;
48.34 (7) for individuals assigned a case mix classification A as described under section
48.35 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily

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

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

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

49.15 (i) the appointment of a representative payee;

49.16 (ii) automatic payment from a financial account;

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

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

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

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

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

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

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

50.13 Subd. 17. **Essential community supports grants.** (a) Notwithstanding subdivisions
50.14 1 to 14, the purpose of the essential community supports grant program is to provide
50.15 targeted services to persons age 65 and older who need essential community support, but
50.16 whose needs do not meet the level of care required for nursing facility placement under
50.17 section 144.0724, subdivision 11.

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

50.21 (1) is age 65 or older;

50.22 (2) is not eligible for medical assistance;

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

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

50.27 (5) has a community support plan; and

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

50.32 (i) caregiver support;

50.33 (ii) homemaker support;

50.34 (iii) chores; or

50.35 (iv) a personal emergency response device or system.

51.1 (c) The person receiving any of the essential community supports in this subdivision
51.2 must also receive service coordination, not to exceed $600 in a 12-month authorization
51.3 period, as part of their community support plan.
51.4 (d) A person who has been determined to be eligible for an essential community
51.5 supports grant must be reassessed at least annually and continue to meet the criteria in
51.6 paragraph (b) to remain eligible for an essential community supports grant.
51.7 (e) The commissioner is authorized to use federal matching funds for essential
51.8 community supports as necessary and to meet demand for essential community supports
51.9 grants as outlined in paragraphs (f) and (g), and that amount of federal funds is
51.10 appropriated to the commissioner for this purpose.
51.11 (f) Upon federal approval and following a reasonable implementation period
51.12 determined by the commissioner, essential community supports are available to an
51.13 individual who:
51.14 (1) is receiving nursing facility services or home and community-based long-term
51.15 services and supports under section 256B.0915 or 256B.49 on the effective date of
51.16 implementation of the revised nursing facility level of care under section 144.0724,
51.17 subdivision 11;
51.18 (2) meets one of the following criteria:
51.19 (i) due to the implementation of the revised nursing facility level of care, loses
51.20 eligibility for continuing medical assistance payment of nursing facility services at the
51.21 first reassessment under section 144.0724, subdivision 11, paragraph (b), that occurs on or
51.22 after the effective date of the revised nursing facility level of care criteria under section
51.23 144.0724, subdivision 11; or
51.24 (ii) due to the implementation of the revised nursing facility level of care, loses
51.25 eligibility for continuing medical assistance payment of home and community-based
51.26 long-term services and supports under section 256B.0915 or 256B.49 at the first
51.27 reassessment required under those sections that occurs on or after the effective date of
51.28 implementation of the revised nursing facility level of care under section 144.0724,
51.29 subdivision 11;
51.30 (3) is not eligible for personal care attendant services; and
51.31 (4) has an assessed need for one or more of the supportive services offered under
51.32 essential community supports.
51.33 Individuals eligible under this paragraph includes individuals who continue to be
51.34 eligible for medical assistance state plan benefits and those who are not or are no longer
51.35 financially eligible for medical assistance.

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

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

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

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

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

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

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

53.1 (c) If extended medical supplies and equipment or environmental modifications are
53.2 or will be purchased for an elderly waiver client, the costs may be prorated for up to
53.3 12 consecutive months beginning with the month of purchase. If the monthly cost of a
53.4 recipient's waivered services exceeds the monthly limit established in paragraph (a) or
53.5 (b), the annual cost of all waivered services shall be determined. In this event, the annual
53.6 cost of all waivered services shall not exceed 12 times the monthly limit of waivered
53.7 services as described in paragraph (a) or (b).

53.8 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
53.9 any necessary home care services described in section 256B.0651, subdivision 2, for
53.10 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
53.11 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
53.12 amount established for home care services as described in section 256B.0652, subdivision
53.13 7, and the annual average contracted amount established by the commissioner for nursing
53.14 facility services for ventilator-dependent individuals. This monthly limit shall be increased
53.15 annually as described in paragraph (a).

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

53.18 Subd. 3j. **Individual community living support.** Upon federal approval, there
53.19 is established a new service called individual community living support (ICLS) that is
53.20 available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor
53.21 have any interest in the recipient's housing. ICLS must be delivered in a single-family
53.22 home or apartment where the service recipient or their family owns or rents, as
53.23 demonstrated by a lease agreement, and maintains control over the individual unit. Case
53.24 managers or care coordinators must develop individual ICLS plans in consultation with
53.25 the client using a tool developed by the commissioner. The commissioner shall establish
53.26 payment rates and mechanisms to align payments with the type and amount of service
53.27 provided, assure statewide uniformity, and assure cost-effectiveness. ICLS shall not be
53.28 considered home care services for purposes of section 144A.43.

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

53.30 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
53.31 shall receive an initial assessment of strengths, informal supports, and need for services
53.32 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
53.33 client served under the elderly waiver must be conducted at least every 12 months and at
53.34 other times when the case manager determines that there has been significant change in

54.1 the client's functioning. This may include instances where the client is discharged from
54.2 the hospital. There must be a determination that the client requires nursing facility level
54.3 of care as defined in section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, at initial and
54.4 subsequent assessments to initiate and maintain participation in the waiver program.

54.5 (b) Regardless of other assessments identified in section 144.0724, subdivision
54.6 4, as appropriate to determine nursing facility level of care for purposes of medical
54.7 assistance payment for nursing facility services, only face-to-face assessments conducted
54.8 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
54.9 level of care determination will be accepted for purposes of initial and ongoing access to
54.10 waiver service payment.

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

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

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

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

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

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

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

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

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

55.1 (8) strengthen and develop additional home and community-based services and
55.2 alternatives to nursing homes and other residential services; and
55.3 (9) strengthen programs that use volunteers.
55.4 (b) The services provided by these projects are available to older adults who are
55.5 eligible for medical assistance and the elderly waiver under section 256B.0915, the
55.6 alternative care program under section 256B.0913, or essential community supports grant
55.7 under subdivision 14, paragraph (b), and to persons who have their own funds to pay for
55.8 services.

55.9 Sec. 29. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
55.10 subdivision to read:
55.11 Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have
55.12 the meanings given.
55.13 (b) "Community" means a town; township; city; or targeted neighborhood within a
55.14 city; or a consortium of towns, townships, cities, or specific neighborhoods within a city.
55.15 (c) "Core home and community-based services provider" means a Faith in Action,
55.16 Living at Home Block Nurse, Congregational Nurse, or similar community-based program
55.17 that organizes and uses volunteers and paid staff to deliver nonmedical services intended
55.18 to assist older adults to identify and manage risks and to maintain their community living
55.19 and integration in the community.
55.20 (d) "Eldercare development partnership" means a team of representatives of county
55.21 social service and public health agencies, the area agency on aging, local nursing home
55.22 providers, local home care providers, and other appropriate home and community-based
55.23 providers in the area agency's planning and service area.
55.24 (e) "Long-term services and supports" means any service available under the
55.25 elderly waiver program or alternative care grant programs; nursing facility services;
55.26 transportation services; caregiver support and respite care services; and other home and
55.27 community-based services identified as necessary either to maintain lifestyle choices for
55.28 older adults or to support them to remain in their own home.
55.29 (f) "Older adult" refers to an individual who is 65 years of age or older.

55.30 Sec. 30. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
55.31 subdivision to read:
55.32 Subd. 1c. **Eldercare development partnerships.** The commissioner of human
55.33 services shall select and contract with eldercare development partnerships sufficient to

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

56.17 Sec. 31. Minnesota Statutes 2012, section 256B.0917, subdivision 6, is amended to read:
56.18 Subd. 6. **Caregiver support and respite care projects.** (a) The commissioner
56.19 shall establish ~~up to 36~~ projects to expand the ~~respite care network in the state and to~~
56.20 ~~support caregivers in their responsibilities for care. The purpose of each project shall~~
56.21 ~~be to~~ availability of caregiver support and respite care services for family and other
56.22 caregivers. The commissioner shall use a request for proposals to select nonprofit entities
56.23 to administer the projects. Projects shall:
56.24 (1) establish a local coordinated network of volunteer and paid respite workers;
56.25 (2) coordinate assignment of respite ~~workers~~ care services to ~~clients and care~~
56.26 ~~receivers and assure the health and safety of the client; and~~ caregivers of older adults;
56.27 ~~(3) provide training for caregivers and ensure that support groups are available~~
56.28 ~~in the community.~~
56.29 (3) assure the health and safety of the older adults;
56.30 (4) identify at-risk caregivers;
56.31 (5) provide information, education, and training for caregivers in the designated
56.32 community; and
56.33 (6) demonstrate the need in the proposed service area particularly where nursing
56.34 facility closures have occurred or are occurring or areas with service needs identified

57.1 by section 144A.351. Preference must be given for projects that reach underserved
57.2 populations.

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

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

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

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

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

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

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

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

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

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

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

57.30 (2) recruit and train volunteer providers;

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

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

57.33 ~~(5)~~ (4) advertise the availability of the caregiver support and respite care project; and

57.34 ~~(6)~~ (5) purchase equipment to maintain a system of assigning workers to clients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

59.11 (1) conduct a functional assessment of the crisis incident as defined in section
59.12 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
59.13 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
59.14 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

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

59.27 Subdivision 1. **Development and implementation of quality profiles.** (a) The
59.28 commissioner of human services, in cooperation with the commissioner of health,
59.29 shall develop and implement ~~a~~ quality ~~profile system~~ profiles for nursing facilities and,
59.30 beginning not later than July 1, ~~2004~~ 2014, other providers of long-term care services,
59.31 except when the quality profile system would duplicate requirements under section
59.32 256B.5011, 256B.5012, or 256B.5013. The ~~system~~ quality profiles must be developed
59.33 ~~and implemented to the extent possible without the collection of significant amounts of~~
59.34 ~~new data. To the extent possible, the system~~ using existing data sets maintained by the
59.35 commissioners of health and human services to the extent possible. The profiles must

incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The ~~system~~ profiles must be designed to provide information on quality to:

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

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

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

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

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

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

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

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

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

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

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

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

61.1 Subd. 3a. **Home and community-based services report card in cooperation with**
61.2 **the commissioner of health.** The profiles developed for home and community-based
61.3 services providers under this section shall be incorporated into a report card and
61.4 maintained by the Minnesota Board on Aging pursuant to section 256.975, subdivision
61.5 7, paragraph (b), clause (2), as data becomes available. The commissioner, in
61.6 cooperation with the commissioner of health, shall use consumer choice, quality of life,
61.7 care approaches, and cost or flexible purchasing categories to organize the consumer
61.8 information in the profiles. The final categories used shall include consumer input and
61.9 survey data to the extent that is available through the state agencies. The commissioner
61.10 shall develop and disseminate the qualify profiles for a limited number of provider types
61.11 initially, and develop quality profiles for additional provider types as measurement tools
61.12 are developed and data becomes available. This includes providers of services to older
61.13 adults and people with disabilities, regardless of payor source.

61.14 Sec. 39. Minnesota Statutes 2012, section 256B.439, subdivision 4, is amended to read:
61.15 Subd. 4. **Dissemination of quality profiles.** By July 1, ~~2003~~ 2014, the
61.16 commissioners shall implement a ~~system~~ public awareness effort to disseminate the quality
61.17 profiles ~~developed from consumer surveys using the quality measurement tool~~. Profiles
61.18 may be disseminated ~~to~~ through the Senior LinkAge Line and Disability Linkage Line and
61.19 to consumers, providers, and purchasers of long-term care services ~~through all feasible~~
61.20 ~~printed and electronic outlets. The commissioners may conduct a public awareness~~
61.21 ~~campaign to inform potential users regarding profile contents and potential uses~~.

61.22 Sec. 40. Minnesota Statutes 2012, section 256B.49, subdivision 12, is amended to read:
61.23 Subd. 12. **Informed choice.** Persons who are determined likely to require the level
61.24 of care provided in a nursing facility as determined under section 256B.0911, subdivision
61.25 4e, or a hospital shall be informed of the home and community-based support alternatives
61.26 to the provision of inpatient hospital services or nursing facility services. Each person
61.27 must be given the choice of either institutional or home and community-based services
61.28 using the provisions described in section 256B.77, subdivision 2, paragraph (p).

61.29 Sec. 41. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:
61.30 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments
61.31 shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.
61.32 With the permission of the recipient or the recipient's designated legal representative,
61.33 the recipient's current provider of services may submit a written report outlining their

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

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

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

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

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

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

Subd. 25. **Reduce avoidable behavioral crisis emergency room, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have two or more

63.1 admissions within a calendar year to an emergency room, psychiatric unit, or institution
63.2 must receive consultation from a mental health professional as defined in section 245.462,
63.3 subdivision 18, or a behavioral professional as defined in the home and community-based
63.4 services state plan within 30 days of discharge. The mental health professional or
63.5 behavioral professional must:

63.6 (1) conduct a functional assessment of the crisis incident as defined in section
63.7 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
63.8 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
63.9 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

63.20 Sec. 43. **[256B.85] COMMUNITY FIRST SERVICES AND SUPPORTS.**

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

63.25 (b) CFSS is a participant-controlled method of selecting and providing services
63.26 and supports that allows the participant maximum control of the services and supports.
63.27 Participants may choose the degree to which they direct and manage their supports
63.28 by choosing to have a significant and meaningful role in the management of services
63.29 and supports including acting as the employer of record with the necessary supports
63.30 to perform that function.

63.31 (c) CFSS is available statewide to eligible individuals to assist with accomplishing
63.32 activities of daily living (ADLs), instrumental activities of daily living (IADLs), and
63.33 health-related procedures and tasks through hands-on assistance to complete the task or
63.34 supervision and cueing to complete the task; and to assist with acquiring, maintaining, and
63.35 enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures

64.1 and tasks. CFSS allows payment for certain supports and goods such as environmental
64.2 modifications and technology that are intended to replace or decrease the need for human
64.3 assistance.

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

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

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

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

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

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

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

64.26 (g) "Community first services and supports service delivery plan" or "service delivery
64.27 plan" means a written summary of the services and supports, that is based on the community
64.28 support plan identified in section 256B.0911 and coordinated services and support plan
64.29 and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined
64.30 by the participant to meet the assessed needs, using a person-centered planning process.

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

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

64.35 (j) "Financial management services contractor or vendor" means a qualified
64.36 organization having a written contract with the department to provide services necessary

65.1 to use the flexible spending model under subdivision 13, that include but are not limited
65.2 to: participant education and technical assistance; CFSS service delivery planning and
65.3 budgeting; billing, making payments, and monitoring of spending; and assisting the
65.4 participant in fulfilling regulatory requirements when acting as an employer of record for
65.5 support workers or employer agent, that are in accordance with Section 3504 of the IRS
65.6 code and the IRS Revenue Procedure 70-6.

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

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

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

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

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

65.27 (1) under the direction of the participant or the participant's representative, bringing
65.28 medications to the participant including medications given through a nebulizer, opening a
65.29 container of previously set up medications, emptying the container into the participant's
65.30 hand, opening and giving the medication in the original container to the participant, or
65.31 bringing to the participant liquids or food to accompany the medication;

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

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

65.35 (p) "Participant's representative" means a parent, family member, advocate, or
65.36 other adult authorized by the participant to serve as a representative in connection with

66.1 the provision of CFSS. This authorization must be in writing or by another method
66.2 that clearly indicates the participant's free choice. The participant's representative must
66.3 have no financial interest in the provision of any services included in the participant's
66.4 service delivery plan and must be capable of providing the support necessary to assist
66.5 the participant in the use of CFSS. If through the assessment process described in
66.6 subdivision 5 a participant is determined to be in need of a participant's representative, one
66.7 must be selected. If the participant is unable to assist in the selection of a participant's
66.8 representative, the legal representative shall appoint one. Two persons may be designated
66.9 as a participant's representative for reasons such as divided households and court-ordered
66.10 custodies. Duties of a participant's representatives may include:

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

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

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

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

66.21 (1) include people chosen by the participant;

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

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

66.26 (4) reflect cultural considerations of the participant;

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

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

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

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

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

67.1 (s) "Support specialist" means a professional with the skills and ability to assist the
67.2 participant using either the agency provider model under subdivision 11 or the flexible
67.3 spending model under subdivision 13, in services including, but not limited to:
67.4 (1) the development, implementation, and evaluation of the CFSS service delivery
67.5 plan under subdivision 6;
67.6 (2) recruitment, training, or supervision, including supervision of health-related
67.7 tasks or behavioral supports appropriately delegated by a health care professional, and
67.8 evaluation of support workers; and
67.9 (3) facilitating the use of informal and community supports, goods, or resources.
67.10 (t) "Support worker" means a regular or temporary employee of the agency-provider,
67.11 the financial management services contractor, or the participant who has direct contact
67.12 with the participant and provides services as specified within the participant's service
67.13 delivery plan.
67.14 (u) "Wages and benefits" means the hourly wages and salaries, the employer's
67.15 share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers'
67.16 compensation, mileage reimbursement, health and dental insurance, life insurance,
67.17 disability insurance, long-term care insurance, uniform allowance, and contributions to
67.18 employee retirement accounts.
67.19 Subd. 3. **Eligibility.** CFSS is available to a person who meets one of the following:
67.20 (1) is a recipient of medical assistance as determined under section 256B.055,
67.21 256B.056, or 256B.057, subdivisions 5 and 9;
67.22 (2) is a recipient of the alternative care program under section 256B.0913;
67.23 (3) is a waiver recipient as defined under section 256B.0915, 256B.092, 256B.093,
67.24 or 256B.49; or
67.25 (4) has medical services identified in a participant's individualized education
67.26 program and is eligible for services as determined in section 256B.0625, subdivision 26.
67.27 (b) In addition to meeting the eligibility criteria in paragraph (a), a person must also
67.28 meet all of the following:
67.29 (1) is determined eligible based on assessment under section 256B.0911;
67.30 (2) is not a recipient under the family support grant under section 252.32;
67.31 (3) lives in the person's own apartment or home including a family foster care setting
67.32 licensed under chapter 245A, but not in corporate foster care under chapter 245A; or a
67.33 noncertified boarding care or boarding and lodging establishments under chapter 157;
67.34 unless transitioning into the community from an institution; and
67.35 (4) has not been excluded or disenrolled from the flexible spending model.

68.1 (c) The commissioner shall disenroll or exclude participants from the flexible
68.2 spending model and transfer them to the agency-provider model under the following
68.3 circumstances that include but are not limited to:
68.4 (1) when a participant has been restricted by the Minnesota restricted recipient
68.5 program, the participant may be excluded for a specified time period;
68.6 (2) when a participant exits the flexible spending service delivery model during the
68.7 participant's service plan year. Upon transfer, the participant shall not access the flexible
68.8 spending model for the remainder of that service plan year; or
68.9 (3) when the department determines that the participant or participant's representative
68.10 or legal representative cannot manage participant responsibilities under the service
68.11 delivery model. The commissioner must develop policies for determining if a participant
68.12 is unable to manage responsibilities under a service model.
68.13 (d) A participant may appeal in writing to the department to contest the department's
68.14 decision under paragraph (c), clause (3), to remove or exclude the participant from the
68.15 flexible spending model.
68.16 Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not
68.17 restrict access to other medically necessary care and services furnished under the state
68.18 plan medical assistance benefit or other services available through alternative care.
68.19 Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:
68.20 (1) be conducted by a certified assessor according to the criteria established in
68.21 section 256B.0911;
68.22 (2) be conducted face-to-face, initially and at least annually thereafter, or when there
68.23 is a significant change in the participant's condition or a change in the need for services
68.24 and supports; and
68.25 (3) be completed using the format established by the commissioner.
68.26 (b) A participant who is residing in a facility may be assessed and choose CFSS for
68.27 the purpose of using CFSS to return to the community as described in subdivisions 3
68.28 and 7, paragraph (a), clause (5).
68.29 (c) The results of the assessment and any recommendations and authorizations for
68.30 CFSS must be determined and communicated in writing by the lead agency's certified
68.31 assessor as defined in section 256B.0911 to the participant and the agency-provider or
68.32 financial management services provider chosen by the participant within 40 calendar days
68.33 and must include the participant's right to appeal under section 256.045.
68.34 Subd. 6. **Community first services and support service delivery plan.** (a) The
68.35 CFSS service delivery plan must be developed, implemented, and evaluated through a
68.36 person-centered planning process by the participant, or the participant's representative

69.1 or legal representative who may be assisted by a support specialist. The CFSS service
69.2 delivery plan must reflect the services and supports that are important to the participant
69.3 and for the participant to meet the needs assessed by the certified assessor and identified
69.4 in the community support plan under section 256B.0911 or the coordinated services and
69.5 support plan identified in section 256B.0915, subdivision 6, if applicable. The CFSS
69.6 service delivery plan must be reviewed by the participant and the agency-provider or
69.7 financial management services contractor at least annually upon reassessment, or when
69.8 there is a significant change in the participant's condition, or a change in the need for
69.9 services and supports.

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

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

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

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

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

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

69.19 (5) include individually identified goals and desired outcomes;

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

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

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

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

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

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

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

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

69.33 (d) The total units of agency-provider services or the budget allocation amount for
69.34 the flexible spending model include both annual totals and a monthly average amount
69.35 that cover the number of months of the service authorization. The amount used each
69.36 month may vary, but additional funds must not be provided above the annual service

70.1 authorization amount unless a change in condition is assessed and authorized by the
70.2 certified assessor and documented in the community support plan, coordinated services
70.3 and supports plan, and service delivery plan.

70.4 Subd. 7. **Community first services and supports; covered services.** (a) Services
70.5 and supports covered under CFSS include:

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

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

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

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

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

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

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

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

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

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

70.31 (6) transition costs, including:

70.32 (i) deposits for rent and utilities;

70.33 (ii) first month's rent and utilities;

70.34 (iii) bedding;

70.35 (iv) basic kitchen supplies;

71.1 (v) other necessities, to the extent that these necessities are not otherwise covered
71.2 under any other funding that the participant is eligible to receive; and
71.3 (vi) other required necessities for an individual to make the transition from a nursing
71.4 facility, institution for mental diseases, or intermediate care facility for persons with
71.5 developmental disabilities to a community-based home setting where the participant
71.6 resides; and
71.7 (7) services by a support specialist defined under subdivision 2 that are chosen
71.8 by the participant.
71.9 (b) Services and supports received under this section are not home care services for
71.10 the purposes of section 144A.43.
71.11 Subd. 8. **Determination of CFSS service methodology.** (a) All community first
71.12 services and supports must be authorized by the commissioner or the commissioner's
71.13 designee before services begin except for the assessments established in section
71.14 256B.0911. The authorization for CFSS must be completed within 30 days after receiving
71.15 a complete request.
71.16 (b) The amount of CFSS authorized must be based on the recipient's home
71.17 care rating. The home care rating shall be determined by the commissioner or the
71.18 commissioner's designee based on information submitted to the commissioner identifying
71.19 the following for a recipient:
71.20 (1) the total number of dependencies of activities of daily living as defined in
71.21 subdivision 2;
71.22 (2) the presence of complex health-related needs as defined in subdivision 2; and
71.23 (3) the presence of Level I behavior as defined in subdivision 2.
71.24 (c) For purposes meeting the criteria in paragraph (b), the methodology to determine
71.25 the total minutes for CFSS for each home care rating is based on the median paid units per
71.26 day for each home care rating from fiscal year 2007 data for the CFSS program. Each
71.27 home care rating has a base number of minutes assigned. Additional minutes are added
71.28 through the assessment and identification of the following:
71.29 (1) 30 additional minutes per day for a dependency in each critical activity of daily
71.30 living as defined in subdivision 2;
71.31 (2) 30 additional minutes per day for each complex health-related function as
71.32 defined in subdivision 2; and
71.33 (3) 30 additional minutes per day for each behavior issue as defined in subdivision 2.
71.34 Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for
71.35 payment under this section include those that:

72.1 (1) are not authorized by the certified assessor or included in the written service
72.2 delivery plan;
72.3 (2) are provided prior to the authorization of services and the approval of the written
72.4 CFSS service delivery plan;
72.5 (3) are duplicative of other paid services in the written service delivery plan;
72.6 (4) supplant natural unpaid supports that are provided voluntarily to the participant
72.7 and are selected by the participant in lieu of a support worker and appropriately meeting
72.8 the participant's needs;
72.9 (5) are not effective means to meet the participant's needs; and
72.10 (6) are available through other funding sources, including, but not limited to, funding
72.11 through Title IV-E of the Social Security Act.
72.12 (b) Additional services, goods, or supports that are not covered include:
72.13 (1) those that are not for the direct benefit of the participant;
72.14 (2) any fees incurred by the participant, such as Minnesota health care programs fees
72.15 and co-pays, legal fees, or costs related to advocate agencies;
72.16 (3) insurance, except for insurance costs related to employee coverage;
72.17 (4) room and board costs for the participant with the exception of allowable
72.18 transition costs in subdivision 7, clause (6);
72.19 (5) services, supports, or goods that are not related to the assessed needs;
72.20 (6) special education and related services provided under the Individuals with
72.21 Disabilities Education Act and vocational rehabilitation services provided under the
72.22 Rehabilitation Act of 1973;
72.23 (7) assistive technology devices and assistive technology services other than those
72.24 for back-up systems or mechanisms to ensure continuity of service and supports listed in
72.25 subdivision 7;
72.26 (8) medical supplies and equipment;
72.27 (9) environmental modifications, except as specified in subdivision 7;
72.28 (10) expenses for travel, lodging, or meals related to training the participant, the
72.29 participant's representative, legal representative, or paid or unpaid caregivers that exceed
72.30 $500 in a 12-month period;
72.31 (11) experimental treatments;
72.32 (12) any service or good covered by other medical assistance state plan services,
72.33 including prescription and over-the-counter medications, compounds, and solutions and
72.34 related fees, including premiums and co-payments;
72.35 (13) membership dues or costs, except when the service is necessary and appropriate
72.36 to treat a physical condition or to improve or maintain the participant's physical condition.

73.1 The condition must be identified in the participant's CFSS plan and monitored by a
73.2 physician enrolled in a Minnesota health care program;

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

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

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

73.8 Subd. 10. **Provider qualifications and general requirements.** (a)
73.9 Agency-providers delivering services under the agency-provider model under subdivision
73.10 11 or financial management service (FMS) contractors under subdivision 13 shall:

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

73.13 (2) comply with medical assistance provider enrollment requirements;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

74.31 (4) proof of workers' compensation insurance coverage;

74.32 (5) proof of liability insurance;

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

75.1 (7) a copy of the CFSS provider agency's written policies and procedures including:
75.2 hiring of employees; training requirements; service delivery; and employee and consumer
75.3 safety including process for notification and resolution of consumer grievances,
75.4 identification and prevention of communicable diseases, and employee misconduct;
75.5 (8) copies of all other forms the CFSS provider agency uses in the course of daily
75.6 business including, but not limited to:
75.7 (i) a copy of the CFSS provider agency's time sheet if the time sheet varies from
75.8 the standard time sheet for CFSS services approved by the commissioner, and a letter
75.9 requesting approval of the CFSS provider agency's nonstandard time sheet;
75.10 (ii) the CFSS provider agency's template for the CFSS care plan; and
75.11 (iii) the CFSS provider agency's template for the written agreement in subdivision
75.12 21 for recipients using the CFSS choice option, if applicable;
75.13 (9) a list of all training and classes that the CFSS provider agency requires of its
75.14 staff providing CFSS services;
75.15 (10) documentation that the CFSS provider agency and staff have successfully
75.16 completed all the training required by this section;
75.17 (11) documentation of the agency's marketing practices;
75.18 (12) disclosure of ownership, leasing, or management of all residential properties
75.19 that is used or could be used for providing home care services;
75.20 (13) documentation that the agency will use the following percentages of revenue
75.21 generated from the medical assistance rate paid for CFSS services for employee personal
75.22 care assistant wages and benefits: 72.5 percent of revenue from CFSS providers. The
75.23 revenue generated by the support specialist and the reasonable costs associated with the
75.24 support specialist shall not be used in making this calculation; and
75.25 (14) documentation that the agency does not burden recipients' free exercise of their
75.26 right to choose service providers by requiring personal care assistants to sign an agreement
75.27 not to work with any particular CFSS recipient or for another CFSS provider agency after
75.28 leaving the agency and that the agency is not taking action on any such agreements or
75.29 requirements regardless of the date signed.
75.30 (b) CFSS provider agencies shall provide the information specified in paragraph
75.31 (a) to the commissioner.
75.32 (c) All CFSS provider agencies shall require all employees in management and
75.33 supervisory positions and owners of the agency who are active in the day-to-day
75.34 management and operations of the agency to complete mandatory training as determined
75.35 by the commissioner. Employees in management and supervisory positions and owners
75.36 who are active in the day-to-day operations of an agency who have completed the required

76.1 training as an employee with a CFSS provider agency do not need to repeat the required
76.2 training if they are hired by another agency, if they have completed the training within
76.3 the past three years. CFSS provider agency billing staff shall complete training about
76.4 CFSS program financial management. Any new owners or employees in management
76.5 and supervisory positions involved in the day-to-day operations are required to complete
76.6 mandatory training as a requisite of working for the agency. CFSS provider agencies
76.7 certified for participation in Medicare as home health agencies are exempt from the
76.8 training required in this subdivision.

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

76.12 (1) using a budget allocation, participants may directly employ and pay support
76.13 workers and obtain other supports and goods as defined in subdivision 7; and

76.14 (2) from the financial management services (FMS) contractor the participant may
76.15 choose a range of support assistance for:

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

76.17 (ii) the employment, training, supervision, and evaluation of workers;

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

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

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

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

76.26 (1) information and consultation about CFSS;

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

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

76.30 (4) employer and employer agent functions according to Internal Revenue Code
76.31 Procedure 70-6, section 3504, Agency Employer Tax Liability, regulation 137036-08,
76.32 which includes assistance with filing and paying payroll taxes, and obtaining worker
76.33 compensation coverage;

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

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

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

77.5 (e) The FMS contractor shall:

77.6 (1) not limit or restrict the participant's choice of service or support providers,
77.7 including the use of any available employment models;

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

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

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

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

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

77.28 (f) The commissioner of human services shall:

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

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

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

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

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

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

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

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

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

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

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

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

78.26 Subd. 15. **Documentation of support services provided.** (a) Support services
78.27 provided to a participant by a support worker employed by either an agency-provider
78.28 or the participant acting as the employer must be documented daily by each support
78.29 worker, on a time sheet form approved by the commissioner. All documentation may be
78.30 Web-based, electronic, or paper documentation. The completed form must be submitted
78.31 on a monthly basis to the provider or the participant and the FMS contractor selected by
78.32 the participant to provide assistance with meeting the participant's employer obligations
78.33 and kept in the recipient's health record.

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

79.1 (c) The time sheet must be on a form approved by the commissioner documenting
79.2 time the support worker provides services in the home. The following criteria must be
79.3 included in the time sheet:
79.4 (1) full name of the support worker and individual provider number;
79.5 (2) provider name and telephone numbers, if an agency-provider is responsible for
79.6 delivery services under the written service plan;
79.7 (3) full name of the participant;
79.8 (4) consecutive dates, including month, day, and year, and arrival and departure
79.9 times with a.m. or p.m. notations;
79.10 (5) signatures of the participant or the participant's representative;
79.11 (6) personal signature of the support worker;
79.12 (7) any shared care provided, if applicable;
79.13 (8) a statement that it is a federal crime to provide false information on CFSS
79.14 billings for medical assistance payments; and
79.15 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.
79.16 Subd. 16. **Support workers requirements.** (a) Support workers shall:
79.17 (1) enroll with the department as a support worker after a background study under
79.18 chapter 245C has been completed and the support worker has received a notice from the
79.19 commissioner that:
79.20 (i) the support worker is not disqualified under section 245C.14; or
79.21 (ii) is disqualified, but the support worker has received a set-aside of the
79.22 disqualification under section 245C.22;
79.23 (2) have the ability to effectively communicate with the participant or the
79.24 participant's representative;
79.25 (3) have the skills and ability to provide the services and supports according to the
79.26 person's CFSS service delivery plan and respond appropriately to the participant's needs;
79.27 (4) not be a participant of CFSS;
79.28 (5) complete the basic standardized training as determined by the commissioner
79.29 before completing enrollment. The training must be available in languages other than
79.30 English and to those who need accommodations due to disabilities. Support worker
79.31 training must include successful completion of the following training components:
79.32 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
79.33 roles and responsibilities of support workers including information about basic body
79.34 mechanics, emergency preparedness, orientation to positive behavioral practices, fraud
79.35 issues, time cards and documentation, and an overview of person-centered planning and

80.1 self-direction. Upon completion of the training components, the support worker must pass
80.2 the certification test to provide assistance to participants;

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

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

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

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

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

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

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

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

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

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

80.24 Subd. 18. **Service unit and budget allocation requirements.** (a) For the
80.25 agency-provider model, services will be authorized in units of service. The total service
80.26 unit amount must be established based upon the assessed need for CFSS services, and
80.27 must not exceed the maximum number of units available as determined by section
80.28 256B.0652, subdivision 6. The unit rate established by the commissioner is used with
80.29 assessed units to determine the maximum available CFSS allocation.

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

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

80.35 Subd. 19. **Support system.** (a) The commissioner shall provide information,
80.36 consultation, training, and assistance to ensure the participant is able to manage the

81.1 services and supports and budgets, if applicable. This support shall include individual
81.2 consultation on how to select and employ workers, manage responsibilities under CFSS,
81.3 and evaluate personal outcomes.

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

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

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

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

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

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

81.35 Subd. 23. **Commissioner's access.** When the commissioner is investigating a
81.36 possible overpayment of Medicaid funds, the commissioner must be given immediate

82.1 access without prior notice to the agency provider or FMS contractor's office during
82.2 regular business hours and to documentation and records related to services provided and
82.3 submission of claims for services provided. Denying the commissioner access to records
82.4 is cause for immediate suspension of payment and terminating the agency provider's
82.5 enrollment according to section 256B.064 or terminating the FMS contract.

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

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

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

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

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

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

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

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

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

82.34 Sec. 45. Minnesota Statutes 2012, section 626.557, subdivision 4, is amended to read:

83.1 Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter
83.2 shall immediately make an oral report to the common entry point. The common entry
83.3 point may accept electronic reports submitted through a Web-based reporting system
83.4 established by the commissioner. Use of a telecommunications device for the deaf or other
83.5 similar device shall be considered an oral report. The common entry point may not require
83.6 written reports. To the extent possible, the report must be of sufficient content to identify
83.7 the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment,
83.8 any evidence of previous maltreatment, the name and address of the reporter, the time,
83.9 date, and location of the incident, and any other information that the reporter believes
83.10 might be helpful in investigating the suspected maltreatment. A mandated reporter may
83.11 disclose not public data, as defined in section 13.02, and medical records under sections
83.12 144.291 to 144.298, to the extent necessary to comply with this subdivision.
83.13 (b) A boarding care home that is licensed under sections 144.50 to 144.58 and
83.14 certified under Title 19 of the Social Security Act, a nursing home that is licensed under
83.15 section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a
83.16 hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under
83.17 Code of Federal Regulations, title 42, section 482.66, may submit a report electronically
83.18 to the common entry point instead of submitting an oral report. The report may be a
83.19 duplicate of the initial report the facility submits electronically to the commissioner of
83.20 health to comply with the reporting requirements under Code of Federal Regulations, title
83.21 42, section 483.13. The commissioner of health may modify these reporting requirements
83.22 to include items required under paragraph (a) that are not currently included in the
83.23 electronic reporting form.

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

83.25 Sec. 46. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:
83.26 Subd. 9. **Common entry point designation.** (a) ~~Each county board shall designate~~
83.27 ~~a common entry point for reports of suspected maltreatment. Two or more county boards~~
83.28 ~~may jointly designate a single~~ The commissioner of human services shall establish a
83.29 common entry point effective July 1, 2014. The common entry point is the unit responsible
83.30 for receiving the report of suspected maltreatment under this section.
83.31 (b) The common entry point must be available 24 hours per day to take calls from
83.32 reporters of suspected maltreatment. The common entry point shall use a standard intake
83.33 form that includes:
83.34 (1) the time and date of the report;
83.35 (2) the name, address, and telephone number of the person reporting;

84.1 (3) the time, date, and location of the incident;
84.2 (4) the names of the persons involved, including but not limited to, perpetrators,
84.3 alleged victims, and witnesses;
84.4 (5) whether there was a risk of imminent danger to the alleged victim;
84.5 (6) a description of the suspected maltreatment;
84.6 (7) the disability, if any, of the alleged victim;
84.7 (8) the relationship of the alleged perpetrator to the alleged victim;
84.8 (9) whether a facility was involved and, if so, which agency licenses the facility;
84.9 (10) any action taken by the common entry point;
84.10 (11) whether law enforcement has been notified;
84.11 (12) whether the reporter wishes to receive notification of the initial and final
84.12 reports; and
84.13 (13) if the report is from a facility with an internal reporting procedure, the name,
84.14 mailing address, and telephone number of the person who initiated the report internally.
84.15 (c) The common entry point is not required to complete each item on the form prior
84.16 to dispatching the report to the appropriate lead investigative agency.
84.17 (d) The common entry point shall immediately report to a law enforcement agency
84.18 any incident in which there is reason to believe a crime has been committed.
84.19 (e) If a report is initially made to a law enforcement agency or a lead investigative
84.20 agency, those agencies shall take the report on the appropriate common entry point intake
84.21 forms and immediately forward a copy to the common entry point.
84.22 (f) The common entry point staff must receive training on how to screen and
84.23 dispatch reports efficiently and in accordance with this section.
84.24 (g) The commissioner of human services shall maintain a centralized database
84.25 for the collection of common entry point data, lead investigative agency data including
84.26 maltreatment report disposition, and appeals data. The common entry point shall
84.27 have access to the centralized database and must log the reports into the database and
84.28 immediately identify and locate prior reports of abuse, neglect, or exploitation.
84.29 (h) When appropriate, the common entry point staff must refer calls that do not
84.30 allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations
84.31 that might resolve the reporter's concerns.
84.32 (i) a common entry point must be operated in a manner that enables the
84.33 commissioner of human services to:
84.34 (1) track critical steps in the reporting, evaluation, referral, response, disposition,
84.35 and investigative process to ensure compliance with all requirements for all reports;

85.1 (2) maintain data to facilitate the production of aggregate statistical reports for
85.2 monitoring patterns of abuse, neglect, or exploitation;
85.3 (3) serve as a resource for the evaluation, management, and planning of preventative
85.4 and remedial services for vulnerable adults who have been subject to abuse, neglect,
85.5 or exploitation;
85.6 (4) set standards, priorities, and policies to maximize the efficiency and effectiveness
85.7 of the common entry point; and
85.8 (5) track and manage consumer complaints related to the common entry point.
85.9 (j) The commissioners of human services and health shall collaborate on the creation
85.10 of a triage system for investigations. This system shall enable the commissioner of human
85.11 services to track critical steps in the reporting, evaluation, referral, response, disposition,
85.12 investigation, notification, determination, and appeal processes.

85.13 Sec. 47. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:
85.14 Subd. 9e. **Education requirements.** (a) The commissioners of health, human
85.15 services, and public safety shall cooperate in the development of a joint program for
85.16 education of lead investigative agency investigators in the appropriate techniques for
85.17 investigation of complaints of maltreatment. This program must be developed by July
85.18 1, 1996. The program must include but need not be limited to the following areas: (1)
85.19 information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4)
85.20 conclusions based on evidence; (5) interviewing skills, including specialized training to
85.21 interview people with unique needs; (6) report writing; (7) coordination and referral
85.22 to other necessary agencies such as law enforcement and judicial agencies; (8) human
85.23 relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family
85.24 systems and the appropriate methods for interviewing relatives in the course of the
85.25 assessment or investigation; (10) the protective social services that are available to protect
85.26 alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by
85.27 which lead investigative agency investigators and law enforcement workers cooperate in
85.28 conducting assessments and investigations in order to avoid duplication of efforts; and
85.29 (12) data practices laws and procedures, including provisions for sharing data.
85.30 (b) The commissioner of human services shall conduct an outreach campaign to
85.31 promote the common entry point for reporting vulnerable adult maltreatment. This
85.32 campaign shall assist potential reporters, mandated reporters, and vulnerable adults in
85.33 finding information on reporting to the common entry point. This campaign shall use the
85.34 Internet and other means of communication.

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

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

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

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

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

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

86.24 Sec. 48. **REPEALER.**

86.25 Minnesota Statutes 2012, sections 245A.655; 256B.0911, subdivisions 4a, 4b, and
86.26 4c; and 256B.0917, subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14, are repealed.

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

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

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

86.33 (c) "Contingent systems modernization appropriation" refers to the appropriation in
86.34 article 14, section 3, subdivision 4, paragraph (a).

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

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

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

87.9 Subd. 2. **Intent; effective dates generally.** (a) Because the changes contained in
87.10 this article generate savings that are contingent on federal approval of Reform 2020,
87.11 the legislature has also made an appropriation for systems modernization contingent on
87.12 federal approval of Reform 2020. The purpose of this section is to outline how this article
87.13 and the contingent systems modernization appropriation are implemented if Reform 2020
87.14 is fully, partially, or incrementally approved or denied.

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

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

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

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

87.24 (2) include the contingent systems modernization appropriation, which cannot
87.25 exceed $18,814,000 for the biennium ending June 30, 2015; and

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

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

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

87.33 (e) The commissioner must notify the chairs and ranking minority members of the
87.34 legislative committees with jurisdiction over health and human services funding of the
87.35 plan. The plan must be made publicly available online.

88.1 Subd. 4. **Disbursement; implementation.** The commissioner of management and
88.2 budget shall disburse the appropriations in article 14, section 3, subdivision 4, paragraphs
88.3 (a), (b), and (d); subdivision 5, paragraphs (e), (g), and (h); and subdivision 6, paragraphs
88.4 (f), (i), and (k), to the commissioner to allow for implementation of the approved plan
88.5 and make necessary adjustments in the accounting system to reflect any modified funding
88.6 levels. Notwithstanding Minnesota Statutes, section 16A.11, subdivision 3, paragraph (b),
88.7 these fiscal estimates must be considered in establishing the appropriation base for the
88.8 biennium ending June 30, 2017. The commissioner of management and budget shall reflect
88.9 the modified funding levels in the first fund balance following the approval of the plan.

88.10 **ARTICLE 3**

88.11 **SAFE AND HEALTHY DEVELOPMENT OF CHILDREN**

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

88.14 Subd. 19b. **Student parent.** "Student parent" means a person who is:
88.15 (1) under 21 years of age and has a child;
88.16 (2) pursuing a high school or general equivalency diploma;
88.17 (3) residing within a county that has a basic sliding fee waiting list under section
88.18 119B.03, subdivision 4; and
88.19 (4) not an MFIP participant.

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

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

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

88.26 **EFFECTIVE DATE.** This section is effective September 16, 2013.

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

88.28 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the
88.29 following at all initial child care applications using the universal application:
88.30 (1) identity of adults;
88.31 (2) presence of the minor child in the home, if questionable;

89.1 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible
89.2 relative caretaker, or the spouses of any of the foregoing;
89.3 (4) age;
89.4 (5) immigration status, if related to eligibility;
89.5 (6) Social Security number, if given;
89.6 (7) income;
89.7 (8) spousal support and child support payments made to persons outside the
89.8 household;
89.9 (9) residence; and
89.10 (10) inconsistent information, if related to eligibility.
89.11 (b) If a family did not use the universal application or child care addendum to apply
89.12 for child care assistance, the family must complete the universal application or child care
89.13 addendum at its next eligibility redetermination and the county must verify the factors
89.14 listed in paragraph (a) as part of that redetermination. Once a family has completed a
89.15 universal application or child care addendum, the county shall use the redetermination
89.16 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility
89.17 must be redetermined at least every six months. A family is considered to have met the
89.18 eligibility redetermination requirement if a complete redetermination form and all required
89.19 verifications are received within 30 days after the date the form was due. Assistance shall
89.20 be payable retroactively from the redetermination due date. For a family where at least
89.21 one parent is under the age of 21, does not have a high school or general equivalency
89.22 diploma, and is a student in a school district or another similar program that provides or
89.23 arranges for child care, as well as parenting, social services, career and employment
89.24 supports, and academic support to achieve high school graduation, the redetermination of
89.25 eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of
89.26 the student's school year. If a family reports a change in an eligibility factor before the
89.27 family's next regularly scheduled redetermination, the county must recalculate eligibility
89.28 without requiring verification of any eligibility factor that did not change.
89.29 (c) The commissioner shall develop a redetermination form to redetermine eligibility
89.30 and a change report form to report changes that minimize paperwork for the county and
89.31 the participant.

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

89.33 Sec. 4. Minnesota Statutes 2012, section 119B.03, subdivision 4, is amended to read:
89.34 Subd. 4. **Funding priority.** (a) First priority for child care assistance under the
89.35 basic sliding fee program must be given to eligible non-MFIP families who do not have a

90.1 high school or general equivalency diploma or who need remedial and basic skill courses
90.2 in order to pursue employment or to pursue education leading to employment and who
90.3 need child care assistance to participate in the education program. This includes student
90.4 parents as defined under section 119B.011, subdivision 19b. Within this priority, the
90.5 following subpriorities must be used:

90.6 (1) child care needs of minor parents;

90.7 (2) child care needs of parents under 21 years of age; and

90.8 (3) child care needs of other parents within the priority group described in this
90.9 paragraph.

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

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

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

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

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

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

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

90.25 (1) MFIP participants who are employed or in job search and meet the requirements
90.26 of section 119B.10;

90.27 (2) persons who are members of transition year families under section 119B.011,
90.28 subdivision 20, and meet the requirements of section 119B.10;

90.29 (3) families who are participating in employment orientation or job search, or
90.30 other employment or training activities that are included in an approved employability
90.31 development plan under section 256J.95;

90.32 (4) MFIP families who are participating in work job search, job support,
90.33 employment, or training activities as required in their employment plan, or in appeals,
90.34 hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; ~~and~~

(8) families who are participating in the transition year extension under section 119B.011, subdivision 20a~~.~~; and

(9) student parents as defined under section 119B.011, subdivision 19b.

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

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

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~October 31, 2011~~ September 16, 2013, the maximum rate paid for child care assistance in any county or ~~multicounty region~~ county price cluster under the child care fund shall be the ~~rate for like-care arrangements in the county effective July 1, 2006, decreased by 2.5 percent~~ greater of the 25th percentile of the 2011 child care provider rate survey or the maximum rate effective November 28, 2011. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

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

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

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

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

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

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

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

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

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

92.15 (b) The maximum rate paid to legal nonlicensed family child care providers must be
92.16 68 percent of the county maximum hourly rate for licensed family child care providers. In
92.17 counties or county price clusters where the maximum hourly rate for licensed family child
92.18 care providers is higher than the maximum weekly rate for those providers divided by 50,
92.19 the maximum hourly rate that may be paid to legal nonlicensed family child care providers
92.20 is the rate equal to the maximum weekly rate for licensed family child care providers
92.21 divided by 50 and then multiplied by 0.68. The maximum payment to a provider for one
92.22 day of care must not exceed the maximum hourly rate times ten. The maximum payment
92.23 to a provider for one week of care must not exceed the maximum hourly rate times 50.

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

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

92.28 **EFFECTIVE DATE.** This section is effective September 16, 2013.

92.29 Sec. 8. Minnesota Statutes 2012, section 119B.13, is amended by adding a subdivision
92.30 to read:

92.31 Subd. 3b. **Provider rate differential for Parent Aware.** A family child care
92.32 provider or child care center shall be paid a 15 percent differential if they hold a three-star
92.33 Parent Aware rating or a 20 percent differential if they hold a four-star Parent Aware

93.1 rating. A 15 percent or 20 percent rate differential must be paid above the maximum rate
93.2 established in subdivision 1, up to the actual provider rate.

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

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

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

93.10 (1) the child is age birth to five years, but not yet in kindergarten;

93.11 (2) the child attends a child care provider that qualifies for the rate differential
93.12 identified in subdivision 3a or 3b; and

93.13 (3) the applicant's activities qualify for at least 30 hours of care per week under
93.14 sections 119B.03, 119B.05, 119B.10, and Minnesota Rules, chapter 3400.

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

93.16 Sec. 10. Minnesota Statutes 2012, section 119B.13, subdivision 6, is amended to read:

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

93.22 (b) If a provider has received an authorization of care and been issued a billing form
93.23 for an eligible family, the bill must be submitted within 60 days of the last date of service on
93.24 the bill. A bill submitted more than 60 days after the last date of service must be paid if the
93.25 county determines that the provider has shown good cause why the bill was not submitted
93.26 within 60 days. Good cause must be defined in the county's child care fund plan under
93.27 section 119B.08, subdivision 3, and the definition of good cause must include county error.
93.28 Any bill submitted more than a year after the last date of service on the bill must not be paid.

93.29 (c) If a provider provided care for a time period without receiving an authorization
93.30 of care and a billing form for an eligible family, payment of child care assistance may only
93.31 be made retroactively for a maximum of six months from the date the provider is issued
93.32 an authorization of care and billing form.

94.1 (d) A county may refuse to issue a child care authorization to a licensed or legal
94.2 nonlicensed provider, revoke an existing child care authorization to a licensed or legal
94.3 nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or
94.4 refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

94.5 (1) the provider admits to intentionally giving the county materially false information
94.6 on the provider's billing forms;

94.7 (2) a county finds by a preponderance of the evidence that the provider intentionally
94.8 gave the county materially false information on the provider's billing forms;

94.9 (3) the provider is in violation of child care assistance program rules, until the
94.10 agency determines those violations have been corrected;

94.11 (4) the provider is operating after receipt of an order of suspension or an order
94.12 of revocation of the provider's license, or the provider has been issued an order citing
94.13 violations of licensing standards that affect the health and safety of children in care due to
94.14 the nature, chronicity, or severity of the licensing violations, until the licensing agency
94.15 determines those violations have been corrected;

94.16 (5) the provider submits false attendance reports or refuses to provide documentation
94.17 of the child's attendance upon request; or

94.18 (6) the provider gives false child care price information.

94.19 The county may withhold the provider's authorization or payment for a period of
94.20 time not to exceed three months beyond the time the condition has been corrected.

94.21 (e) A county's payment policies must be included in the county's child care plan
94.22 under section 119B.08, subdivision 3. If payments are made by the state, in addition to
94.23 being in compliance with this subdivision, the payments must be made in compliance
94.24 with section 16A.124.

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

94.26 Sec. 11. Minnesota Statutes 2012, section 245A.07, subdivision 2a, is amended to read:

94.27 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days
94.28 of receipt of the license holder's timely appeal, the commissioner shall request assignment
94.29 of an administrative law judge. The request must include a proposed date, time, and place
94.30 of a hearing. A hearing must be conducted by an administrative law judge within 30
94.31 calendar days of the request for assignment, unless an extension is requested by either
94.32 party and granted by the administrative law judge for good cause. The commissioner shall
94.33 issue a notice of hearing by certified mail or personal service at least ten working days
94.34 before the hearing. The scope of the hearing shall be limited solely to the issue of whether
94.35 the temporary immediate suspension should remain in effect pending the commissioner's

95.1 final order under section 245A.08, regarding a licensing sanction issued under subdivision
95.2 3 following the immediate suspension. The burden of proof in expedited hearings under
95.3 this subdivision shall be limited to the commissioner's demonstration that reasonable
95.4 cause exists to believe that the license holder's actions or failure to comply with applicable
95.5 law or rule poses, or if the actions of other individuals or conditions in the program poses
95.6 an imminent risk of harm to the health, safety, or rights of persons served by the program.
95.7 "Reasonable cause" means there exist specific articulable facts or circumstances which
95.8 provide the commissioner with a reasonable suspicion that there is an imminent risk of harm
95.9 to the health, safety, or rights of persons served by the program. When the commissioner
95.10 has determined there is reasonable cause to order the temporary immediate suspension of
95.11 a license based on a violation of safe sleep requirements, the commissioner is not required
95.12 to demonstrate that an infant died or was injured as a result of the safe sleep violations.

95.13 (b) The administrative law judge shall issue findings of fact, conclusions, and a
95.14 recommendation within ten working days from the date of hearing. The parties shall have
95.15 ten calendar days to submit exceptions to the administrative law judge's report. The
95.16 record shall close at the end of the ten-day period for submission of exceptions. The
95.17 commissioner's final order shall be issued within ten working days from the close of the
95.18 record. Within 90 calendar days after a final order affirming an immediate suspension, the
95.19 commissioner shall make a determination regarding whether a final licensing sanction
95.20 shall be issued under subdivision 3. The license holder shall continue to be prohibited
95.21 from operation of the program during this 90-day period.

95.22 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
95.23 final licensing sanction is issued under subdivision 3 and the license holder appeals that
95.24 sanction, the license holder continues to be prohibited from operation of the program
95.25 pending a final commissioner's order under section 245A.08, subdivision 5, regarding the
95.26 final licensing sanction.

95.27 Sec. 12. Minnesota Statutes 2012, section 245A.1435, is amended to read:

95.28 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT**
95.29 **DEATH ~~SYNDROME~~ IN LICENSED PROGRAMS.**

95.30 (a) When a license holder is placing an infant to sleep, the license holder must
95.31 place the infant on the infant's back, unless the license holder has documentation from
95.32 the infant's ~~parent~~ physician directing an alternative sleeping position for the infant. The
95.33 ~~parent~~ physician directive must be on a form approved by the commissioner and must
95.34 ~~include a statement that the parent or legal guardian has read the information provided by~~
95.35 ~~the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance~~

96.1 ~~of placing an infant or child on its back to sleep to reduce the risk of SIDS~~ remain on file
96.2 at the licensed location. An infant who independently rolls onto its stomach after being
96.3 placed to sleep on its back may be allowed to remain sleeping on its stomach.
96.4 (b) The license holder must place the infant in a crib directly on a firm mattress with
96.5 a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be
96.6 dislodged by pulling on the corner of the sheet. The license holder must not place pillows,
96.7 quilts, comforters, sheepskin, pillow-like stuffed toys, any loose bedding including but
96.8 not limited to blankets and sheets, or other soft products in the crib with the infant. The
96.9 requirements of this section apply to license holders serving infants up to and including
96.10 12 months of age. Licensed child care providers must meet the crib requirements under
96.11 section 245A.146.
96.12 (c) If an infant falls asleep before being placed in a crib, the license holder must
96.13 move the infant to a crib as soon as practicable, and must keep the infant within sight of
96.14 the license holder until the infant is placed in a crib. When an infant falls asleep while
96.15 being held, the license holder must consider the supervision needs of other children in
96.16 care when determining how long to hold the infant before placing the infant in a crib to
96.17 sleep. The sleeping infant must not be in a position where the airway may be blocked or
96.18 with anything covering the infant's face.

96.19 Sec. 13. Minnesota Statutes 2012, section 245A.144, is amended to read:

96.20 **245A.144 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
96.21 **DEATH AND ~~SHAKEN BABY SYNDROME~~ ABUSIVE HEAD TRAUMA FOR**
96.22 **CHILD FOSTER CARE PROVIDERS.**
96.23 (a) Licensed child foster care providers that care for infants or children through five
96.24 years of age must document that before staff persons and caregivers assist in the care
96.25 of infants or children through five years of age, they are instructed on the standards in
96.26 section 245A.1435 and receive training on reducing the risk of sudden unexpected infant
96.27 death ~~syndrome~~ and ~~shaken baby syndrome for~~ abusive head trauma from shaking infants
96.28 and young children. This section does not apply to emergency relative placement under
96.29 section 245A.035. The training on reducing the risk of sudden unexpected infant death
96.30 ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma may be provided as:
96.31 (1) orientation training to child foster care providers, who care for infants or children
96.32 through five years of age, under Minnesota Rules, part 2960.3070, subpart 1; or
96.33 (2) in-service training to child foster care providers, who care for infants or children
96.34 through five years of age, under Minnesota Rules, part 2960.3070, subpart 2.

(b) Training required under this section must be at least one hour in length and must be completed at least once every five years. At a minimum, the training must address the risk factors related to sudden unexpected infant death ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma, means of reducing the risk of sudden unexpected infant death ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma.

(c) Training for child foster care providers must be approved by the county or private licensing agency that is responsible for monitoring the child foster care provider under section 245A.16. The approved training fulfills, in part, training required under Minnesota Rules, part 2960.3070.

Sec. 14. Minnesota Statutes 2012, section 245A.1444, is amended to read:

245A.1444 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT DEATH ~~SYNDROME~~ AND ~~SHAKEN BABY SYNDROME~~ ABUSIVE HEAD TRAUMA BY OTHER PROGRAMS.

A licensed chemical dependency treatment program that serves clients with infants or children through five years of age, who sleep at the program and a licensed children's residential facility that serves infants or children through five years of age, must document that before program staff persons or volunteers assist in the care of infants or children through five years of age, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death ~~syndrome~~ and ~~shaken baby syndrome~~ abusive head trauma from shaking infants and young children. The training conducted under this section may be used to fulfill training requirements under Minnesota Rules, parts 2960.0100, subpart 3; and 9530.6490, subpart 4, item B.

This section does not apply to child care centers or family child care programs governed by sections 245A.40 and 245A.50.

Sec. 15. **[245A.147] FAMILY CHILD CARE INFANT SLEEP SUPERVISION REQUIREMENTS.**

Subdivision 1. **In-person checks on infants.** (a) License holders that serve infants must monitor sleeping infants by conducting in-person checks on each infant in their care every 30 minutes.

(b) Upon enrollment of an infant in a family child care program, the license holder must conduct in-person checks on the infant every 15 minutes, during the first four months of care.

98.1 (c) When an infant has an upper respiratory infection, the license holder must
98.2 conduct in-person checks on the infant every 15 minutes throughout the hours of care.

98.3 Subd. 2. **Use of audio or visual monitoring devices.** In addition to conducting
98.4 the in-person checks required under subdivision 1, license holders serving infants must
98.5 use and maintain an audio or visual monitoring device to monitor each infant in care
98.6 during all hours of care.

98.7 Sec. 16. **[245A.152] CHILD CARE LICENSE HOLDER INSURANCE.**

98.8 Subdivision 1. **Insurance coverage required for child care licensure.** (a) All
98.9 licensed family child care providers and child care centers shall maintain insurance
98.10 coverage for personal injury, death, or property damage resulting from any act or omission
98.11 related to the provision of services under the license. The coverage limits shall be at least
98.12 $100,000 per person and $250,000 per occurrence.

98.13 (b) No license to provide child care shall take effect before the insurance coverage
98.14 required under this section becomes effective. A license shall be suspended or revoked
98.15 any time the insurance coverage required under this section lapses or is terminated and
98.16 replacement coverage has not taken effect.

98.17 (c) A license holder shall immediately notify the commissioner if the insurance
98.18 coverage required under this section lapses or is terminated and no replacement coverage
98.19 has taken effect.

98.20 Subd. 2. **Evidence of insurance.** (a) A current certificate of coverage for insurance
98.21 required under this section shall be posted in a place in the licensed family child care
98.22 home or center that is conspicuous to all visitors and parents of children receiving services
98.23 from the program.

98.24 (b) A license holder shall, upon request, provide a copy of the current certificate of
98.25 coverage for insurance required under this section to the commissioner or to any parent
98.26 of a child receiving services from the licensed program.

98.27 Sec. 17. Minnesota Statutes 2012, section 245A.40, subdivision 5, is amended to read:

98.28 Subd. 5. **Sudden unexpected infant death ~~syndrome~~ and ~~shaken baby syndrome~~**
98.29 **abusive head trauma training.** (a) License holders must document that before staff
98.30 persons and volunteers care for infants, they are instructed on the standards in section
98.31 245A.1435 and receive training on reducing the risk of sudden unexpected infant death
98.32 ~~syndrome~~. In addition, license holders must document that before staff persons care for
98.33 infants or children under school age, they receive training on the risk of ~~shaken baby~~
98.34 ~~syndrome~~ abusive head trauma from shaking infants and young children. The training

in this subdivision may be provided as orientation training under subdivision 1 and in-service training under subdivision 7.

(b) Sudden unexpected infant death ~~syndrome~~ reduction training required under this subdivision must be at least one-half hour in length and must be completed at least once every ~~five years~~ year. At a minimum, the training must address the risk factors related to sudden unexpected infant death ~~syndrome~~, means of reducing the risk of sudden unexpected infant death ~~syndrome~~ in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death ~~syndrome~~.

(c) ~~Shaken baby syndrome~~ Abusive head trauma training under this subdivision must be at least one-half hour in length and must be completed at least once every ~~five years~~ year. At a minimum, the training must address the risk factors related to ~~shaken baby syndrome for~~ shaking infants and young children, means to reduce the risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive head trauma.

(d) The commissioner shall make available for viewing a video presentation on the dangers associated with shaking infants and young children. The video presentation must be part of the orientation and annual in-service training of licensed child care center staff persons caring for children under school age. The commissioner shall provide to child care providers and interested individuals, at cost, copies of a video approved by the commissioner of health under section 144.574 on the dangers associated with shaking infants and young children.

Sec. 18. Minnesota Statutes 2012, section 245A.50, is amended to read:

245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.

Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes must comply with the training requirements in this section.

(b) Helpers who assist with care on a regular basis must complete six hours of training within one year after the date of initial employment.

Subd. 2. **Child growth and development and behavior guidance training.** (a) For purposes of family and group family child care, the license holder and each adult caregiver who provides care in the licensed setting for more than 30 days in any 12-month period shall complete and document at least ~~two~~ four hours of child growth and development and behavior guidance training ~~within the first year of~~ prior to initial licensure, and before caring for children. For purposes of this subdivision, "child growth and development training" means training in understanding how children acquire language and develop physically, cognitively, emotionally, and socially. "Behavior guidance training" means

training in the understanding of the functions of child behavior and strategies for managing challenging situations. Child growth and development and behavior guidance training must be repeated annually. Training curriculum shall be developed by the commissioner of human services by January 1, 2014.

(b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

(1) have taken a three-credit course on early childhood development within the past five years;

(2) have received a baccalaureate or master's degree in early childhood education or school-age child care within the past five years;

(3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(4) have received a baccalaureate degree with a Montessori certificate within the past five years.

Subd. 3. **First aid.** (a) When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present in the home who has been trained in first aid. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training include individuals approved as first aid instructors. First aid training must be repeated every two years.

(b) A family child care provider is exempt from the first aid training requirements under this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.

(c) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.

Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present in the home who has been trained in cardiopulmonary resuscitation (CPR) and in the treatment of obstructed airways that includes CPR techniques for infants and children. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every ~~three~~ two years, and must be documented in the staff person's records.

101.1 (b) A family child care provider is exempt from the CPR training requirement in
101.2 this subdivision related to any substitute caregiver who provides less than 30 hours of
101.3 care during any 12-month period.

101.4 (c) ~~Video training reviewed and approved by the county licensing agency satisfies~~
101.5 ~~the training requirement of this subdivision.~~ Persons providing CPR training must use
101.6 CPR training that has been developed:

101.7 (1) by the American Heart Association or the American Red Cross and incorporates
101.8 psychomotor skills to support the instruction; or

101.9 (2) using nationally recognized, evidence-based guidelines for CPR training and
101.10 incorporates psychomotor skills to support the instruction.

101.11 Subd. 5. **Sudden unexpected infant death ~~syndrome~~ and ~~shaken baby syndrome~~**
101.12 **abusive head trauma training.** (a) License holders must document that before staff
101.13 persons, caregivers, and helpers assist in the care of infants, they are instructed on the
101.14 standards in section 245A.1435 and receive training on reducing the risk of sudden
101.15 unexpected infant death ~~syndrome~~. In addition, license holders must document that before
101.16 staff persons, caregivers, and helpers assist in the care of infants and children under
101.17 school age, they receive training on reducing the risk of ~~shaken baby syndrome~~ abusive
101.18 head trauma from shaking infants and young children. The training in this subdivision
101.19 may be provided as initial training under subdivision 1 or ongoing annual training under
101.20 subdivision 7.

101.21 (b) Sudden unexpected infant death ~~syndrome~~ reduction training required under
101.22 this subdivision must be at least one-half hour in length and must be completed at least
101.23 once every ~~five years~~ year. At a minimum, the training must address the risk factors
101.24 related to sudden unexpected infant death ~~syndrome~~, means of reducing the risk of sudden
101.25 unexpected infant death ~~syndrome~~ in child care, and license holder communication with
101.26 parents regarding reducing the risk of sudden unexpected infant death ~~syndrome~~.

101.27 (c) ~~Shaken baby syndrome~~ Abusive head trauma training required under this
101.28 subdivision must be at least one-half hour in length and must be completed at least once
101.29 every ~~five years~~ year. At a minimum, the training must address the risk factors related
101.30 to ~~shaken baby syndrome~~ shaking infants and young children, means of reducing the
101.31 risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder
101.32 communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive
101.33 head trauma.

101.34 (d) Training for family and group family child care providers must be approved
101.35 by the county licensing agency.

102.1 ~~(c) The commissioner shall make available for viewing by all licensed child care~~
102.2 ~~providers a video presentation on the dangers associated with shaking infants and young~~
102.3 ~~children. The video presentation shall be part of the initial and ongoing annual training of~~
102.4 ~~licensed child care providers, caregivers, and helpers caring for children under school age.~~
102.5 ~~The commissioner shall provide to child care providers and interested individuals, at cost,~~
102.6 ~~copies of a video approved by the commissioner of health under section 144.574 on the~~
102.7 ~~dangers associated with shaking infants and young children.~~

102.8 Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license
102.9 holder must comply with all seat belt and child passenger restraint system requirements
102.10 under section 169.685.

102.11 (b) Family and group family child care programs licensed by the Department of
102.12 Human Services that serve a child or children under nine years of age must document
102.13 training that fulfills the requirements in this subdivision.

102.14 (1) Before a license holder, staff person, caregiver, or helper transports a child or
102.15 children under age nine in a motor vehicle, the person placing the child or children in a
102.16 passenger restraint must satisfactorily complete training on the proper use and installation
102.17 of child restraint systems in motor vehicles. Training completed under this subdivision may
102.18 be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

102.19 (2) Training required under this subdivision must be at least one hour in length,
102.20 completed at initial training, and repeated at least once every five years. At a minimum,
102.21 the training must address the proper use of child restraint systems based on the child's
102.22 size, weight, and age, and the proper installation of a car seat or booster seat in the motor
102.23 vehicle used by the license holder to transport the child or children.

102.24 (3) Training under this subdivision must be provided by individuals who are certified
102.25 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
102.26 may obtain a list of certified and approved trainers through the Department of Public
102.27 Safety Web site or by contacting the agency.

102.28 (c) Child care providers that only transport school-age children as defined in section
102.29 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
102.30 subdivision 1, paragraph (e), are exempt from this subdivision.

102.31 Subd. 7. **Training requirements for family and group family child care.** For
102.32 purposes of family and group family child care, the license holder and each primary
102.33 caregiver must complete ~~eight~~ 16 hours of ongoing training each year. For purposes
102.34 of this subdivision, a primary caregiver is an adult caregiver who provides services in
102.35 the licensed setting for more than 30 days in any 12-month period. Repeat of topical
102.36 training requirements in subdivisions 2 to 7 shall count toward the annual 16-hour training

103.1 requirement. Additional ongoing training subjects to meet the annual 16-hour training
103.2 requirement must be selected from the following areas:
103.3 (1) "child growth and development training" has the meaning given in under
103.4 subdivision 2, paragraph (a);
103.5 (2) "learning environment and curriculum" includes, including training in
103.6 establishing an environment and providing activities that provide learning experiences to
103.7 meet each child's needs, capabilities, and interests;
103.8 (3) "assessment and planning for individual needs" includes, including training in
103.9 observing and assessing what children know and can do in order to provide curriculum
103.10 and instruction that addresses their developmental and learning needs, including children
103.11 with special needs and bilingual children or children for whom English is not their
103.12 primary language;
103.13 (4) "interactions with children" includes, including training in establishing
103.14 supportive relationships with children, guiding them as individuals and as part of a group;
103.15 (5) "families and communities" includes, including training in working
103.16 collaboratively with families and agencies or organizations to meet children's needs and to
103.17 encourage the community's involvement;
103.18 (6) "health, safety, and nutrition" includes, including training in establishing and
103.19 maintaining an environment that ensures children's health, safety, and nourishment,
103.20 including child abuse, maltreatment, prevention, and reporting; home and fire safety; child
103.21 injury prevention; communicable disease prevention and control; first aid; and CPR; and
103.22 (7) "program planning and evaluation" includes, including training in establishing,
103.23 implementing, evaluating, and enhancing program operations.
103.24 Subd. 8. **Other required training requirements.** (a) The training required of
103.25 family and group family child care providers and staff must include training in the cultural
103.26 dynamics of early childhood development and child care. The cultural dynamics and
103.27 disabilities training and skills development of child care providers must be designed to
103.28 achieve outcomes for providers of child care that include, but are not limited to:
103.29 (1) an understanding and support of the importance of culture and differences in
103.30 ability in children's identity development;
103.31 (2) understanding the importance of awareness of cultural differences and
103.32 similarities in working with children and their families;
103.33 (3) understanding and support of the needs of families and children with differences
103.34 in ability;
103.35 (4) developing skills to help children develop unbiased attitudes about cultural
103.36 differences and differences in ability;

104.1 (5) developing skills in culturally appropriate caregiving; and

104.2 (6) developing skills in appropriate caregiving for children of different abilities.

104.3 The commissioner shall approve the curriculum for cultural dynamics and disability
104.4 training.

104.5 (b) The provider must meet the training requirement in section 245A.14, subdivision
104.6 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child
104.7 care or group family child care home to use the swimming pool located at the home.

104.8 Subd. 9. **Supervising for safety; training requirement.** Effective July 1, 2014,
104.9 all family child care license holders and each adult caregiver who provides care in the
104.10 licensed family child care home for more than 30 days in any 12-month period shall
104.11 complete and document at least six hours approved training on supervising for safety
104.12 prior to initial licensure, and before caring for children. At least two hours of training
104.13 on supervising for safety must be repeated annually. For purposes of this subdivision,
104.14 "supervising for safety" includes supervision basics, supervision outdoors, equipment and
104.15 materials, illness, injuries, and disaster preparedness. The commissioner shall develop
104.16 the supervising for safety curriculum by January 1, 2014.

104.17 Sec. 19. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:

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

104.21 (1) information related to names of substantiated perpetrators of maltreatment of
104.22 vulnerable adults that has been received by the commissioner as required under section
104.23 626.557, subdivision 9c, paragraph (j);

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

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

104.29 (4) information from the Bureau of Criminal Apprehension;

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

104.33 (6) for a background study related to a child foster care application for licensure, a
104.34 transfer of permanent legal and physical custody under section 260C.515, or adoptions,
104.35 the commissioner shall also review:

105.1 (i) information from the child abuse and neglect registry for any state in which the
105.2 background study subject has resided for the past five years; and
105.3 (ii) information from national crime information databases, when the background
105.4 study subject is 18 years of age or older.
105.5 (b) Notwithstanding expungement by a court, the commissioner may consider
105.6 information obtained under paragraph (a), clauses (3) and (4), unless the commissioner
105.7 received notice of the petition for expungement and the court order for expungement is
105.8 directed specifically to the commissioner.

105.9 Sec. 20. Minnesota Statutes 2012, section 245C.33, subdivision 1, is amended to read:
105.10 Subdivision 1. **Background studies conducted by commissioner.** (a) Before
105.11 placement of a child for purposes of adoption, the commissioner shall conduct a
105.12 background study on individuals listed in section 259.41, subdivision 3, for county
105.13 agencies and private agencies licensed to place children for adoption.
105.14 (b) Before placement of a child for the purposes of a transfer of permanent legal and
105.15 physical custody to a relative under section 260C.515, the commissioner shall conduct a
105.16 background study on each person over the age of 13 living in the home. New background
105.17 studies do not need to be completed if the proposed relative custodian has a valid foster
105.18 care license, and background studies according to section 245C.08, subdivision 1, were
105.19 completed as part of the licensure process.

105.20 Sec. 21. Minnesota Statutes 2012, section 256.0112, is amended by adding a
105.21 subdivision to read:
105.22 Subd. 10. **Contracts for child foster care services.** When local agencies negotiate
105.23 lead county contracts or purchase of service contracts for child foster care services, the
105.24 foster care maintenance payment made on behalf of the child shall follow the provisions of
105.25 Northstar Care for Children, chapter 256N. Foster care maintenance payments as defined
105.26 in section 256N.02, subdivision 15, represents costs for activities similar in nature to those
105.27 expected of parents and do not cover services rendered by the licensed or tribally approved
105.28 foster parent, facility, or administrative costs or fees. Payments made to foster parents
105.29 must follow the requirements of section 256N.26, subdivision 15. The legally responsible
105.30 agency must provide foster parents with the assessment and notice as specified in section
105.31 256N.24. The financially responsible agency is permitted to make additional payments for
105.32 specific services provided by the foster parents or facility, as permitted in section 256N.21,
105.33 subdivision 5. These additional payments are not considered foster care maintenance.

106.1 Sec. 22. Minnesota Statutes 2012, section 256.82, subdivision 2, is amended to read:
106.2 Subd. 2. **Foster care maintenance payments.** ~~Beginning January 1, 1986,~~ For the
106.3 purpose of foster care maintenance payments under title IV-E of the Social Security Act,
106.4 United States Code, title 42, sections 670 to 676, the county paying the maintenance
106.5 costs must be reimbursed for the costs from the federal money available for the purpose.
106.6 Beginning July 1, 1997, for the purposes of determining a child's eligibility under title
106.7 IV-E of the Social Security Act, the placing agency shall use AFDC requirements in
106.8 effect on July 16, 1996.

106.9 Sec. 23. Minnesota Statutes 2012, section 256.82, subdivision 3, is amended to read:
106.10 Subd. 3. **Setting foster care standard rates.** (a) The commissioner shall annually
106.11 establish minimum ~~standard maintenance~~ rates for foster care maintenance ~~and~~ including
106.12 supplemental difficulty of care payments for all children ~~in foster care~~ eligible for
106.13 Northstar Care for Children under chapter 256N.
106.14 (b) All children entering foster care on or after January 1, 2015, are eligible for
106.15 Northstar Care for Children under chapter 256N. Any increase in rates shall in no case
106.16 exceed three percent per annum.
106.17 (c) All children in foster care on December 31, 2014, must remain in the
106.18 pre-Northstar Care for Children foster care program under sections 256N.21, subdivision
106.19 6, and 260C.4411, subdivision 1. The rates for the pre-Northstar Care for Children foster
106.20 care program shall remain those in effect on January 1, 2013.

106.21 Sec. 24. Minnesota Statutes 2012, section 256.98, subdivision 8, is amended to read:
106.22 Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of
106.23 wrongfully obtaining assistance by a federal or state court or by an administrative hearing
106.24 determination, or waiver thereof, through a disqualification consent agreement, or as part
106.25 of any approved diversion plan under section 401.065, or any court-ordered stay which
106.26 carries with it any probationary or other conditions, in the Minnesota family investment
106.27 program and any affiliated program to include the diversionary work program and the
106.28 work participation cash benefit program, the food stamp or food support program, the
106.29 general assistance program, the group residential housing program, or the Minnesota
106.30 supplemental aid program shall be disqualified from that program. In addition, any person
106.31 disqualified from the Minnesota family investment program shall also be disqualified from
106.32 the food stamp or food support program. The needs of that individual shall not be taken
106.33 into consideration in determining the grant level for that assistance unit:
106.34 (1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of ~~three months, six months, and~~ one year and two years for the first~~,~~ and second~~, and third~~ offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of one year for the first offense and two years for the second offense. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

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

Sec. 25. Minnesota Statutes 2012, section 256J.08, subdivision 24, is amended to read:

Subd. 24. **Disregard.** "Disregard" means earned income that is not counted ~~when determining initial eligibility~~ in the initial income test in section 256J.21, subdivision 3, or income that is not counted when determining ongoing eligibility and calculating the amount of the assistance payment for participants. The ~~commissioner shall determine the amount of the~~ disregard ~~according to section 256J.24, subdivision 10~~ for ongoing eligibility shall be 50 percent of gross earned income.

EFFECTIVE DATE. This section is effective October 1, 2013, or upon approval from the United States Department of Agriculture, whichever is later.

Sec. 26. Minnesota Statutes 2012, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, payments for family foster care to

109.1 children under chapter 256N, and payments received and used for care and maintenance of
109.2 a third-party beneficiary who is not a household member;
109.3 (2) reimbursements for employment training received through the Workforce
109.4 Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;
109.5 (3) reimbursement for out-of-pocket expenses incurred while performing volunteer
109.6 services, jury duty, employment, or informal carpooling arrangements directly related to
109.7 employment;
109.8 (4) all educational assistance, except the county agency must count graduate student
109.9 teaching assistantships, fellowships, and other similar paid work as earned income and,
109.10 after allowing deductions for any unmet and necessary educational expenses, shall
109.11 count scholarships or grants awarded to graduate students that do not require teaching
109.12 or research as unearned income;
109.13 (5) loans, regardless of purpose, from public or private lending institutions,
109.14 governmental lending institutions, or governmental agencies;
109.15 (6) loans from private individuals, regardless of purpose, provided an applicant or
109.16 participant documents that the lender expects repayment;
109.17 (7)(i) state income tax refunds; and
109.18 (ii) federal income tax refunds;
109.19 (8)(i) federal earned income credits;
109.20 (ii) Minnesota working family credits;
109.21 (iii) state homeowners and renters credits under chapter 290A; and
109.22 (iv) federal or state tax rebates;
109.23 (9) funds received for reimbursement, replacement, or rebate of personal or real
109.24 property when these payments are made by public agencies, awarded by a court, solicited
109.25 through public appeal, or made as a grant by a federal agency, state or local government,
109.26 or disaster assistance organizations, subsequent to a presidential declaration of disaster;
109.27 (10) the portion of an insurance settlement that is used to pay medical, funeral, and
109.28 burial expenses, or to repair or replace insured property;
109.29 (11) reimbursements for medical expenses that cannot be paid by medical assistance;
109.30 (12) payments by a vocational rehabilitation program administered by the state
109.31 under chapter 268A, except those payments that are for current living expenses;
109.32 (13) in-kind income, including any payments directly made by a third party to a
109.33 provider of goods and services;
109.34 (14) assistance payments to correct underpayments, but only for the month in which
109.35 the payment is received;
109.36 (15) payments for short-term emergency needs under section 256J.626, subdivision 2;

110.1 (16) funeral and cemetery payments as provided by section 256.935;
110.2 (17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in
110.3 a calendar month;
110.4 (18) any form of energy assistance payment made through Public Law 97-35,
110.5 Low-Income Home Energy Assistance Act of 1981, payments made directly to energy
110.6 providers by other public and private agencies, and any form of credit or rebate payment
110.7 issued by energy providers;
110.8 (19) Supplemental Security Income (SSI), including retroactive SSI payments and
110.9 other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;
110.10 (20) Minnesota supplemental aid, including retroactive payments;
110.11 (21) proceeds from the sale of real or personal property;
110.12 (22) ~~state adoption assistance payments under section 259.67, and up to an equal~~
110.13 ~~amount of county adoption assistance payments~~ adoption assistance payments under
110.14 chapter 259A and Minnesota Permanency Demonstration, Title IV-E waiver payments
110.15 under section 256.01, subdivision 14a;
110.16 (23) state-funded family subsidy program payments made under section 252.32 to
110.17 help families care for children with developmental disabilities, consumer support grant
110.18 funds under section 256.476, and resources and services for a disabled household member
110.19 under one of the home and community-based waiver services programs under chapter 256B;
110.20 (24) interest payments and dividends from property that is not excluded from and
110.21 that does not exceed the asset limit;
110.22 (25) rent rebates;
110.23 (26) income earned by a minor caregiver, minor child through age 6, or a minor
110.24 child who is at least a half-time student in an approved elementary or secondary education
110.25 program;
110.26 (27) income earned by a caregiver under age 20 who is at least a half-time student in
110.27 an approved elementary or secondary education program;
110.28 (28) MFIP child care payments under section 119B.05;
110.29 (29) all other payments made through MFIP to support a caregiver's pursuit of
110.30 greater economic stability;
110.31 (30) income a participant receives related to shared living expenses;
110.32 (31) reverse mortgages;
110.33 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title
110.34 42, chapter 13A, sections 1771 to 1790;
110.35 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
110.36 United States Code, title 42, chapter 13A, section 1786;

111.1 (34) benefits from the National School Lunch Act, United States Code, title 42,
111.2 chapter 13, sections 1751 to 1769e;
111.3 (35) relocation assistance for displaced persons under the Uniform Relocation
111.4 Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title
111.5 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States
111.6 Code, title 12, chapter 13, sections 1701 to 1750jj;
111.7 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter
111.8 12, part 2, sections 2271 to 2322;
111.9 (37) war reparations payments to Japanese Americans and Aleuts under United
111.10 States Code, title 50, sections 1989 to 1989d;
111.11 (38) payments to veterans or their dependents as a result of legal settlements
111.12 regarding Agent Orange or other chemical exposure under Public Law 101-239, section
111.13 10405, paragraph (a)(2)(E);
111.14 (39) income that is otherwise specifically excluded from MFIP consideration in
111.15 federal law, state law, or federal regulation;
111.16 (40) security and utility deposit refunds;
111.17 (41) American Indian tribal land settlements excluded under Public Laws 98-123,
111.18 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech
111.19 Lake, and Mille Lacs reservations and payments to members of the White Earth Band,
111.20 under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;
111.21 (42) all income of the minor parent's parents and stepparents when determining the
111.22 grant for the minor parent in households that include a minor parent living with parents or
111.23 stepparents on MFIP with other children;
111.24 (43) income of the minor parent's parents and stepparents equal to 200 percent of the
111.25 federal poverty guideline for a family size not including the minor parent and the minor
111.26 parent's child in households that include a minor parent living with parents or stepparents
111.27 not on MFIP when determining the grant for the minor parent. The remainder of income is
111.28 deemed as specified in section 256J.37, subdivision 1b;
111.29 (44) payments made to children eligible for relative custody assistance under section
111.30 257.85 and guardianship assistance under section 256N.20;
111.31 (45) vendor payments for goods and services made on behalf of a client unless the
111.32 client has the option of receiving the payment in cash;
111.33 (46) the principal portion of a contract for deed payment; and
111.34 (47) cash payments to individuals enrolled for full-time service as a volunteer under
111.35 AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps
111.36 National, and AmeriCorps NCCC.

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

112.2 Sec. 27. Minnesota Statutes 2012, section 256J.21, subdivision 3, is amended to read:

112.3 Subd. 3. **Initial income test.** The county agency shall determine initial eligibility
112.4 by considering all earned and unearned income that is not excluded under subdivision 2.
112.5 To be eligible for MFIP, the assistance unit's countable income minus the disregards in
112.6 paragraphs (a) and (b) must be below the ~~transitional standard of assistance~~ family wage
112.7 level according to section 256J.24 for that size assistance unit.

112.8 (a) The initial eligibility determination must disregard the following items:

112.9 (1) the employment disregard is 18 percent of the gross earned income whether or
112.10 not the member is working full time or part time;

112.11 (2) dependent care costs must be deducted from gross earned income for the actual
112.12 amount paid for dependent care up to a maximum of $200 per month for each child less
112.13 than two years of age, and $175 per month for each child two years of age and older under
112.14 this chapter and chapter 119B;

112.15 (3) all payments made according to a court order for spousal support or the support
112.16 of children not living in the assistance unit's household shall be disregarded from the
112.17 income of the person with the legal obligation to pay support, provided that, if there has
112.18 been a change in the financial circumstances of the person with the legal obligation to pay
112.19 support since the support order was entered, the person with the legal obligation to pay
112.20 support has petitioned for a modification of the support order; and

112.21 (4) an allocation for the unmet need of an ineligible spouse or an ineligible child
112.22 under the age of 21 for whom the caregiver is financially responsible and who lives with
112.23 the caregiver according to section 256J.36.

112.24 (b) Notwithstanding paragraph (a), when determining initial eligibility for applicant
112.25 units when at least one member has received MFIP in this state within four months of
112.26 the most recent application for MFIP, apply the disregard as defined in section 256J.08,
112.27 subdivision 24, for all unit members.

112.28 After initial eligibility is established, the assistance payment calculation is based on
112.29 the monthly income test.

112.30 **EFFECTIVE DATE.** This section is effective October 1, 2013, or upon approval
112.31 from the United States Department of Agriculture, whichever is later.

112.32 Sec. 28. Minnesota Statutes 2012, section 256J.24, subdivision 3, is amended to read:

Subd. 3. **Individuals who must be excluded from an assistance unit.** (a) The following individuals who are part of the assistance unit determined under subdivision 2 are ineligible to receive MFIP:

(1) individuals who are recipients of Supplemental Security Income or Minnesota supplemental aid;

(2) individuals disqualified from the food stamp or food support program or MFIP, until the disqualification ends;

(3) children on whose behalf federal, state or local foster care payments are made, except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2;

(4) children receiving ongoing guardianship assistance payments under chapter 256N;

~~(4)~~ (5) children receiving ongoing monthly adoption assistance payments under ~~section 259.67~~ chapter 259A or 256N; and

~~(5)~~ (6) individuals disqualified from the work participation cash benefit program until that disqualification ends.

(b) The exclusion of a person under this subdivision does not alter the mandatory assistance unit composition.

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

Sec. 29. Minnesota Statutes 2012, section 256J.24, subdivision 7, is amended to read:

Subd. 7. **Family wage level.** The family wage level is 110 percent of the transitional standard under subdivision 5 or 6~~, when applicable, and is the standard used when there is earned income in the assistance unit. As specified in section 256J.21~~. If there is earned income in the assistance unit, earned income is subtracted from the family wage level to determine the amount of the assistance payment, as specified in section 256J.21. The assistance payment may not exceed the transitional standard under subdivision 5 or 6, or the shared household standard under subdivision 9, whichever is applicable, for the assistance unit.

EFFECTIVE DATE. This section is effective October 1, 2013, or upon approval from the United States Department of Agriculture, whichever is later.

Sec. 30. Minnesota Statutes 2012, section 256J.621, is amended to read:

256J.621 WORK PARTICIPATION CASH BENEFITS.

Subdivision 1. **Program characteristics.** (a) Effective October 1, 2009, upon exiting the diversionary work program (DWP) or upon terminating the Minnesota family investment program with earnings, a participant who is employed may be eligible for work

114.1 participation cash benefits of $25 per month to assist in meeting the family's basic needs
114.2 as the participant continues to move toward self-sufficiency.
114.3 (b) To be eligible for work participation cash benefits, the participant shall not
114.4 receive MFIP or diversionary work program assistance during the month and the
114.5 participant or participants must meet the following work requirements:
114.6 (1) if the participant is a single caregiver and has a child under six years of age, the
114.7 participant must be employed at least 87 hours per month;
114.8 (2) if the participant is a single caregiver and does not have a child under six years of
114.9 age, the participant must be employed at least 130 hours per month; or
114.10 (3) if the household is a two-parent family, at least one of the parents must be
114.11 employed 130 hours per month.
114.12 Whenever a participant exits the diversionary work program or is terminated from
114.13 MFIP and meets the other criteria in this section, work participation cash benefits are
114.14 available for up to 24 consecutive months.
114.15 (c) Expenditures on the program are maintenance of effort state funds under
114.16 a separate state program for participants under paragraph (b), clauses (1) and (2).
114.17 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
114.18 funds. Months in which a participant receives work participation cash benefits under this
114.19 section do not count toward the participant's MFIP 60-month time limit.
114.20 Subd. 2. **Program suspension.** (a) Effective December 1, 2013, the work
114.21 participation cash benefits program shall be suspended.
114.22 (b) The commissioner of human services may reinstate the work participation cash
114.23 benefits program if the United States Department of Human Services determines that the
114.24 state of Minnesota did not meet the federal TANF work participation rate, and sends a
114.25 notice of penalty to reduce Minnesota's federal TANF block grant authorized under title I
114.26 of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation
114.27 Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.
114.28 (c) The commissioner shall notify the chairs of the legislative committees with
114.29 jurisdiction over human services policy and funding of the potential penalty and the
114.30 commissioner's plans to reinstate the work participation cash benefit program within 30
114.31 days of the date the commissioner receives notification that the state failed to meet the
114.32 federal work participation rate.

114.33 Sec. 31. Minnesota Statutes 2012, section 256J.626, subdivision 7, is amended to read:
114.34 Subd. 7. **Performance base funds.** ~~(a) For the purpose of this section, the following~~
114.35 ~~terms have the meanings given.~~

~~(1) "Caseload Reduction Credit" (CRC) means the measure of how much Minnesota TANF and separate state program caseload has fallen relative to federal fiscal year 2005 based on caseload data from October 1 to September 30.~~

~~(2) "TANF participation rate target" means a 50 percent participation rate reduced by the CRC for the previous year.~~

~~(b)~~ (a) For calendar year ~~2010~~ 2016 and yearly thereafter, each county and tribe ~~will~~ must be allocated ~~95~~ 100 percent of their initial calendar year allocation. Allocations for counties and tribes ~~will~~ must be ~~allocated additional funds~~ adjusted based on performance as follows:

~~(1) a county or tribe that achieves the TANF participation rate target or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation;~~

~~(2)~~ (1) a county or tribe that performs ~~within or~~ above its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will~~ must receive an additional allocation equal to 2.5 percent of its initial allocation; and

~~(3) a county or tribe that does not achieve the TANF participation rate target or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent year for which the measurements are available, will not receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear improvement plan with the commissioner; or~~

~~(4)~~ (2) a county or tribe that ~~does not perform within or above~~ performs below its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to 2.5 percent of its initial allocation until after negotiating~~ for two consecutive years must negotiate a multiyear improvement plan with the commissioner. If no improvement is shown by the end of the multiyear plan, the county's or tribe's allocation must be decreased by 2.5 percent. The decrease must remain in effect until the tribe performs within or above its range of expected performance.

~~(c)~~ (b) For calendar year ~~2009~~ 2016 and yearly thereafter, performance-based funds for a federally approved tribal TANF program in which the state and tribe have in place a contract under section 256.01, addressing consolidated funding, ~~will~~ must be allocated as follows:

116.1 ~~(1) a tribe that achieves the participation rate approved in its federal TANF plan~~
116.2 ~~using the average of 12 consecutive months for the most recent year for which the~~
116.3 ~~measurements are available, will receive an additional allocation equal to 2.5 percent of~~
116.4 ~~its initial allocation; and~~
116.5 ~~(2)~~ (1) a tribe that performs ~~within or~~ above its range of expected performance on the
116.6 annualized three-year self-support index under section 256J.751, subdivision 2, clause (6),
116.7 ~~will~~ must receive an additional allocation equal to 2.5 percent of its initial allocation; or
116.8 ~~(3) a tribe that does not achieve the participation rate approved in its federal TANF~~
116.9 ~~plan using the average of 12 consecutive months for the most recent year for which the~~
116.10 ~~measurements are available, will not receive an additional allocation equal to 2.5 percent~~
116.11 ~~of its initial allocation until after negotiating a multiyear improvement plan with the~~
116.12 ~~commissioner; or~~
116.13 ~~(4)~~ (2) a tribe that ~~does not perform within or above~~ performs below its range of
116.14 expected performance on the annualized three-year self-support index under section
116.15 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to~~
116.16 ~~2.5 percent until after negotiating~~ for two consecutive years must negotiate a multiyear
116.17 improvement plan with the commissioner. If no improvement is shown by the end of the
116.18 multiyear plan, the tribe's allocation must be decreased by 2.5 percent. The decrease must
116.19 remain in effect until the tribe performs within or above its range of expected performance.
116.20 ~~(d)~~ (c) Funds remaining unallocated after the performance-based allocations
116.21 in paragraph ~~(b)~~ (a) are available to the commissioner for innovation projects under
116.22 subdivision 5.
116.23 ~~(1)~~ (d) If available funds are insufficient to meet county and tribal allocations under
116.24 ~~paragraph~~ paragraphs (a) and (b), the commissioner ~~may make available for allocation~~
116.25 ~~funds that are unobligated and available from the innovation projects through the end of~~
116.26 ~~the current biennium~~ shall proportionally prorate funds to counties and tribes that qualify
116.27 for a bonus under paragraphs (a), clause (1), and (b), clause (2).
116.28 ~~(2) If after the application of clause (1) funds remain insufficient to meet county and~~
116.29 ~~tribal allocations under paragraph (b), the commissioner must proportionally reduce the~~
116.30 ~~allocation of each county and tribe with respect to their maximum allocation available~~
116.31 ~~under paragraph (b).~~

116.32 Sec. 32. **[256J.78] TANF DEMONSTRATION PROJECTS OR WAIVER FROM**
116.33 **FEDERAL RULES AND REGULATIONS.**
116.34 Subdivision 1. **Duties of the commissioner.** The commissioner of human services
116.35 may pursue TANF demonstration projects or waivers of TANF requirements from the

117.1 United States Department of Health and Human Services as needed to allow the state to
117.2 build a more results-oriented Minnesota Family Investment Program to better meet the
117.3 needs of Minnesota families.

117.4 Subd. 2. **Purpose.** The purpose of the TANF demonstration projects or waivers is to:

117.5 (1) replace the federal TANF process measure and its complex administrative
117.6 requirements with state-developed outcomes measures that track adult employment and
117.7 exits from MFIP cash assistance;

117.8 (2) simplify programmatic and administrative requirements; and

117.9 (3) make other policy or programmatic changes that improve the performance of the
117.10 program and the outcomes for participants.

117.11 Subd. 3. **Report to legislature.** The commissioner shall report to the members of
117.12 the legislative committees having jurisdiction over human services issues by March 1,
117.13 2014, regarding the progress of this waiver or demonstration project.

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

117.15 Sec. 33. **[256N.001] CITATION.**

117.16 Sections 256N.001 to 256N.28 may be cited as the "Northstar Care for Children Act."
117.17 Sections 256N.001 to 256N.28 establish Northstar Care for Children, which authorizes
117.18 certain benefits to support a child in need who is served by the Minnesota child welfare
117.19 system and who is the responsibility of the state, local county social service agencies, or
117.20 tribal social service agencies authorized under section 256.01, subdivision 14b, or are
117.21 otherwise eligible for federal adoption assistance. A child eligible under this chapter
117.22 has experienced a child welfare intervention that has resulted in the child being placed
117.23 away from the child's parents' care and is receiving foster care services consistent with
117.24 chapter 260B, 260C, or 260D, or is in the permanent care of relatives through a transfer of
117.25 permanent legal and physical custody, or in the permanent care of adoptive parents.

117.26 Sec. 34. **[256N.01] PUBLIC POLICY.**

117.27 (a) The legislature declares that the public policy of this state is to keep children safe
117.28 from harm and to ensure that when children suffer harmful or injurious experiences in
117.29 their lives, appropriate services are immediately available to keep them safe.

117.30 (b) Children do best in permanent, safe, nurturing homes where they can maintain
117.31 lifelong relationships with adults. Whenever safely possible, children are best served
117.32 when they can be nurtured and raised by their parents. Where services cannot be provided
117.33 to allow a child to remain safely at home, an out-of-home placement may be required.
117.34 When this occurs, reunification should be sought if it can be accomplished safely. When

118.1 it is not possible for parents to provide safety and permanency for their children, an
118.2 alternative permanent home must quickly be made available to the child, drawing from
118.3 kinship sources whenever possible.

118.4 (c) Minnesota understands the importance of having a comprehensive approach to
118.5 temporary out-of-home care and to permanent homes for children who cannot be reunited
118.6 with their families. It is critical that stable benefits be available to caregivers to ensure
118.7 that the child's needs can be met whether the child's situation and best interests call for
118.8 temporary foster care, transfer of permanent legal and physical custody to a relative, or
118.9 adoption. Northstar Care for Children focuses on the child's needs and strengths, and
118.10 the actual level of care provided by the caregiver, without consideration for the type of
118.11 placement setting. In this way caregivers are not faced with the burden of making specific
118.12 long-term decisions based upon competing financial incentives.

118.13 Sec. 35. **[256N.02] DEFINITIONS.**

118.14 Subdivision 1. **Scope.** For the purposes of sections 256N.001 to 256N.28, the terms
118.15 defined in this section have the meanings given them.

118.16 Subd. 2. **Adoption assistance.** "Adoption assistance" means medical coverage as
118.17 allowable under section 256B.055 and reimbursement of nonrecurring expenses associated
118.18 with adoption and may include financial support provided under agreement with the
118.19 financially responsible agency, the commissioner, and the parents of an adoptive child
118.20 whose special needs would otherwise make it difficult to place the child for adoption to
118.21 assist with the cost of caring for the child. Financial support may include a basic rate
118.22 payment and a supplemental difficulty of care rate.

118.23 Subd. 3. **Assessment.** "Assessment" means the process under section 256N.24 that
118.24 determines the benefits an eligible child may receive under section 256N.26.

118.25 Subd. 4. **At-risk child.** "At-risk child" means a child who does not have a
118.26 documented disability but who is at risk of developing a physical, mental, emotional, or
118.27 behavioral disability based on being related within the first or second degree to persons
118.28 who have an inheritable physical, mental, emotional, or behavioral disabling condition,
118.29 or from a background which has the potential to cause the child to develop a physical,
118.30 mental, emotional, or behavioral disability that the child is at risk of developing. The
118.31 disability must manifest during childhood.

118.32 Subd. 5. **Basic rate.** "Basic rate" means the maintenance payment made on behalf
118.33 of a child to support the costs caregivers incur to provide for a child's needs consistent with
118.34 the care parents customarily provide, including: food, clothing, shelter, daily supervision,
118.35 school supplies, and a child's personal incidentals. It also supports typical travel to the

119.1 child's home for visitation, and reasonable travel for the child to remain in the school in
119.2 which the child is enrolled at the time of placement.

119.3 Subd. 6. **Caregiver.** "Caregiver" means the foster parent or parents of a child in
119.4 foster care who meet the requirements of emergency relative placement, licensed foster
119.5 parents under chapter 245A, or foster parents licensed or approved by a tribe; the relative
119.6 custodian or custodians; or the adoptive parent or parents who have legally adopted a child.

119.7 Subd. 7. **Commissioner.** "Commissioner" means the commissioner of human
119.8 services or any employee of the Department of Human Services to whom the
119.9 commissioner has delegated appropriate authority.

119.10 Subd. 8. **County board.** "County board" means the board of county commissioners
119.11 in each county.

119.12 Subd. 9. **Disability.** "Disability" means a physical, mental, emotional, or behavioral
119.13 impairment that substantially limits one or more major life activities. Major life activities
119.14 include, but are not limited to: thinking, walking, hearing, breathing, working, seeing,
119.15 speaking, communicating, learning, developing and maintaining healthy relationships,
119.16 safely caring for oneself, and performing manual tasks. The nature, duration, and severity
119.17 of the impairment must be considered in determining if the limitation is substantial.

119.18 Subd. 10. **Financially responsible agency.** "Financially responsible agency" means
119.19 the agency that is financially responsible for a child. These agencies include both local
119.20 social service agencies under section 393.07 and tribal social service agencies authorized
119.21 in section 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative,
119.22 and Minnesota tribes who assume financial responsibility of children from other states.
119.23 Under Northstar Care for Children, the agency that is financially responsible at the time of
119.24 placement for foster care continues to be responsible under section 256N.27 for the local
119.25 share of any maintenance payments, even after finalization of the adoption of transfer of
119.26 permanent legal and physical custody of a child.

119.27 Subd. 11. **Guardianship assistance.** "Guardianship assistance" means medical
119.28 coverage, as allowable under section 256B.055, and reimbursement of nonrecurring
119.29 expenses associated with obtaining permanent legal and physical custody of a child, and
119.30 may include financial support provided under agreement with the financially responsible
119.31 agency, the commissioner, and the relative who has received a transfer of permanent legal
119.32 and physical custody of a child. Financial support may include a basic rate payment and a
119.33 supplemental difficulty of care rate to assist with the cost of caring for the child.

119.34 Subd. 12. **Human services board.** "Human services board" means a board
119.35 established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

120.1 Subd. 13. **Initial assessment.** "Initial assessment" means the assessment conducted
120.2 within the first 30 days of a child's initial placement into foster care under section
120.3 256N.24, subdivisions 4 and 5.

120.4 Subd. 14. **Legally responsible agency.** "Legally responsible agency" means the
120.5 Minnesota agency that is assigned responsibility for placement, care, and supervision
120.6 of the child through a court order, voluntary placement agreement, or voluntary
120.7 relinquishment. These agencies include local social service agencies under section 393.07,
120.8 tribal social service agencies authorized in section 256.01, subdivision 14b, and Minnesota
120.9 tribes that assume court jurisdiction when legal responsibility is transferred to the tribal
120.10 social service agency through a Minnesota district court order. A Minnesota local social
120.11 service agency is otherwise financially responsible.

120.12 Subd. 15. **Maintenance payments.** "Maintenance payments" means the basic
120.13 rate plus any supplemental difficulty of care rate under Northstar Care for Children. It
120.14 specifically does not include the cost of initial clothing allowance, payment for social
120.15 services, or administrative payments to a child-placing agency. Payments are paid
120.16 consistent with section 256N.26.

120.17 Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical
120.18 custody" means a transfer of permanent legal and physical custody to a relative ordered by
120.19 a Minnesota juvenile court under section 260C.515, subdivision 4, or for a child under
120.20 jurisdiction of a tribal court, a judicial determination under a similar provision in tribal
120.21 code which means that a relative will assume the duty and authority to provide care,
120.22 control, and protection of a child who is residing in foster care, and to make decisions
120.23 regarding the child's education, health care, and general welfare until adulthood.

120.24 Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment
120.25 through the process under section 256N.24 for a child who has been continuously eligible
120.26 for Northstar Care for Children, or when a child identified as an at-risk child (Level A)
120.27 under guardianship or adoption assistance has manifested the disability upon which
120.28 eligibility for the agreement was based according to section 256N.25, subdivision 3,
120.29 paragraph (b). A reassessment may be used to update an initial assessment, a special
120.30 assessment, or a previous reassessment.

120.31 Subd. 18. **Relative.** "Relative," as described in section 260C.007, subdivision 27,
120.32 means a person related to the child by blood, marriage, or adoption, or an individual who
120.33 is an important friend with whom the child has resided or had significant contact. For an
120.34 Indian child, relative includes members of the extended family as defined by the law or
120.35 custom of the Indian child's tribe or, in the absence of law or custom, nieces, nephews,

121.1 or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United
121.2 States Code, title 25, section 1903.

121.3 Subd. 19. **Relative custodian.** "Relative custodian" means a person to whom
121.4 permanent legal and physical custody of a child has been transferred under section
121.5 260C.515, subdivision 4, or for a child under jurisdiction of a tribal court, a judicial
121.6 determination under a similar provision in tribal code, which means that a relative will
121.7 assume the duty and authority to provide care, control, and protection of a child who is
121.8 residing in foster care, and to make decisions regarding the child's education, health
121.9 care, and general welfare until adulthood.

121.10 Subd. 20. **Special assessment.** "Special assessment" means an assessment
121.11 performed under section 256N.24 that determines the benefits that an eligible child may
121.12 receive under section 256N.26 at the time when a special assessment is required. A special
121.13 assessment is used in the following circumstances when a child's status within Northstar
121.14 Care is shifted from a pre-Northstar Care program into Northstar Care for Children when
121.15 the commissioner determines that a special assessment is appropriate instead of assigning
121.16 the transition child to a level under section 256N.28.

121.17 Subd. 21. **Supplemental difficulty of care rate.** "Supplemental difficulty of care
121.18 rate" means the supplemental payment under section 256N.26, if any, as determined by
121.19 the financially responsible agency or the state, based upon an assessment under section
121.20 256N.24. The rate must support activities consistent with the care a parent provides a child
121.21 with special needs and not the equivalent of a purchased service. The rate must consider
121.22 the capacity and intensity of the activities associated with parenting duties provided in
121.23 the home to nurture the child, preserve the child's connections, and support the child's
121.24 functioning in the home and community.

121.25 Sec. 36. **[256N.20] NORTHSTAR CARE FOR CHILDREN; GENERALLY.**

121.26 Subdivision 1. **Eligibility.** A child is eligible for Northstar Care for Children if
121.27 the child is eligible for:

121.28 (1) foster care under section 256N.21;

121.29 (2) guardianship assistance under section 256N.22; or

121.30 (3) adoption assistance under section 256N.23.

121.31 Subd. 2. **Assessments.** Except as otherwise specified, a child eligible for Northstar
121.32 Care for Children shall receive an assessment under section 256N.24.

121.33 Subd. 3. **Agreements.** When a child is eligible for guardianship assistance or
121.34 adoption assistance, negotiations with caregivers and the development of a written,
121.35 binding agreement must be conducted under section 256N.25.

122.1 Subd. 4. **Benefits and payments.** A child eligible for Northstar Care for Children is
122.2 entitled to benefits specified in section 256N.26, based primarily on assessments under
122.3 section 256N.24, and, if appropriate, negotiations and agreements under section 256N.25.
122.4 Although paid to the caregiver, these benefits must be considered benefits of the child
122.5 rather than of the caregiver.

122.6 Subd. 5. **Federal, state, and local shares.** The cost of Northstar Care for Children
122.7 must be shared among the federal government, state, counties of financial responsibility,
122.8 and certain tribes as specified in section 256N.27.

122.9 Subd. 6. **Administration and appeals.** The commissioner and financially
122.10 responsible agency, or other agency designated by the commissioner, shall administer
122.11 Northstar Care for Children according to section 256N.28. The notification and fair
122.12 hearing process applicable to this chapter is defined in section 256N.28.

122.13 Subd. 7. **Transition.** A child in foster care, relative custody assistance, or adoption
122.14 assistance prior to January 1, 2015, who remains with the same caregivers continues
122.15 to receive benefits under programs preceding Northstar Care for Children, unless the
122.16 child moves to a new foster care placement, permanency is obtained for the child, or the
122.17 commissioner initiates transition of a child receiving pre-Northstar Care for Children
122.18 relative custody assistance, guardianship assistance, or adoption assistance under this
122.19 chapter. Provisions for the transition to Northstar Care for Children for certain children in
122.20 preceding programs are specified in section 256N.28, subdivisions 2 and 7. Additional
122.21 provisions for children in: foster care are specified in section 256N.21, subdivision
122.22 6; relative custody assistance under section 257.85 are specified in section 256N.22,
122.23 subdivision 12; and adoption assistance under chapter 259A are specified in section
122.24 256N.23, subdivision 13.

122.25 Sec. 37. **[256N.21] ELIGIBILITY FOR FOSTER CARE BENEFITS.**

122.26 Subdivision 1. **General eligibility requirements.** (a) A child is eligible for foster
122.27 care benefits under this section if the child meets the requirements of subdivision 2 on
122.28 or after January 1, 2015.

122.29 (b) The financially responsible agency shall make a title IV-E eligibility determination
122.30 for all foster children meeting the requirements of subdivision 2, provided the agency has
122.31 such authority under the state title IV-E plan. To be eligible for title IV-E foster care, a child
122.32 must also meet any additional criteria specified in section 472 of the Social Security Act.

122.33 (c) Except as provided under section 256N.26, subdivision 1 or 6, the foster care
122.34 benefit to the child under this section must be determined under sections 256N.24 and
122.35 256N.26 through an individual assessment. Information from this assessment must be

123.1 used to determine a potential future benefit under guardianship assistance or adoption
123.2 assistance, if needed.

123.3 (d) When a child is eligible for additional services, subdivisions 3 and 4 govern
123.4 the co-occurrence of program eligibility.

123.5 Subd. 2. **Placement in foster care.** To be eligible for foster care benefits under this
123.6 section, the child must be in placement away from the child's legal parent or guardian and
123.7 all of the following criteria must be met:

123.8 (1) the legally responsible agency must have placement authority and care
123.9 responsibility, including for a child 18 years old or older and under age 21, who maintains
123.10 eligibility for foster care consistent with section 260C.451;

123.11 (2) the legally responsible agency must have authority to place the child with a
123.12 voluntary placement agreement or a court order, consistent with sections 260B.198,
123.13 260C.001, 260D.01, or continued eligibility consistent with section 260C.451; and

123.14 (3) the child must be placed in an emergency relative placement under section
123.15 245A.035, a licensed foster family setting, foster residence setting, or treatment foster
123.16 care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, a family
123.17 foster home licensed or approved by a tribal agency or, for a child 18 years old or older
123.18 and under age 21, an unlicensed supervised independent living setting approved by the
123.19 agency responsible for the youth's care.

123.20 Subd. 3. **Minor parent.** A child who is a minor parent in placement with the minor
123.21 parent's child in the same home is eligible for foster care benefits under this section. The
123.22 foster care benefit is limited to the minor parent, unless the legally responsible agency has
123.23 separate legal authority for placement of the minor parent's child.

123.24 Subd. 4. **Foster children ages 18 up to 21 placed in an unlicensed supervised**
123.25 **independent living setting.** A foster child 18 years old or older and under age 21 who
123.26 maintains eligibility consistent with section 260C.451 and who is placed in an unlicensed
123.27 supervised independent living setting shall receive the level of benefit under section
123.28 256N.26.

123.29 Subd. 5. **Excluded activities.** The basic and supplemental difficulty of care
123.30 payment represents costs for activities similar in nature to those expected of parents,
123.31 and does not cover services rendered by the licensed or tribally approved foster parent,
123.32 facility, or administrative costs or fees. The financially responsible agency may pay an
123.33 additional fee for specific services provided by the licensed foster parent or facility. A
123.34 foster parent or residence setting must distinguish such a service from the daily care of the
123.35 child as assessed through the process under section 256N.24.

124.1 Subd. 6. **Transition from pre-Northstar Care for Children program.** (a) Section
124.2 256.82 establishes the pre-Northstar Care for Children foster care program for all children
124.3 residing in family foster care on December 31, 2014. Unless transitioned under paragraph
124.4 (b), a child in foster care with the same caregiver receives benefits under this pre-Northstar
124.5 Care for Children foster care program.

124.6 (b) Transition from the pre-Northstar Care for Children foster care program to
124.7 Northstar Care for Children takes place on or after January 1, 2015, when the child:

124.8 (1) moves to a different foster home or unlicensed supervised independent living
124.9 setting;

124.10 (2) has permanent legal and physical custody transferred and, if applicable, meets
124.11 eligibility requirements in section 256N.22;

124.12 (3) is adopted and, if applicable, meets eligibility requirements in section 256N.23; or

124.13 (4) re-enters foster care after reunification or a trial home visit.

124.14 (c) Upon becoming eligible, a foster child must be assessed according to section
124.15 256N.24 and then transitioned into Northstar Care for Children according to section
124.16 256N.28.

124.17 Sec. 38. **[256N.22] GUARDIANSHIP ASSISTANCE ELIGIBILITY.**

124.18 Subdivision 1. **General eligibility requirements.** (a) To be eligible for the
124.19 guardianship assistance under this section, there must be a judicial determination under
124.20 section 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to
124.21 a relative is in the child's best interest. For a child under jurisdiction of a tribal court, a
124.22 judicial determination under a similar provision in tribal code indicating that a relative
124.23 will assume the duty and authority to provide care, control, and protection of a child who
124.24 is residing in foster care, and to make decisions regarding the child's education, health
124.25 care, and general welfare until adulthood, and that this is in the child's best interest is
124.26 considered equivalent. Additionally, a child must:

124.27 (1) have been removed from the child's home pursuant to a voluntary placement
124.28 agreement or court order;

124.29 (2)(i) have resided in foster care for at least six consecutive months in the home
124.30 of the prospective relative custodian; or

124.31 (ii) have received an exemption from the requirement in item (i) from the court
124.32 based on a determination that:

124.33 (A) an expedited move to permanency is in the child's best interest;

124.34 (B) expedited permanency cannot be completed without provision of guardianship
124.35 assistance; and

125.1 (C) the prospective relative custodian is uniquely qualified to meet the child's needs
125.2 on a permanent basis;
125.3 (3) meet the agency determinations regarding permanency requirements in
125.4 subdivision 2;
125.5 (4) meet the applicable citizenship and immigration requirements in subdivision
125.6 3; and
125.7 (5) have been consulted regarding the proposed transfer of permanent legal and
125.8 physical custody to a relative, if the child is at least 14 years of age or is expected to attain
125.9 14 years of age prior to the transfer of permanent legal and physical custody; and
125.10 (6) have a written, binding agreement under section 256N.25 among the caregiver or
125.11 caregivers, the financially responsible agency, and the commissioner established prior to
125.12 transfer of permanent legal and physical custody.
125.13 (b) In addition to the requirements in paragraph (a), the child's prospective relative
125.14 custodian or custodians must meet the applicable background study requirements in
125.15 subdivision 4.
125.16 (c) To be eligible for title IV-E guardianship assistance, a child must also meet any
125.17 additional criteria in section 473(d) of the Social Security Act. The sibling of a child
125.18 who meets the criteria for title IV-E guardianship assistance in section 473(d) of the
125.19 Social Security Act is eligible for title IV-E guardianship assistance if the child and
125.20 sibling are placed with the same prospective relative custodian or custodians, and the
125.21 legally responsible agency, relatives, and commissioner agree on the appropriateness of
125.22 the arrangement for the sibling. A child who meets all eligibility criteria except those
125.23 specific to title IV-E guardianship assistance is entitled to guardianship assistance paid
125.24 through funds other than title IV-E.
125.25 Subd. 2. **Agency determinations regarding permanency.** (a) To be eligible for
125.26 guardianship assistance, the legally responsible agency must complete the following
125.27 determinations regarding permanency for the child prior to the transfer of permanent
125.28 legal and physical custody:
125.29 (1) a determination that reunification and adoption are not appropriate permanency
125.30 options for the child; and
125.31 (2) a determination that the child demonstrates a strong attachment to the prospective
125.32 relative custodian and the prospective relative custodian has a strong commitment to
125.33 caring permanently for the child.
125.34 (b) The legally responsible agency shall document the determinations in paragraph
125.35 (a) and the supporting information for completing each determination in the case file and

126.1 make them available for review as requested by the financially responsible agency and the
126.2 commissioner during the guardianship assistance eligibility determination process.

126.3 Subd. 3. **Citizenship and immigration status.** A child must be a citizen of the
126.4 United States or otherwise be eligible for federal public benefits according to the Personal
126.5 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order
126.6 to be eligible for guardianship assistance.

126.7 Subd. 4. **Background study.** (a) A background study under section 245C.33 must
126.8 be completed on each prospective relative custodian and any other adult residing in the
126.9 home of the prospective relative custodian. A background study on the prospective
126.10 relative custodian or adult residing in the household previously completed under section
126.11 245C.04 for the purposes of foster care licensure may be used for the purposes of this
126.12 section, provided that the background study is current at the time of the application for
126.13 guardianship assistance.

126.14 (b) If the background study reveals:

126.15 (1) a felony conviction at any time for:

126.16 (i) child abuse or neglect;

126.17 (ii) spousal abuse;

126.18 (iii) a crime against a child, including child pornography; or

126.19 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not
126.20 including other physical assault or battery; or

126.21 (2) a felony conviction within the past five years for:

126.22 (i) physical assault;

126.23 (ii) battery; or

126.24 (iii) a drug-related offense;

126.25 the prospective relative custodian is prohibited from receiving guardianship assistance
126.26 on behalf of an otherwise eligible child.

126.27 Subd. 5. **Responsibility for determining guardianship assistance eligibility.** The
126.28 commissioner shall determine eligibility for:

126.29 (1) a child under the legal custody or responsibility of a Minnesota county social
126.30 service agency who would otherwise remain in foster care;

126.31 (2) a Minnesota child under tribal court jurisdiction who would otherwise remain
126.32 in foster care; and

126.33 (3) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
126.34 in section 473(d) of the Social Security Act. The agency or entity assuming responsibility
126.35 for the child is responsible for the nonfederal share of the guardianship assistance payment.

127.1 Subd. 6. **Exclusions.** (a) A child with a guardianship assistance agreement under
127.2 Northstar Care for Children is not eligible for the Minnesota family investment program
127.3 child-only grant under chapter 256J.

127.4 (b) The commissioner shall not enter into a guardianship assistance agreement with:

127.5 (1) a child's biological parent;

127.6 (2) an individual assuming permanent legal and physical custody of a child or the
127.7 equivalent under tribal code without involvement of the child welfare system; or

127.8 (3) an individual assuming permanent legal and physical custody of a child who was
127.9 placed in Minnesota by another state or a tribe outside of Minnesota.

127.10 Subd. 7. **Guardianship assistance eligibility determination.** The financially
127.11 responsible agency shall prepare a guardianship assistance eligibility determination
127.12 for review and final approval by the commissioner. The eligibility determination must
127.13 be completed according to requirements and procedures and on forms prescribed by
127.14 the commissioner. Supporting documentation for the eligibility determination must be
127.15 provided to the commissioner. The financially responsible agency and the commissioner
127.16 must make every effort to establish a child's eligibility for title IV-E guardianship
127.17 assistance. A child who is determined to be eligible for guardianship assistance must
127.18 have a guardianship assistance agreement negotiated on the child's behalf according to
127.19 section 256N.25.

127.20 Subd. 8. **Termination of agreement.** (a) A guardianship assistance agreement must
127.21 be terminated in any of the following circumstances:

127.22 (1) the child has attained the age of 18, or up to age 21 when the child meets a
127.23 condition for extension in subdivision 11;

127.24 (2) the child has not attained the age of 18 years of age, but the commissioner
127.25 determines the relative custodian is no longer legally responsible for support of the child;

127.26 (3) the commissioner determines the relative custodian is no longer providing
127.27 financial support to the child up to age 21;

127.28 (4) the death of the child; or

127.29 (5) the relative custodian requests in writing termination of the guardianship
127.30 assistance agreement.

127.31 (b) A relative custodian is considered no longer legally responsible for support of
127.32 the child in any of the following circumstances:

127.33 (1) permanent legal and physical custody or guardianship of the child is transferred
127.34 to another individual;

127.35 (2) death of the relative custodian under subdivision 9;

127.36 (3) child enlists in the military;

128.1 (4) child gets married; or

128.2 (5) child is determined an emancipated minor through legal action.

128.3 Subd. 9. **Death of relative custodian or dissolution of custody.** The guardianship
128.4 assistance agreement ends upon death or dissolution of permanent legal and physical
128.5 custody of both relative custodians in the case of assignment of custody to two individuals,
128.6 or the sole relative custodian in the case of assignment of custody to one individual.
128.7 Guardianship assistance eligibility may be continued according to subdivision 10.

128.8 Subd. 10. **Assigning a child's guardianship assistance to a court-appointed**
128.9 **guardian or custodian.** (a) Guardianship assistance may be continued with the written
128.10 consent of the commissioner to an individual who is a guardian or custodian appointed by
128.11 a court for the child upon the death of both relative custodians in the case of assignment
128.12 of custody to two individuals, or the sole relative custodian in the case of assignment
128.13 of custody to one individual, unless the child is under the custody of a county, tribal,
128.14 or child-placing agency.

128.15 (b) Temporary assignment of guardianship assistance may be approved for a
128.16 maximum of six consecutive months from the death of the relative custodian or custodians
128.17 as provided in paragraph (a) and must adhere to the policies and procedures prescribed by
128.18 the commissioner. If a court has not appointed a permanent legal guardian or custodian
128.19 within six months, the guardianship assistance must terminate and must not be resumed.

128.20 (c) Upon assignment of assistance payments under this subdivision, assistance must
128.21 be provided from funds other than title IV-E.

128.22 Subd. 11. **Extension of guardianship assistance after age 18.** (a) Under the
128.23 circumstances outlined in paragraph (e), a child may qualify for extension of the
128.24 guardianship assistance agreement beyond the date the child attains age 18, up to the
128.25 date the child attains the age of 21.

128.26 (b) A request for extension of the guardianship assistance agreement must be
128.27 completed in writing and submitted, including all supporting documentation, by the
128.28 relative custodian to the commissioner at least 60 calendar days prior to the date that the
128.29 current agreement will terminate.

128.30 (c) A signed amendment to the current guardianship assistance agreement must be
128.31 fully executed between the relative custodian and the commissioner at least ten business
128.32 days prior to the termination of the current agreement. The request for extension and
128.33 the fully executed amendment must be made according to requirements and procedures
128.34 prescribed by the commissioner, including documentation of eligibility, and on forms
128.35 prescribed by the commissioner.

129.1 (d) If an agency is certifying a child for guardianship assistance and the child will
129.2 attain the age of 18 within 60 calendar days of submission, the request for extension must
129.3 be completed in writing and submitted, including all supporting documentation, with
129.4 the guardianship assistance application.
129.5 (e) A child who has attained the age of 16 prior to the effective date of the
129.6 guardianship assistance agreement is eligible for extension of the agreement up to the
129.7 date the child attains age 21 if the child:
129.8 (1) is dependent on the relative custodian for care and financial support; and
129.9 (2) meets at least one of the following conditions:
129.10 (i) is completing a secondary education program or a program leading to an
129.11 equivalent credential;
129.12 (ii) is enrolled in an institution which provides postsecondary or vocational education;
129.13 (iii) is participating in a program or activity designed to promote or remove barriers
129.14 to employment;
129.15 (iv) is employed for at least 80 hours per month; or
129.16 (v) is incapable of doing any of the activities described in items (i) to (iv) due to
129.17 a medical condition where incapability is supported by professional documentation
129.18 according to the requirements and procedures prescribed by the commissioner.
129.19 (f) A child who has not attained the age of 16 prior to the effective date of the
129.20 guardianship assistance agreement is eligible for extension of the guardianship assistance
129.21 agreement up to the date the child attains the age of 21 if the child is:
129.22 (1) dependent on the relative custodian for care and financial support; and
129.23 (2) possesses a physical or mental disability which impairs the capacity for
129.24 independent living and warrants continuation of financial assistance, as determined by
129.25 the commissioner.
129.26 Subd. 12. **Beginning guardianship assistance component of Northstar Care for**
129.27 **Children.** Effective November 27, 2014, a child who meets the eligibility criteria for
129.28 guardianship assistance in subdivision 1 may have a guardianship assistance agreement
129.29 negotiated on the child's behalf according to section 256N.25. The effective date of the
129.30 agreement must be January 1, 2015, or the date of the court order transferring permanent
129.31 legal and physical custody, whichever is later. Except as provided under section 256N.26,
129.32 subdivision 1, paragraph (c), the rate schedule for an agreement under this subdivision
129.33 is determined under section 256N.26 based on the age of the child on the date that the
129.34 prospective relative custodian signs the agreement.
129.35 Subd. 13. **Transition to guardianship assistance under Northstar Care for**
129.36 **Children.** The commissioner may execute guardianship assistance agreements for a child

130.1 with a relative custody agreement under section 257.85 executed on the child's behalf
130.2 on or before November 26, 2014, in accordance with the priorities outlined in section
130.3 256N.28, subdivision 7, paragraph (b). To facilitate transition into the guardianship
130.4 assistance program, the commissioner may waive any guardianship assistance eligibility
130.5 requirements for a child with a relative custody agreement under section 257.85 executed
130.6 on the child's behalf on or before November 26, 2014. Agreements negotiated under
130.7 this subdivision must be done according to the process outlined in section 256N.28,
130.8 subdivision 7. The maximum rate used in the negotiation process for an agreement under
130.9 this subdivision must be as outlined in section 256N.28, subdivision 7.

130.10 Sec. 39. **[256N.23] ADOPTION ASSISTANCE ELIGIBILITY.**

130.11 Subdivision 1. **General eligibility requirements.** (a) To be eligible for adoption
130.12 assistance under this section, a child must:
130.13 (1) be determined to be a child with special needs under subdivision 2;
130.14 (2) meet the applicable citizenship and immigration requirements in subdivision 3;
130.15 (3)(i) meet the criteria in section 473 of the Social Security Act; or
130.16 (ii) have had foster care payments paid on the child's behalf while in out-of-home
130.17 placement through the county or tribe and be either under the guardianship of the
130.18 commissioner or under the jurisdiction of a Minnesota tribe and adoption, according to
130.19 tribal law, is in the child's documented permanency plan; and
130.20 (4) have a written, binding agreement under section 256N.25 among the adoptive
130.21 parent, the financially responsible agency, or if there is no financially responsible agency,
130.22 the agency designated by the commissioner, and the commissioner established prior to
130.23 finalization of the adoption.
130.24 (b) In addition to the requirements in paragraph (a), an eligible child's adoptive parent
130.25 or parents must meet the applicable background study requirements in subdivision 4.
130.26 (c) A child who meets all eligibility criteria except those specific to title IV-E adoption
130.27 assistance shall receive adoption assistance paid through funds other than title IV-E.
130.28 Subd. 2. **Special needs determination.** (a) A child is considered a child with
130.29 special needs under this section if the requirements in paragraphs (b) to (g) are met.
130.30 (b) There must be a determination that the child must not or should not be returned
130.31 to the home of the child's parents as evidenced by:
130.32 (1) a court-ordered termination of parental rights;
130.33 (2) a petition to terminate parental rights;
130.34 (3) consent of parent to adoption accepted by the court under chapter 260C;

131.1 (4) in circumstances when tribal law permits the child to be adopted without a
131.2 termination of parental rights, a judicial determination by a tribal court indicating the valid
131.3 reason why the child cannot or should not return home;
131.4 (5) a voluntary relinquishment under section 259.25 or 259.47 or, if relinquishment
131.5 occurred in another state, the applicable laws in that state; or
131.6 (6) the death of the legal parent or parents if the child has two legal parents.
131.7 (c) There exists a specific factor or condition of which it is reasonable to conclude
131.8 that the child cannot be placed with adoptive parents without providing adoption
131.9 assistance as evidenced by:
131.10 (1) a determination by the Social Security Administration that the child meets all
131.11 medical or disability requirements of title XVI of the Social Security Act with respect to
131.12 eligibility for Supplemental Security Income benefits;
131.13 (2) a documented physical, mental, emotional, or behavioral disability not covered
131.14 under clause (1);
131.15 (3) a member of a sibling group being adopted at the same time by the same parent;
131.16 (4) an adoptive placement in the home of a parent who previously adopted a sibling
131.17 for whom they receive adoption assistance; or
131.18 (5) documentation that the child is an at-risk child.
131.19 (d) A reasonable but unsuccessful effort must have been made to place the child
131.20 with adoptive parents without providing adoption assistance as evidenced by:
131.21 (1) a documented search for an appropriate adoptive placement; or
131.22 (2) a determination by the commissioner that a search under clause (1) is not in the
131.23 best interests of the child.
131.24 (e) The requirement for a documented search for an appropriate adoptive placement
131.25 under paragraph (d), including the registration of the child with the state adoption
131.26 exchange and other recruitment methods under paragraph (f), must be waived if:
131.27 (1) the child is being adopted by a relative and it is determined by the child-placing
131.28 agency that adoption by the relative is in the best interests of the child;
131.29 (2) the child is being adopted by a foster parent with whom the child has developed
131.30 significant emotional ties while in the foster parent's care as a foster child and it is
131.31 determined by the child-placing agency that adoption by the foster parent is in the best
131.32 interests of the child; or
131.33 (3) the child is being adopted by a parent that previously adopted a sibling of the
131.34 child, and it is determined by the child-placing agency that adoption by this parent is
131.35 in the best interests of the child.

132.1 For an Indian child covered by the Indian Child Welfare Act, a waiver must not be
132.2 granted unless the child-placing agency has complied with the placement preferences
132.3 required by the Indian Child Welfare Act, United States Code, title 25, section 1915(a).

132.4 (f) To meet the requirement of a documented search for an appropriate adoptive
132.5 placement under paragraph (d), clause (1), the child-placing agency minimally must:

132.6 (1) conduct a relative search as required by section 260C.221 and give consideration
132.7 to placement with a relative, as required by section 260C.212, subdivision 2;

132.8 (2) comply with the placement preferences required by the Indian Child Welfare Act
132.9 when the Indian Child Welfare Act, United States Code, title 25, section 1915(a), applies;

132.10 (3) locate prospective adoptive families by registering the child on the state adoption
132.11 exchange, as required under section 259.75; and

132.12 (4) if registration with the state adoption exchange does not result in the identification
132.13 of an appropriate adoptive placement, the agency must employ additional recruitment
132.14 methods prescribed by the commissioner.

132.15 (g) Once the legally responsible agency has determined that placement with an
132.16 identified parent is in the child's best interests and made full written disclosure about the
132.17 child's social and medical history, the agency must ask the prospective adoptive parent if
132.18 the prospective adoptive parent is willing to adopt the child without receiving adoption
132.19 assistance under this section. If the identified parent is either unwilling or unable to
132.20 adopt the child without adoption assistance, the legally responsible agency must provide
132.21 documentation as prescribed by the commissioner to fulfill the requirement to make a
132.22 reasonable effort to place the child without adoption assistance. If the identified parent is
132.23 willing to adopt the child without adoption assistance, the parent must provide a written
132.24 statement to this effect to the legally responsible agency and the statement must be
132.25 maintained in the permanent adoption record of the legally responsible agency. For children
132.26 under guardianship of the commissioner, the legally responsible agency shall submit a copy
132.27 of this statement to the commissioner to be maintained in the permanent adoption record.

132.28 Subd. 3. **Citizenship and immigration status.** (a) A child must be a citizen of the
132.29 United States or otherwise eligible for federal public benefits according to the Personal
132.30 Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to
132.31 be eligible for the title IV-E adoption assistance program.

132.32 (b) A child must be a citizen of the United States or meet the qualified alien
132.33 requirements as defined in the Personal Responsibility and Work Opportunity
132.34 Reconciliation Act of 1996, as amended, in order to be eligible for adoption assistance
132.35 paid through funds other than title IV-E.

133.1 Subd. 4. **Background study.** A background study under section 259.41 must be
133.2 completed on each prospective adoptive parent. If the background study reveals:
133.3 (1) a felony conviction at any time for:
133.4 (i) child abuse or neglect;
133.5 (ii) spousal abuse;
133.6 (iii) a crime against a child, including child pornography; or
133.7 (iv) a crime involving violence, including rape, sexual assault, or homicide, but not
133.8 including other physical assault or battery; or
133.9 (2) a felony conviction within the past five years for:
133.10 (i) physical assault;
133.11 (ii) battery; or
133.12 (iii) a drug-related offense;
133.13 the adoptive parent is prohibited from receiving adoption assistance on behalf of an
133.14 otherwise eligible child.
133.15 Subd. 5. **Responsibility for determining adoption assistance eligibility.** The
133.16 commissioner must determine eligibility for:
133.17 (1) a child under the guardianship of the commissioner who would otherwise remain
133.18 in foster care;
133.19 (2) a child who is not under the guardianship of the commissioner who meets title
133.20 IV-E eligibility defined in section 473 of the Social Security Act and no state agency has
133.21 legal responsibility for placement and care of the child;
133.22 (3) a Minnesota child under tribal jurisdiction who would otherwise remain in foster
133.23 care; and
133.24 (4) an Indian child being placed in Minnesota who meets title IV-E eligibility defined
133.25 in section 473 of the Social Security Act. The agency or entity assuming responsibility for
133.26 the child is responsible for the nonfederal share of the adoption assistance payment.
133.27 Subd. 6. **Exclusions.** The commissioner must not enter into an adoption assistance
133.28 agreement with the following individuals:
133.29 (1) a child's biological parent or stepparent;
133.30 (2) a child's relative under section 260C.007, subdivision 27, with whom the child
133.31 resided immediately prior to child welfare involvement unless:
133.32 (i) the child was in the custody of a Minnesota county or tribal agency pursuant to
133.33 an order under chapter 260C or equivalent provisions of tribal code and the agency had
133.34 placement and care responsibility for permanency planning for the child; and
133.35 (ii) the child is under guardianship of the commissioner of human services according
133.36 to the requirements of section 260C.325, subdivision 1 or 3, or is a ward of a Minnesota

134.1 tribal court after termination of parental rights, suspension of parental rights, or a finding
134.2 by the tribal court that the child cannot safely return to the care of the parent;

134.3 (3) an individual adopting a child who is the subject of a direct adoptive placement
134.4 under section 259.47 or the equivalent in tribal code;

134.5 (4) a child's legal custodian or guardian who is now adopting the child; or

134.6 (5) an individual who is adopting a child who is not a citizen or resident of the
134.7 United States and was either adopted in another country or brought to the United States
134.8 for the purposes of adoption.

134.9 Subd. 7. **Adoption assistance eligibility determination.** (a) The financially
134.10 responsible agency shall prepare an adoption assistance eligibility determination for
134.11 review and final approval by the commissioner. When there is no financially responsible
134.12 agency, the adoption assistance eligibility determination must be completed by the
134.13 agency designated by the commissioner. The eligibility determination must be completed
134.14 according to requirements and procedures and on forms prescribed by the commissioner.
134.15 The financially responsible agency and the commissioner shall make every effort to
134.16 establish a child's eligibility for title IV-E adoption assistance. Documentation from a
134.17 qualified expert for the eligibility determination must be provided to the commissioner
134.18 to verify that a child meets the special needs criteria in subdivision 2. A child who
134.19 is determined to be eligible for adoption assistance must have an adoption assistance
134.20 agreement negotiated on the child's behalf according to section 256N.25.

134.21 (b) Documentation from a qualified expert of a disability is limited to evidence
134.22 deemed appropriate by the commissioner and must be submitted to the commissioner with
134.23 the eligibility determination. Examples of appropriate documentation include, but are not
134.24 limited to, medical records, psychological assessments, educational or early childhood
134.25 evaluations, court findings, and social and medical history.

134.26 (c) Documentation that the child is at risk of developing physical, mental, emotional,
134.27 or behavioral disabilities must be submitted according to policies and procedures
134.28 prescribed by the commissioner.

134.29 Subd. 8. **Termination of agreement.** (a) An adoption assistance agreement must
134.30 terminate in any of the following circumstances:

134.31 (1) the child has attained the age of 18, or up to age 21 when the child meets a
134.32 condition for extension in subdivision 12;

134.33 (2) the child has not attained the age of 18, but the commissioner determines the
134.34 adoptive parent is no longer legally responsible for support of the child;

134.35 (3) the commissioner determines the adoptive parent is no longer providing financial
134.36 support to the child up to age 21;

135.1 (4) the death of the child; or

135.2 (5) the adoptive parent requests in writing the termination of the adoption assistance
135.3 agreement.

135.4 (b) An adoptive parent is considered no longer legally responsible for support of the
135.5 child in any of the following circumstances:

135.6 (1) parental rights to the child are legally terminated or a court accepted the parent's
135.7 consent to adoption under chapter 260C;

135.8 (2) permanent legal and physical custody or guardianship of the child is transferred
135.9 to another individual;

135.10 (3) death of the adoptive parent under subdivision 9;

135.11 (4) the child enlists in the military;

135.12 (5) the child gets married; or

135.13 (6) the child is determined an emancipated minor through legal action.

135.14 Subd. 9. **Death of adoptive parent or adoption dissolution.** The adoption
135.15 assistance agreement ends upon death or termination of parental rights of both adoptive
135.16 parents in the case of a two-parent adoption, or the sole adoptive parent in the case of
135.17 a single-parent adoption. The child's adoption assistance eligibility may be continued
135.18 according to subdivision 10.

135.19 Subd. 10. **Continuing a child's title IV-E adoption assistance in a subsequent**
135.20 **adoption.** (a) The child maintains eligibility for title IV-E adoption assistance in a
135.21 subsequent adoption if the following criteria are met:

135.22 (1) the child is determined to be a child with special needs as outlined in subdivision
135.23 2; and

135.24 (2) the subsequent adoptive parent resides in Minnesota.

135.25 (b) If a child had a title IV-E adoption assistance agreement in effect prior to the
135.26 death of the adoptive parent or dissolution of the adoption, and the subsequent adoptive
135.27 parent resides outside of Minnesota, the commissioner is not responsible for determining
135.28 whether the child meets the definition of special needs, entering into the adoption
135.29 assistance agreement, and making any adoption assistance payments outlined in the new
135.30 agreement unless a state agency in Minnesota has responsibility for placement and care of
135.31 the child at the time of the subsequent adoption. If there is no state agency in Minnesota
135.32 that has responsibility for placement and care of the child at the time of the subsequent
135.33 adoption, the public child welfare agency in the subsequent adoptive parent's residence is
135.34 responsible for determining whether the child meets the definition of special needs and
135.35 entering into the adoption assistance agreement.

136.1 Subd. 11. **Assigning a child's adoption assistance to a court-appointed guardian**
136.2 **or custodian.** (a) State-funded adoption assistance may be continued with the written
136.3 consent of the commissioner to an individual who is a guardian appointed by a court for
136.4 the child upon the death of both the adoptive parents in the case of a two-parent adoption,
136.5 or the sole adoptive parent in the case of a single-parent adoption, unless the child is
136.6 under the custody of a state agency.

136.7 (b) Temporary assignment of adoption assistance may be approved by the
136.8 commissioner for a maximum of six consecutive months from the death of the adoptive
136.9 parent or parents under subdivision 9 and must adhere to the requirements and procedures
136.10 prescribed by the commissioner. If, within six months, the child has not been adopted by a
136.11 person agreed upon by the commissioner, or a court has not appointed a permanent legal
136.12 guardian under section 260C.325, 525.5-313, or similar law of another jurisdiction, the
136.13 adoption assistance must terminate.

136.14 (c) Upon assignment of payments under this subdivision, assistance must be from
136.15 funds other than title IV-E.

136.16 Subd. 12. **Extension of adoption assistance agreement.** (a) Under certain limited
136.17 circumstances a child may qualify for extension of the adoption assistance agreement
136.18 beyond the date the child attains age 18, up to the date the child attains the age of 21.

136.19 (b) A request for extension of the adoption assistance agreement must be completed
136.20 in writing and submitted, including all supporting documentation, by the adoptive parent
136.21 to the commissioner at least 60 calendar days prior to the date that the current agreement
136.22 will terminate.

136.23 (c) A signed amendment to the current adoption assistance agreement must be
136.24 fully executed between the adoptive parent and the commissioner at least ten business
136.25 days prior to the termination of the current agreement. The request for extension and the
136.26 fully executed amendment must be made according to the requirements and procedures
136.27 prescribed by the commissioner, including documentation of eligibility, on forms
136.28 prescribed by the commissioner.

136.29 (d) If an agency is certifying a child for adoption assistance and the child will attain
136.30 the age of 18 within 60 calendar days of submission, the request for extension must be
136.31 completed in writing and submitted, including all supporting documentation, with the
136.32 adoption assistance application.

136.33 (e) A child who has attained the age of 16 prior to the finalization of the child's
136.34 adoption is eligible for extension of the adoption assistance agreement up to the date the
136.35 child attains age 21 if the child is:

136.36 (1) dependent on the adoptive parent for care and financial support; and

137.1 (2)(i) completing a secondary education program or a program leading to an
137.2 equivalent credential;
137.3 (ii) enrolled in an institution that provides postsecondary or vocational education;
137.4 (iii) participating in a program or activity designed to promote or remove barriers to
137.5 employment;
137.6 (iv) employed for at least 80 hours per month; or
137.7 (v) incapable of doing any of the activities described in items (i) to (iv) due to
137.8 a medical condition where incapability is supported by documentation from an expert
137.9 according to the requirements and procedures prescribed by the commissioner.
137.10 (f) A child who has not attained the age of 16 prior to finalization of the child's
137.11 adoption is eligible for extension of the adoption assistance agreement up to the date the
137.12 child attains the age of 21 if the child is:
137.13 (1) dependent on the adoptive parent for care and financial support; and
137.14 (2)(i) enrolled in a secondary education program or a program leading to the
137.15 equivalent; or
137.16 (ii) possesses a physical or mental disability that impairs the capacity for independent
137.17 living and warrants continuation of financial assistance as determined by the commissioner.
137.18 Subd. 13. **Beginning adoption assistance under Northstar Care for Children.**
137.19 Effective November 27, 2014, a child who meets the eligibility criteria for adoption
137.20 assistance in subdivision 1, may have an adoption assistance agreement negotiated on
137.21 the child's behalf according to section 256N.25, and the effective date of the agreement
137.22 must be January 1, 2015, or the date of the court order finalizing the adoption, whichever
137.23 is later. Except as provided under section 256N.26, subdivision 1, paragraph (c), the
137.24 maximum rate schedule for the agreement must be determined according to section
137.25 256N.26 based on the age of the child on the date that the prospective adoptive parent or
137.26 parents sign the agreement.
137.27 Subd. 14. **Transition to adoption assistance under Northstar Care for Children.**
137.28 The commissioner may offer adoption assistance agreements under this chapter to a
137.29 child with an adoption assistance agreement under chapter 259A executed on the child's
137.30 behalf on or before November 26, 2014, according to the priorities outlined in section
137.31 256N.28, subdivision 7, paragraph (b). To facilitate transition into the Northstar Care for
137.32 Children adoption assistance program, the commissioner has the authority to waive any
137.33 Northstar Care for Children adoption assistance eligibility requirements for a child with
137.34 an adoption assistance agreement under chapter 259A executed on the child's behalf on
137.35 or before November 26, 2014. Agreements negotiated under this subdivision must be in
137.36 accordance with the process in section 256N.28, subdivision 7. The maximum rate used in

138.1 the negotiation process for an agreement under this subdivision must be as outlined in
138.2 section 256N.28, subdivision 7.

138.3 Sec. 40. **[256N.24] ASSESSMENTS.**

138.4 Subdivision 1. **Assessment.** (a) Each child eligible under sections 256N.21,
138.5 256N.22, and 256N.23, must be assessed to determine the benefits the child may receive
138.6 under section 256N.26, in accordance with the assessment tool, process, and requirements
138.7 specified in subdivision 2.

138.8 (b) If an agency applies the emergency foster care rate for initial placement under
138.9 section 256N.26, the agency may wait up to 30 days to complete the initial assessment.

138.10 (c) Unless otherwise specified in paragraph (d), a child must be assessed at the basic
138.11 level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

138.12 (d) An assessment must not be completed for:

138.13 (1) a child eligible for guardianship assistance under section 256N.22 or adoption
138.14 assistance under section 256N.23 who is determined to be an at-risk child. A child under
138.15 this clause must be assigned level A under section 256N.26, subdivision 1; and

138.16 (2) a child transitioning into Northstar Care for Children under section 256N.28,
138.17 subdivision 7, unless the commissioner determines an assessment is appropriate.

138.18 Subd. 2. **Establishment of assessment tool, process, and requirements.** Consistent
138.19 with sections 256N.001 to 256N.28, the commissioner shall establish an assessment tool
138.20 to determine the basic and supplemental difficulty of care, and shall establish the process
138.21 to be followed and other requirements, including appropriate documentation, when
138.22 conducting the initial assessment of a child entering Northstar Care for Children or when
138.23 the special assessment and reassessments may be needed for children continuing in the
138.24 program. The assessment tool must take into consideration the strengths and needs of the
138.25 child and the extra parenting provided by the caregiver to meet the child's needs.

138.26 Subd. 3. **Child care allowance portion of assessment.** (a) The assessment tool
138.27 established under subdivision 2 must include consideration of the caregiver's need for
138.28 child care under this subdivision, with greater consideration for children of younger ages.

138.29 (b) The child's assessment must include consideration of the caregiver's need for
138.30 child care if the following criteria are met:

138.31 (1) the child is under age 13;

138.32 (2) all available adult caregivers are employed or attending educational or vocational
138.33 training programs;

138.34 (3) the caregiver does not receive child care assistance for the child under chapter
138.35 119B.

139.1 (c) For children younger than seven years of age, the level determined by the
139.2 non-child care portions of the assessment must be adjusted based on the average number
139.3 of hours child care is needed each week due to employment or attending a training or
139.4 educational program as follows:
139.5 (1) fewer than ten hours or if the caregiver is participating in the child care assistance
139.6 program under chapter 119B, no adjustment;
139.7 (2) ten to 19 hours or if needed during school summer vacation or equivalent only,
139.8 increase one level;
139.9 (3) 20 to 29 hours, increase two levels;
139.10 (4) 30 to 39 hours, increase three levels; and
139.11 (5) 40 or more hours, increase four levels.
139.12 (d) For children at least seven years of age but younger than 13, the level determined
139.13 by the non-child care portions of the assessment must be adjusted based on the average
139.14 number of hours child care is needed each week due to employment or attending a training
139.15 or educational program as follows:
139.16 (1) fewer than 20 hours, needed during school summer vacation or equivalent only,
139.17 or if the caregiver is participating in the child care assistance program under chapter
139.18 119B, no adjustment;
139.19 (2) 20 to 39 hours, increase one level; and
139.20 (3) 40 or more hours, increase two levels.
139.21 (e) When the child attains the age of seven, the child care allowance must be reduced
139.22 by reducing the level to that available under paragraph (d). For children in foster care,
139.23 benefits under section 256N.26 must be automatically reduced when the child turns seven.
139.24 For children who receive guardianship assistance or adoption assistance, agreements must
139.25 include similar provisions to ensure that the benefit provided to these children does not
139.26 exceed the benefit provided to children in foster care.
139.27 (f) When the child attains the age of 13, the child care allowance must be eliminated
139.28 by reducing the level to that available prior to any consideration of the caregiver's need
139.29 for child care. For children in foster care, benefits under section 256N.26 must be
139.30 automatically reduced when the child attains the age of 13. For children who receive
139.31 guardianship assistance or adoption assistance, agreements must include similar provisions
139.32 to ensure that the benefit provided to these children does not exceed the benefit provided
139.33 to children in foster care.
139.34 (g) The child care allowance under this subdivision is not available to caregivers
139.35 who receive the child care assistance under chapter 119B. A caregiver receiving a child
139.36 care allowance under this subdivision must notify the commissioner if the caregiver

140.1 subsequently receives the child care assistance program under chapter 119B, and the
140.2 level must be reduced to that available prior to any consideration of the caregiver's need
140.3 for child care.

140.4 (h) In establishing the assessment tool under subdivision 2, the commissioner must
140.5 design the tool so that the levels applicable to the non-child care portions of the assessment
140.6 at a given age accommodate the requirements of this subdivision.

140.7 Subd. 4. **Timing of initial assessment.** For a child entering Northstar Care for
140.8 Children under section 256N.21, the initial assessment must be completed within 30
140.9 days after the child is placed in foster care.

140.10 Subd. 5. **Completion of initial assessment.** (a) The assessment must be completed
140.11 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
140.12 required to complete the assessment.

140.13 (b) Initial assessments are completed for foster children, eligible under section
140.14 256N.21.

140.15 (c) The initial assessment must be completed by the financially responsible agency,
140.16 in consultation with the legally responsible agency if different, within 30 days of the
140.17 child's placement in foster care.

140.18 (d) If the foster parent is unable or unwilling to cooperate with the assessment process,
140.19 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3.

140.20 (e) Notice to the foster parent shall be provided as specified in subdivision 12.

140.21 Subd. 6. **Timing of special assessment.** (a) A special assessment is required as part
140.22 of the negotiation of the guardianship assistance agreement under section 256N.22 if:

140.23 (1) the child was not placed in foster care with the prospective relative custodian
140.24 or custodians prior to the negotiation of the guardianship assistance agreement under
140.25 section 256N.25; or

140.26 (2) any requirement for reassessment under subdivision 8 is met.

140.27 (b) A special assessment is required as part of the negotiation of the adoption
140.28 assistance agreement under section 256N.23 if:

140.29 (1) the child was not placed in foster care with the prospective adoptive parent
140.30 or parents prior to the negotiation of the adoption assistance agreement under section
140.31 256N.25; or

140.32 (2) any requirement for reassessment under subdivision 8 is met.

140.33 (c) A special assessment is required when a child transitions from a pre-Northstar
140.34 Care for Children program into Northstar Care for Children if the commissioner
140.35 determines that a special assessment is appropriate instead of assigning the transition child
140.36 to a level under section 256N.28.

141.1 (d) The special assessment must be completed prior to the establishment of a
141.2 guardianship assistance or adoption assistance agreement on behalf of the child.

141.3 Subd. 7. **Completing the special assessment.** (a) The special assessment must
141.4 be completed in consultation with the child's caregiver. Face-to-face contact with the
141.5 caregiver is not required to complete the special assessment.

141.6 (b) If a new special assessment is required prior to the effective date of the
141.7 guardianship assistance agreement, it must be completed by the financially responsible
141.8 agency, in consultation with the legally responsible agency if different. If the prospective
141.9 relative custodian is unable or unwilling to cooperate with the special assessment process,
141.10 the child shall be assigned the basic level, level B under section 256N.26, subdivision 3,
141.11 unless the child is known to be an at-risk child, in which case, the child shall be assigned
141.12 level A under section 256N.26, subdivision 1.

141.13 (c) If a special assessment is required prior to the effective date of the adoption
141.14 assistance agreement, it must be completed by the financially responsible agency, in
141.15 consultation with the legally responsible agency if different. If there is no financially
141.16 responsible agency, the special assessment must be completed by the agency designated by
141.17 the commissioner. If the prospective adoptive parent is unable or unwilling to cooperate
141.18 with the special assessment process, the child must be assigned the basic level, level B
141.19 under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in
141.20 which case, the child shall be assigned level A under section 256N.26, subdivision 1.

141.21 (d) Notice to the prospective relative custodians or prospective adoptive parents
141.22 must be provided as specified in subdivision 12.

141.23 Subd. 8. **Timing of and requests for reassessments.** Reassessments for an eligible
141.24 child must be completed within 30 days of any of the following events:

141.25 (1) for a child in continuous foster care, when six months have elapsed since
141.26 completion of the last assessment;

141.27 (2) for a child in continuous foster care, change of placement location;

141.28 (3) for a child in foster care, at the request of the financially responsible agency or
141.29 legally responsible agency;

141.30 (4) at the request of the commissioner; or

141.31 (5) at the request of the caregiver under subdivision 9.

141.32 Subd. 9. **Caregiver requests for reassessments.** (a) A caregiver may initiate
141.33 a reassessment request for an eligible child in writing to the financially responsible
141.34 agency or, if there is no financially responsible agency, the agency designated by the
141.35 commissioner. The written request must include the reason for the request and the
141.36 name, address, and contact information of the caregivers. For an eligible child with a

142.1 guardianship assistance or adoption assistance agreement, the caregiver may request a
142.2 reassessment if at least six months have elapsed since any previously requested review.
142.3 For an eligible foster child, a foster parent may request reassessment in less than six
142.4 months with written documentation that there have been significant changes in the child's
142.5 needs that necessitate an earlier reassessment.

142.6 (b) A caregiver may request a reassessment of an at-risk child for whom a
142.7 guardianship assistance or adoption assistance agreement has been executed if the
142.8 caregiver has satisfied the commissioner with written documentation from a qualified
142.9 expert that the potential disability upon which eligibility for the agreement was based has
142.10 manifested itself, consistent with section 256N.25, subdivision 3, paragraph (b).

142.11 (c) If the reassessment cannot be completed within 30 days of the caregiver's request,
142.12 the agency responsible for reassessment must notify the caregiver of the reason for the
142.13 delay and a reasonable estimate of when the reassessment can be completed.

142.14 Subd. 10. **Completion of reassessment.** (a) The reassessment must be completed
142.15 in consultation with the child's caregiver. Face-to-face contact with the caregiver is not
142.16 required to complete the reassessment.

142.17 (b) For foster children eligible under section 256N.21, reassessments must be
142.18 completed by the financially responsible agency, in consultation with the legally
142.19 responsible agency if different.

142.20 (c) If reassessment is required after the effective date of the guardianship assistance
142.21 agreement, the reassessment must be completed by the financially responsible agency.

142.22 (d) If a reassessment is required after the effective date of the adoption assistance
142.23 agreement, it must be completed by the financially responsible agency or, if there is no
142.24 financially responsible agency, the agency designated by the commissioner.

142.25 (e) If the child's caregiver is unable or unwilling to cooperate with the reassessment,
142.26 the child must be assessed at level B under section 256N.26, subdivision 3, unless the
142.27 child has an adoption assistance or guardianship assistance agreement in place and is
142.28 known to be an at-risk child, in which case the child must be assessed at level A under
142.29 section 256N.26, subdivision 1.

142.30 Subd. 11. **Approval of initial assessments, special assessments, and**
142.31 **reassessments.** (a) Any agency completing initial assessments, special assessments, or
142.32 reassessments must designate one or more supervisors or other staff to examine and approve
142.33 assessments completed by others in the agency under subdivision 2. The person approving
142.34 an assessment must not be the case manager or staff member completing that assessment.

142.35 (b) In cases where a special assessment or reassessment for guardian assistance
142.36 and adoption assistance is required under subdivision 7 or 10, the commissioner shall

143.1 review and approve the assessment as part of the eligibility determination process outlined
143.2 in section 256N.22, subdivision 7, for guardianship assistance, or section 256N.23,
143.3 subdivision 7, for adoption assistance. The assessment determines the maximum for the
143.4 negotiated agreement amount under section 256N.25.

143.5 (c) The new rate is effective the calendar month that the assessment is approved,
143.6 or the effective date of the agreement, whichever is later.

143.7 Subd. 12. **Notice for caregiver.** (a) The agency as defined in subdivision 5 or 10
143.8 that is responsible for completing the initial assessment or reassessment must provide the
143.9 child's caregiver with written notice of the initial assessment or reassessment.

143.10 (b) Initial assessment notices must be sent within 15 days of completion of the initial
143.11 assessment and must minimally include the following:

143.12 (1) a summary of the child's completed individual assessment used to determine the
143.13 initial rating;

143.14 (2) statement of rating and benefit level;

143.15 (3) statement of the circumstances under which the agency must reassess the child;

143.16 (4) procedure to seek reassessment;

143.17 (5) notice that the caregiver has the right to a fair hearing review of the assessment
143.18 and how to request a fair hearing, consistent with section 256.045, subdivision 3; and

143.19 (6) the name, telephone number, and e-mail, if available, of a contact person at the
143.20 agency completing the assessment.

143.21 (c) Reassessment notices must be sent within 15 days after the completion of the
143.22 reassessment and must minimally include the following:

143.23 (1) a summary of the child's individual assessment used to determine the new rating;

143.24 (2) any change in rating and its effective date;

143.25 (3) procedure to seek reassessment;

143.26 (4) notice that if a change in rating results in a reduction of benefits, the caregiver
143.27 has the right to a fair hearing review of the assessment and how to request a fair hearing
143.28 consistent with section 256.045, subdivision 3;

143.29 (5) notice that a caregiver who requests a fair hearing of the reassessed rating within
143.30 ten days may continue at the current rate pending the hearing, but the agency may recover
143.31 any overpayment; and

143.32 (6) name, telephone number, and e-mail, if available, of a contact person at the
143.33 agency completing the reassessment.

143.34 (d) Notice is not required for special assessments since the notice is part of the
143.35 guardianship assistance or adoption assistance negotiated agreement completed according
143.36 to section 256N.25.

144.1 Subd. 13. **Assessment tool determines rate of benefits.** The assessment tool
144.2 established by the commissioner in subdivision 2 determines the monthly benefit level
144.3 for children in foster care. The monthly payment for guardian assistance or adoption
144.4 assistance may be negotiated up to the monthly benefit level under foster care for those
144.5 children eligible for a payment under section 256N.26, subdivision 1.

144.6 Sec. 41. **[256N.25] AGREEMENTS.**

144.7 Subdivision 1. **Agreement; guardianship assistance; adoption assistance.** (a)
144.8 In order to receive guardianship assistance or adoption assistance benefits on behalf of
144.9 an eligible child, a written, binding agreement between the caregiver or caregivers, the
144.10 financially responsible agency, or, if there is no financially responsible agency, the agency
144.11 designated by the commissioner, and the commissioner must be established prior to
144.12 finalization of the adoption or a transfer of permanent legal and physical custody. The
144.13 agreement must be negotiated with the caregiver or caregivers under subdivision 2.

144.14 (b) The agreement must be on a form approved by the commissioner and must
144.15 specify the following:

144.16 (1) duration of the agreement;

144.17 (2) the nature and amount of any payment, services, and assistance to be provided
144.18 under such agreement;

144.19 (3) the child's eligibility for Medicaid services;

144.20 (4) the terms of the payment, including any child care portion as specified in section
144.21 256N.24, subdivision 3;

144.22 (5) eligibility for reimbursement of nonrecurring expenses associated with adopting
144.23 or obtaining permanent legal and physical custody of the child, to the extent that the
144.24 total cost does not exceed $2,000 per child;

144.25 (6) that the agreement must remain in effect regardless of the state of which the
144.26 adoptive parents or relative custodians are residents at any given time;

144.27 (7) provisions for modification of the terms of the agreement, including renegotiation
144.28 of the agreement; and

144.29 (8) the effective date of the agreement.

144.30 (c) The caregivers, the commissioner, and the financially responsible agency, or, if
144.31 there is no financially responsible agency, the agency designated by the commissioner, must
144.32 sign the agreement. A copy of the signed agreement must be given to each party. Once
144.33 signed by all parties, the commissioner shall maintain the official record of the agreement.

145.1 (d) The effective date of the guardianship assistance agreement must be the date of the
145.2 court order that transfers permanent legal and physical custody to the relative. The effective
145.3 date of the adoption assistance agreement is the date of the finalized adoption decree.

145.4 (e) Termination or disruption of the preadoptive placement or the foster care
145.5 placement prior to assignment of custody makes the agreement with that caregiver void.

145.6 Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible
145.7 for guardianship assistance or adoption assistance, the financially responsible agency, or,
145.8 if there is no financially responsible agency, the agency designated by the commissioner,
145.9 must negotiate with the caregiver to develop an agreement under subdivision 1. If and when
145.10 the caregiver and agency reach concurrence as to the terms of the agreement, both parties
145.11 shall sign the agreement. The agency must submit the agreement, along with the eligibility
145.12 determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to
145.13 the commissioner for final review, approval, and signature according to subdivision 1.

145.14 (b) A monthly payment is provided as part of the adoption assistance or guardianship
145.15 assistance agreement to support the care of children unless the child is determined to be an
145.16 at-risk child, in which case the special at-risk monthly payment under section 256N.26,
145.17 subdivision 7, must be made until the caregiver obtains written documentation from a
145.18 qualified expert that the potential disability upon which eligibility for the agreement
145.19 was based has manifested itself.

145.20 (1) The amount of the payment made on behalf of a child eligible for guardianship
145.21 assistance or adoption assistance is determined through agreement between the prospective
145.22 relative custodian or the adoptive parent and the financially responsible agency, or, if there
145.23 is no financially responsible agency, the agency designated by the commissioner, using
145.24 the assessment tool established by the commissioner in section 256N.24, subdivision 2,
145.25 and the associated benefit and payments outlined in section 256N.26. Except as provided
145.26 under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes
145.27 the monthly benefit level for a child under foster care. The monthly payment under a
145.28 guardianship assistance agreement or adoption assistance agreement may be negotiated up
145.29 to the monthly benefit level under foster care. In no case may the amount of the payment
145.30 under a guardianship assistance agreement or adoption assistance agreement exceed the
145.31 foster care maintenance payment which would have been paid during the month if the
145.32 child with respect to whom the guardianship assistance or adoption assistance payment is
145.33 made had been in a foster family home in the state.

145.34 (2) The rate schedule for the agreement is determined based on the age of the
145.35 child on the date that the prospective adoptive parent or parents or relative custodian or
145.36 custodians sign the agreement.

146.1 (3) The income of the relative custodian or custodians or adoptive parent or parents
146.2 must not be taken into consideration when determining eligibility for guardianship
146.3 assistance or adoption assistance or the amount of the payments under section 256N.26.
146.4 (4) With the concurrence of the relative custodian or adoptive parent, the amount of
146.5 the payment may be adjusted periodically using the assessment tool established by the
146.6 commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under
146.7 subdivision 3 when there is a change in the child's needs or the family's circumstances.
146.8 (5) The guardianship assistance or adoption assistance agreement of a child who is
146.9 identified as at-risk receives the special at-risk monthly payment under section 256N.26,
146.10 subdivision 7, unless and until the potential disability manifests itself, as documented by
146.11 an appropriate professional, and the commissioner authorizes commencement of payment
146.12 by modifying the agreement accordingly. A relative custodian or adoptive parent of an
146.13 at-risk child with a guardianship assistance or adoption assistance agreement may request
146.14 a reassessment of the child under section 256N.24, subdivision 9, and renegotiation of
146.15 the guardianship assistance or adoption assistance agreement under subdivision 3 to
146.16 include a monthly payment, if the caregiver has written documentation from a qualified
146.17 expert that the potential disability upon which eligibility for the agreement was based has
146.18 manifested itself. Documentation of the disability must be limited to evidence deemed
146.19 appropriate by the commissioner.
146.20 (c) For guardianship assistance agreements:
146.21 (1) the initial amount of the monthly guardianship assistance payment must be
146.22 equivalent to the foster care rate in effect at the time that the agreement is signed less any
146.23 offsets under section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to
146.24 by the prospective relative custodian and specified in that agreement, unless the child is
146.25 identified as at-risk or the guardianship assistance agreement is entered into when a child
146.26 is under the age of six;
146.27 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
146.28 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
146.29 and until the potential disability manifests itself, as documented by a qualified expert and
146.30 the commissioner authorizes commencement of payment by modifying the agreement
146.31 accordingly; and
146.32 (3) the amount of the monthly payment for a guardianship assistance agreement for
146.33 a child, other than an at-risk child, who is under the age of six must be as specified in
146.34 section 256N.26, subdivision 5.
146.35 (d) For adoption assistance agreements:

147.1 (1) for a child in foster care with the prospective adoptive parent immediately prior
147.2 to adoptive placement, the initial amount of the monthly adoption assistance payment
147.3 must be equivalent to the foster care rate in effect at the time that the agreement is signed
147.4 less any offsets in section 256N.26, subdivision 11, or a lesser negotiated amount if agreed
147.5 to by the prospective adoptive parents and specified in that agreement, unless the child is
147.6 identified as at-risk or the adoption assistance agreement is entered into when a child is
147.7 under the age of six;

147.8 (2) an at-risk child must be assigned level A as outlined in section 256N.26 and
147.9 receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless
147.10 and until the potential disability manifests itself, as documented by an appropriate
147.11 professional and the commissioner authorizes commencement of payment by modifying
147.12 the agreement accordingly;

147.13 (3) the amount of the monthly payment for an adoption assistance agreement for
147.14 a child under the age of six, other than an at-risk child, must be as specified in section
147.15 256N.26, subdivision 5;

147.16 (4) for a child who is in the guardianship assistance program immediately prior
147.17 to adoptive placement, the initial amount of the adoption assistance payment must be
147.18 equivalent to the guardianship assistance payment in effect at the time that the adoption
147.19 assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive
147.20 parent and specified in that agreement; and

147.21 (5) for a child who is not in foster care placement or the guardianship assistance
147.22 program immediately prior to adoptive placement or negotiation of the adoption assistance
147.23 agreement, the initial amount of the adoption assistance agreement must be determined
147.24 using the assessment tool and process in this section and the corresponding payment
147.25 amount outlined in section 256N.26.

147.26 Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive parent
147.27 of a child with a guardianship assistance or adoption assistance agreement may request
147.28 renegotiation of the agreement when there is a change in the needs of the child or in the
147.29 family's circumstances. When a relative custodian or adoptive parent requests renegotiation
147.30 of the agreement, a reassessment of the child must be completed consistent with section
147.31 256N.24, subdivisions 9 and 10. If the reassessment indicates that the child's level has
147.32 changed, the financially responsible agency, or, if there is no financially responsible
147.33 agency, the agency designated by the commissioner or a designee and the caregiver must
147.34 renegotiate the agreement to include a payment with the level determined through the
147.35 reassessment process. The agreement must not be renegotiated unless the commissioner,

148.1 the financially responsible agency, and the caregiver mutually agree to the changes. The
148.2 effective date of any renegotiated agreement must be determined by the commissioner.
148.3 (b) A relative custodian or adoptive parent of an at-risk child with a guardianship
148.4 assistance or adoption assistance agreement may request renegotiation of the agreement to
148.5 include a monthly payment higher than the special at-risk monthly payment under section
148.6 256N.26, subdivision 7, if the caregiver has written documentation from a qualified
148.7 expert that the potential disability upon which eligibility for the agreement was based has
148.8 manifested itself. Documentation of the disability must be limited to evidence deemed
148.9 appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment
148.10 of the child must be conducted as outlined in section 256N.24, subdivision 9. The
148.11 reassessment must be used to renegotiate the agreement to include an appropriate monthly
148.12 payment. The agreement must not be renegotiated unless the commissioner, the financially
148.13 responsible agency, and the caregiver mutually agree to the changes. The effective date of
148.14 any renegotiated agreement must be determined by the commissioner.
148.15 (c) Renegotiation of a guardianship assistance or adoption assistance agreement is
148.16 required when one of the circumstances outlined in section 256N.26, subdivision 13,
148.17 occurs.

148.18 Sec. 42. **[256N.26] BENEFITS AND PAYMENTS.**
148.19 Subdivision 1. **Benefits.** (a) There are three benefits under Northstar Care for
148.20 Children: medical assistance, basic payment, and supplemental difficulty of care payment.
148.21 (b) A child is eligible for medical assistance under subdivision 2.
148.22 (c) A child is eligible for the basic payment under subdivision 3, except for a child
148.23 assigned level A under section 256N.24, subdivision 1, because the child is determined to
148.24 be an at-risk child receiving guardianship assistance or adoption assistance.
148.25 (d) A child, including a foster child age 18 to 21, is eligible for an additional
148.26 supplemental difficulty of care payment under subdivision 4, as determined by the
148.27 assessment under section 256N.24.
148.28 (e) An eligible child entering guardianship assistance or adoption assistance under
148.29 the age of six receives a basic payment and supplemental difficulty of care payment as
148.30 specified in subdivision 5.
148.31 (f) A child transitioning in from a pre-Northstar Care for Children program under
148.32 section 256N.28, subdivision 7, shall receive basic and difficulty of care supplemental
148.33 payments according to those provisions.
148.34 Subd. 2. **Medical assistance.** Eligibility for medical assistance under this chapter
148.35 must be determined according to section 256B.055.

149.1 Subd. 3. **Basic monthly rate.** From January 1, 2015, to June 30, 2016, the basic
149.2 monthly rate must be according to the following schedule:

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

149.6 Subd. 4. **Difficulty of care supplemental monthly rate.** From January 1, 2015,
149.7 to June 30, 2016, the supplemental difficulty of care monthly rate is determined by the
149.8 following schedule:

149.9 149.10 Level A	none (special rate under subdivision 7 applies)
149.11 Level B	none (basic under subdivision 3 only)
149.12 Level C	$100 per month
149.13 Level D	$200 per month
149.14 Level E	$300 per month
149.15 Level F	$400 per month
149.16 Level G	$500 per month
149.17 Level H	$600 per month
149.18 Level I	$700 per month
149.19 Level J	$800 per month
149.20 Level K	$900 per month
149.21 Level L	$1,000 per month

149.22 A child assigned level A is not eligible for either the basic or supplemental difficulty
149.23 of care payment, while a child assigned level B is not eligible for the supplemental
149.24 difficulty of care payment but is eligible for the basic monthly rate under subdivision 3.

149.25 Subd. 5. **Alternate rates for preschool entry and certain transitioned children.**
149.26 A child who entered the guardianship assistance or adoption assistance components
149.27 of Northstar Care for Children while under the age of six shall receive 50 percent of
149.28 the amount the child would otherwise be entitled to under subdivisions 3 and 4. The
149.29 commissioner may also use the 50 percent rate for a child who was transitioned into those
149.30 components through declaration of the commissioner under section 256N.28, subdivision 7.

149.31 Subd. 6. **Emergency foster care rate for initial placement.** (a) A child who enters
149.32 foster care due to immediate custody by a police officer or court order, consistent with
149.33 section 260C.175, subdivisions 1 and 2, or equivalent provision under tribal code, shall
149.34 receive the emergency foster care rate for up to 30 days. The emergency foster care rate
149.35 cannot be extended beyond 30 days of the child's placement.

149.36 (b) For this payment rate to be applied, at least one of three conditions must apply:

149.37 (1) the child's initial placement must be in foster care in Minnesota;

149.38 (2) the child's previous placement was more than two years ago; or

150.1 (3) the child's previous placement was for fewer than 30 days and an assessment
150.2 under section 256N.24 was not completed by an agency under section 256N.24.
150.3 (c) The emergency foster care rate consists of the appropriate basic monthly rate
150.4 under subdivision 3 plus a difficulty of care supplemental monthly rate of level D under
150.5 subdivision 4.
150.6 (d) The emergency foster care rate ends under any of three conditions:
150.7 (1) when an assessment under section 256N.24 is completed;
150.8 (2) when the placement ends; or
150.9 (3) after 30 days have elapsed.
150.10 (e) The financially responsible agency, in consultation with the legally responsible
150.11 agency, if different, may replace the emergency foster care rate at any time by completing
150.12 an initial assessment on which a revised difficulty of care supplemental monthly rate
150.13 would be based. Consistent with section 256N.24, subdivision 9, the caregiver may
150.14 request a reassessment in writing for an initial assessment to replace the emergency foster
150.15 care rate. This written request would initiate an initial assessment under section 256N.24,
150.16 subdivision 5. If the revised difficulty of care supplemental level based on the initial
150.17 assessment is higher than Level D, then the revised higher rate shall apply retroactively to
150.18 the beginning of the placement. If the revised level is lower, the lower rate shall apply on
150.19 the date the initial assessment was completed.
150.20 (f) If a child remains in foster care placement for more than 30 days, the emergency
150.21 foster care rate ends after the 30th day of placement and an assessment under section
150.22 256N.26 must be completed.
150.23 Subd. 7. **Special at-risk monthly payment for at-risk children in guardianship**
150.24 **assistance and adoption assistance.** A child eligible for guardianship assistance under
150.25 section 256N.22 or adoption assistance under section 256N.23 who is determined to be
150.26 an at-risk child shall receive a special at-risk monthly payment of $1 per month basic,
150.27 unless and until the potential disability manifests itself and the agreement is renegotiated
150.28 to include reimbursement. Such an at-risk child shall receive neither a supplemental
150.29 difficulty of care monthly rate under subdivision 4 nor home and vehicle modifications
150.30 under subdivision 10, but must be considered for medical assistance under subdivision 2.
150.31 Subd. 8. **Daily rates.** (a) The commissioner shall establish prorated daily rates to
150.32 the nearest cent for the monthly rates under subdivisions 3 to 7. Daily rates must be
150.33 routinely used when a partial month is involved for foster care, guardianship assistance, or
150.34 adoption assistance.

151.1 (b) A full month payment is permitted if a foster child is temporarily absent from
151.2 the foster home if the brief absence does not exceed 14 days and the child's placement
151.3 continues with the same caregiver.

151.4 Subd. 9. **Revision.** By April 1, 2016, for fiscal year 2017, and by each succeeding
151.5 April 1 for the subsequent fiscal year, the commissioner shall review and revise the rates
151.6 under subdivisions 3 to 7 based on the United States Department of Agriculture, Estimates
151.7 of the Cost of Raising a Child, published by the United States Department of Agriculture,
151.8 Agricultural Resources Service, Publication 1411. The revision shall be the average
151.9 percentage by which costs increase for the age ranges represented in the United States
151.10 Department of Agriculture, Estimates of the Cost of Raising a Child, except that in no
151.11 instance must the increase be more than three percent per annum. The monthly rates must
151.12 be revised to the nearest dollar and the daily rates to the nearest cent.

151.13 Subd. 10. **Home and vehicle modifications.** (a) Except for a child assigned level A
151.14 under section 256N.24, subdivision 1, paragraph (b), clause (1), a child who is eligible
151.15 for an adoption assistance agreement may have reimbursement of home and vehicle
151.16 modifications necessary to accommodate the child's special needs upon which eligibility
151.17 for adoption assistance was based and included as part of the negotiation of the agreement
151.18 under section 256N.25, subdivision 2. Reimbursement of home and vehicle modifications
151.19 must not be available for a child who is assessed at level A under subdivision 1, unless
151.20 and until the potential disability manifests itself and the agreement is renegotiated to
151.21 include reimbursement.

151.22 (b) Application for and reimbursement of modifications must be completed
151.23 according to a process specified by the commissioner. The type and cost of each
151.24 modification must be preapproved by the commissioner. The type of home and vehicle
151.25 modifications must be limited to those specified by the commissioner.

151.26 (c) Reimbursement for home modifications as outlined in this subdivision is limited
151.27 to once every five years per child. Reimbursement for vehicle modifications as outlined in
151.28 this subdivision is limited to once every five years per family.

151.29 Subd. 11. **Child income or income attributable to the child.** (a) A monthly
151.30 guardianship assistance or adoption assistance payment must be considered as income
151.31 and resource attributable to the child. Guardianship assistance and adoption assistance
151.32 are exempt from garnishment, except as permissible under the laws of the state where the
151.33 child resides.

151.34 (b) When a child is placed into foster care, any income and resources attributable
151.35 to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as
151.36 applicable to the child being placed.

152.1 (c) Consideration of income and resources attributable to the child must be part of
152.2 the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances,
152.3 the receipt of other income on behalf of the child may impact the amount of the monthly
152.4 payment received by the relative custodian or adoptive parent on behalf of the child
152.5 through Northstar Care for Children. Supplemental Security Income (SSI), retirement
152.6 survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and
152.7 black lung benefits are considered income and resources attributable to the child.

152.8 Subd. 12. **Treatment of Supplemental Security Income.** If a child placed in foster
152.9 care receives benefits through Supplemental Security Income (SSI) at the time of foster
152.10 care placement or subsequent to placement in foster care, the financially responsible
152.11 agency may apply to be the payee for the child for the duration of the child's placement in
152.12 foster care. If a child continues to be eligible for SSI after finalization of the adoption or
152.13 transfer of permanent legal and physical custody and is determined to be eligible for a
152.14 payment under Northstar Care for Children, a permanent caregiver may choose to receive
152.15 payment from both programs simultaneously. The permanent caregiver is responsible
152.16 to report the amount of the payment to the Social Security Administration and the SSI
152.17 payment will be reduced as required by Social Security.

152.18 Subd. 13. **Treatment of retirement survivor's disability insurance, veteran's**
152.19 **benefits, railroad retirement benefits, and black lung benefits.** (a) If a child placed
152.20 in foster care receives retirement survivor's disability insurance, veteran's benefits,
152.21 railroad retirement benefits, or black lung benefits at the time of foster care placement or
152.22 subsequent to placement in foster care, the financially responsible agency may apply to
152.23 be the payee for the child for the duration of the child's placement in foster care. If it is
152.24 anticipated that a child will be eligible to receive retirement survivor's disability insurance,
152.25 veteran's benefits, railroad retirement benefits, or black lung benefits after finalization
152.26 of the adoption or assignment of permanent legal and physical custody, the permanent
152.27 caregiver shall apply to be the payee of those benefits on the child's behalf. The monthly
152.28 amount of the other benefits must be considered an offset to the amount of the payment
152.29 the child is determined eligible for under Northstar Care for Children.

152.30 (b) If a child becomes eligible for retirement survivor's disability insurance, veteran's
152.31 benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the
152.32 payment under Northstar Care for Children is finalized, the permanent caregiver shall
152.33 contact the commissioner to redetermine the payment under Northstar Care for Children.
152.34 The monthly amount of the other benefits must be considered an offset to the amount of
152.35 the payment the child is determined eligible for under Northstar Care for Children.

153.1 (c) If a child ceases to be eligible for retirement survivor's disability insurance,
153.2 veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount
153.3 of the payment under Northstar Care for Children is finalized, the permanent caregiver
153.4 shall contact the commissioner to redetermine the payment under Northstar Care for
153.5 Children. The monthly amount of the payment under Northstar Care for Children must be
153.6 the amount the child was determined to be eligible for prior to consideration of any offset.
153.7 (d) If the monthly payment received on behalf of the child under retirement survivor's
153.8 disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits
153.9 changes after the adoption assistance or guardianship assistance agreement is finalized,
153.10 the permanent caregiver shall notify the commissioner as to the new monthly payment
153.11 amount, regardless of the amount of the change in payment. If the monthly payment
153.12 changes by $75 or more, even if the change occurs incrementally over the duration of
153.13 the term of the adoption assistance or guardianship assistance agreement, the monthly
153.14 payment under Northstar Care for Children must be adjusted without further consent
153.15 to reflect the amount of the increase or decrease in the offset amount. Any subsequent
153.16 change to the payment must be reported and handled in the same manner. A change of
153.17 monthly payments of less than $75 is not a permissible reason to renegotiate the adoption
153.18 assistance or guardianship assistance agreement under section 256N.25, subdivision 3.
153.19 The commissioner shall review and revise the limit at which the adoption assistance or
153.20 guardian assistance agreement must be renegotiated in accordance with subdivision 9.
153.21 Subd. 14. **Treatment of child support and Minnesota family investment**
153.22 **program.** (a) If a child placed in foster care receives child support, the child support
153.23 payment may be redirected to the financially responsible agency for the duration of the
153.24 child's placement in foster care. In cases where the child qualifies for Northstar Care
153.25 for Children by meeting the adoption assistance eligibility criteria or the guardianship
153.26 assistance eligibility criteria, any court ordered child support must not be considered
153.27 income attributable to the child and must have no impact on the monthly payment.
153.28 (b) Consistent with section 256J.24, a child eligible for Northstar Care for Children
153.29 whose caregiver receives a payment on the child's behalf is excluded from a Minnesota
153.30 family investment program assistance unit.
153.31 Subd. 15. **Payments.** (a) Payments to caregivers under Northstar Care for Children
153.32 must be made monthly. Consistent with section 256N.24, subdivision 12, the financially
153.33 responsible agency must send the caregiver the required written notice within 15 days of
153.34 a completed assessment or reassessment.
153.35 (b) Unless paragraph (c) or (d) applies, the financially responsible agency shall pay
153.36 foster parents directly for eligible children in foster care.

154.1 (c) When the legally responsible agency is different than the financially responsible
154.2 agency, the legally responsible agency may make the payments to the caregiver, provided
154.3 payments are made on a timely basis. The financially responsible agency must pay
154.4 the legally responsible agency on a timely basis. Caregivers must have access to the
154.5 financially and legally responsible agencies' records of the transaction, consistent with
154.6 the retention schedule for the payments.

154.7 (d) For eligible children in foster care, the financially responsible agency may pay
154.8 the foster parent's payment for a licensed child-placing agency instead of paying the foster
154.9 parents directly. The licensed child-placing agency must timely pay the foster parents
154.10 and maintain records of the transaction. Caregivers must have access to the financially
154.11 responsible agency's records on the transaction and the child-placing agency's records of
154.12 the transaction, consistent with the retention schedule for the payments.

154.13 Subd. 16. **Effect of benefit on other aid.** Payments received under this section
154.14 must not be considered as income for child care assistance under chapter 119B or any
154.15 other financial benefit. Consistent with section 256J.24, a child receiving a maintenance
154.16 payment under Northstar Care for Children is excluded from any Minnesota family
154.17 investment program assistance unit.

154.18 Subd. 17. **Home and community-based services waiver for persons with**
154.19 **disabilities.** A child in foster care may qualify for home and community-based waivered
154.20 services, consistent with section 256B.092 for developmental disabilities, or section
154.21 256B.49 for community alternative care, community alternatives for disabled individuals,
154.22 or traumatic brain injury waivers. A waiver service must not be substituted for the foster
154.23 care program. When the child is simultaneously eligible for waivered services and for
154.24 benefits under Northstar Care for Children, the financially responsible agency must
154.25 assess and provide basic and supplemental difficulty of care rates as determined by the
154.26 assessment according to section 256N.24. If it is determined that additional services are
154.27 needed to meet the child's needs in the home that is not or cannot be met by the foster care
154.28 program, the need would be referred to the local waivered service program.

154.29 Subd. 18. **Overpayments.** The commissioner has the authority to collect any
154.30 amount of foster care payment, adoption assistance, or guardianship assistance paid
154.31 to a caregiver in excess of the payment due. Payments covered by this subdivision
154.32 include basic maintenance needs payments, supplemental difficulty of care payments, and
154.33 reimbursement of home and vehicle modifications under subdivision 10. Prior to any
154.34 collection, the commissioner or designee shall notify the caregiver in writing, including:

154.35 (1) the amount of the overpayment and an explanation of the cause of overpayment;

154.36 (2) clarification of the corrected amount;

155.1 (3) a statement of the legal authority for the decision;
155.2 (4) information about how the caregiver can correct the overpayment;
155.3 (5) if repayment is required, when the payment is due and a person to contact to
155.4 review a repayment plan;
155.5 (6) a statement that the caregiver has a right to a fair hearing review by the
155.6 department; and
155.7 (7) the procedure for seeking a fair hearing review by the department.
155.8 Subd. 19. **Payee.** For adoption assistance and guardianship assistance cases, the
155.9 payment must only be made to the adoptive parent or relative custodian specified on the
155.10 agreement. If there is more than one adoptive parent or relative custodian, both parties will
155.11 be listed as the payee unless otherwise specified in writing according to policies outlined
155.12 by the commissioner. In the event of divorce or separation of the caregivers, a change of
155.13 payee must be made in writing according to policies outlined by the commissioner. If both
155.14 caregivers are in agreement as to the change, it may be made according to a process outlined
155.15 by the commissioner. If there is not agreement as to the change, a court order indicating
155.16 the party who is to receive the payment is needed before a change can be processed. If the
155.17 change of payee is disputed, the commissioner may withhold the payment until agreement
155.18 is reached. A noncustodial caregiver may request notice in writing of review, modification,
155.19 or termination of the adoption assistance or guardianship assistance agreement. In the
155.20 event of the death of a payee, a change of payee consistent with sections 256N.22 and
155.21 256N.23 may be made in writing according to policies outlined by the commissioner.
155.22 Subd. 20. **Notification of change.** (a) A caregiver who has an adoption assistance
155.23 agreement or guardianship assistance agreement in place shall keep the agency
155.24 administering the program informed of changes in status or circumstances which would
155.25 make the child ineligible for the payments or eligible for payments in a different amount.
155.26 (b) For the duration of the agreement, the caregiver agrees to notify the agency
155.27 administering the program in writing within 30 days of any of the following:
155.28 (1) a change in the child's or caregiver's legal name;
155.29 (2) a change in the family's address;
155.30 (3) a change in the child's legal custody status;
155.31 (4) the child's completion of high school, if this occurs after the child attains age 18;
155.32 (5) the end of the caregiver's legal responsibility to support the child based on
155.33 termination of parental rights of the caregiver, transfer of guardianship to another person,
155.34 or transfer of permanent legal and physical custody to another person;
155.35 (6) the end of the caregiver's financial support of the child;
155.36 (7) the death of the child;

156.1 (8) the death of the caregiver;

156.2 (9) the child enlists in the military;

156.3 (10) the child gets married;

156.4 (11) the child becomes an emancipated minor through legal action;

156.5 (12) the caregiver separates or divorces; and

156.6 (13) the child is residing outside the caregiver's home for a period of more than
156.7 30 consecutive days.

156.8 Subd. 21. **Correct and true information.** The caregiver must be investigated for
156.9 fraud if the caregiver reports information the caregiver knows is untrue, the caregiver
156.10 fails to notify the commissioner of changes that may affect eligibility, or the agency
156.11 administering the program receives relevant information that the caregiver did not report.

156.12 Subd. 22. **Termination notice for caregiver.** The agency that issues the
156.13 maintenance payment shall provide the child's caregiver with written notice of termination
156.14 of payment. Termination notices must be sent at least 15 days before the final payment or
156.15 in the case of an unplanned termination, the notice is sent within three days of the end of
156.16 the payment. The written notice must minimally include the following:

156.17 (1) the date payment will end;

156.18 (2) the reason payments will end and the event that is the basis to terminate payment;

156.19 (3) a statement that the provider has a right to a fair hearing review by the department
156.20 consistent with section 256.045, subdivision 3;

156.21 (4) the procedure to request a fair hearing; and

156.22 (5) name, telephone number, and email address of a contact person at the agency.

156.23 Sec. 43. **[256N.27] FEDERAL, STATE, AND LOCAL SHARES.**

156.24 Subdivision 1. **Federal share.** For the purposes of determining a child's eligibility
156.25 under title IV-E of the Social Security Act for a child in foster care, the financially
156.26 responsible agency shall use the eligibility requirements outlined in section 472 of the
156.27 Social Security Act. For a child who qualifies for guardianship assistance or adoption
156.28 assistance, the financially responsible agency and the commissioner shall use the
156.29 eligibility requirements outlined in section 473 of the Social Security Act. In each case,
156.30 the agency paying the maintenance payments must be reimbursed for the costs from the
156.31 federal money available for this purpose.

156.32 Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance
156.33 payments as determined under subdivision 4, and an identical share of the pre-Northstar
156.34 Care foster care program under section 260C.4411, subdivision 1, the relative custody
156.35 assistance program under section 257.85, and the pre-Northstar Care for Children adoption

157.1 assistance program under chapter 259A. The commissioner may transfer funds into the
157.2 account if a deficit occurs.

157.3 Subd. 3. **Local share.** (a) The financially responsible agency at the time of
157.4 placement for foster care or finalization of the agreement for guardianship assistance or
157.5 adoption assistance shall pay the local share of the maintenance payments as determined
157.6 under subdivision 4, and an identical share of the pre-Northstar Care for Children foster
157.7 care program under section 260C.4411, subdivision 1, the relative custody assistance
157.8 program under section 257.85, and the pre-Northstar Care for Children adoption assistance
157.9 program under chapter 259A.

157.10 (b) The financially responsible agency shall pay the entire cost of any initial clothing
157.11 allowance, administrative payments to child caring agencies specified in section 317A.907,
157.12 or other support services it authorizes, except as provided under other provisions of law.

157.13 (c) In cases of federally required adoption assistance where there is no financially
157.14 responsible agency as provided in section 256N.24, subdivision 5, the commissioner
157.15 shall pay the local share.

157.16 (d) When an Indian child being placed in Minnesota meets title IV-E eligibility
157.17 defined in section 473(d) of the Social Security Act and is receiving guardianship
157.18 assistance or adoption assistance, the agency or entity assuming responsibility for the
157.19 child is responsible for the nonfederal share of the payment.

157.20 Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share
157.21 of the maintenance payments, reduced by federal reimbursements under title IV-E of the
157.22 Social Security Act, to be paid by the state and to be paid by the financially responsible
157.23 agency.

157.24 (b) These state and local shares must initially be calculated based on the ratio of the
157.25 average appropriate expenditures made by the state and all financially responsible agencies
157.26 during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation,
157.27 appropriate expenditures for the financially responsible agencies must include basic and
157.28 difficulty of care payments for foster care reduced by federal reimbursements, but not
157.29 including any initial clothing allowance, administrative payments to child care agencies
157.30 specified in section 317A.907, child care, or other support or ancillary expenditures. For
157.31 purposes of this calculation, appropriate expenditures for the state shall include adoption
157.32 assistance and relative custody assistance, reduced by federal reimbursements.

157.33 (c) For each of the periods January 1, 2015, to June 30, 2016, fiscal years 2017, 2018,
157.34 and 2019, the commissioner shall adjust this initial percentage of state and local shares to
157.35 reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and 2014,
157.36 taking into account appropriations for Northstar Care for Children and the turnover rates

158.1 of the components. In making these adjustments, the commissioner's goal shall be to make
158.2 these state and local expenditures other than the appropriations for Northstar Care to be
158.3 the same as they would have been had Northstar Care not been implemented, or if that
158.4 is not possible, proportionally higher or lower, as appropriate. The state and local share
158.5 percentages for fiscal year 2019 must be used for all subsequent years.

158.6 Subd. 5. **Adjustments for proportionate shares among financially responsible**
158.7 **agencies.** (a) The commissioner shall adjust the expenditures under subdivision 4 by each
158.8 financially responsible agency so that its relative share is proportional to its foster care
158.9 expenditures, with the goal of making the local share similar to what the county or tribe
158.10 would have spent had Northstar Care for Children not been enacted.

158.11 (b) For the period January 1, 2015, to June 30, 2016, the relative shares must be as
158.12 determined under subdivision 4 for calendar years 2011, 2012, 2013, and 2014 compared
158.13 with similar costs of all financially responsible agencies.

158.14 (c) For subsequent fiscal years, the commissioner shall update the relative shares
158.15 based on actual utilization of Northstar Care for Children by the financially responsible
158.16 agencies during the previous period, so that those using relatively more than they did
158.17 historically are adjusted upward and those using less are adjusted downward.

158.18 (d) The commissioner must ensure that the adjustments are not unduly influenced by
158.19 onetime events, anomalies, small changes that appear large compared to a narrow historic
158.20 base, or fluctuations that are the results of the transfer of responsibilities to tribal social
158.21 service agencies authorized in section 256.01, subdivision 14b, as part of the American
158.22 Indian Child Welfare Initiative.

158.23 Sec. 44. **[256N.28] ADMINISTRATION AND APPEALS.**

158.24 Subdivision 1. **Responsibilities.** (a) The financially responsible agency shall
158.25 determine the eligibility for Northstar Care for Children for children in foster care under
158.26 section 256N.21, and for those children determined eligible, shall further determine each
158.27 child's eligibility for title IV-E of the Social Security Act, provided the agency has such
158.28 authority under the state title IV-E plan.

158.29 (b) Subject to commissioner review and approval, the financially responsible agency
158.30 shall prepare the eligibility determination for Northstar Care for Children for children in
158.31 guardianship assistance under section 256N.22 and children in adoption assistance under
158.32 section 256N.23. The AFDC relatedness determination, when necessary to determine a
158.33 child's eligibility for title IV-E funding, shall be made only by an authorized agency
158.34 according to policies and procedures prescribed by the commissioner.

159.1 (c) The financially responsible agency is responsible for the administration of
159.2 Northstar Care for Children for children in foster care. The agency designated by the
159.3 commissioner is responsible for assisting the commissioner with the administration of
159.4 the Northstar Care for Children for children in guardianship assistance and adoption
159.5 assistance by conducting assessments, reassessments, negotiations, and other activities as
159.6 specified by the commissioner under subdivision 2.

159.7 Subd. 2. **Procedures, requirements, and deadlines.** The commissioner shall
159.8 specify procedures, requirements, and deadlines for the administration of Northstar Care
159.9 for Children in accordance with sections 256N.001 to 256N.28, including for children
159.10 transitioning into Northstar Care for Children under subdivision 7. The commissioner
159.11 shall periodically review all procedures, requirements, and deadlines, including the
159.12 assessment tool and process under section 256N.24, in consultation with counties, tribes,
159.13 and representatives of caregivers, and may alter them as needed.

159.14 Subd. 3. **Administration of title IV-E programs.** The title IV-E foster care,
159.15 guardianship assistance, and adoption assistance programs must operate within the
159.16 statutes, rules, and policies set forth by the federal government in the Social Security Act.

159.17 Subd. 4. **Reporting.** The commissioner shall specify required fiscal and statistical
159.18 reports under section 256.01, subdivision 2, paragraph (q), and other reports as necessary.

159.19 Subd. 5. **Promotion of programs.** Families who adopt a child under the
159.20 commissioner's guardianship must be informed as to the adoption tax credit. The
159.21 commissioner shall actively seek ways to promote the guardianship assistance and
159.22 adoption assistance programs, including informing prospective caregivers of eligible
159.23 children of the availability of guardianship assistance and adoption assistance.

159.24 Subd. 6. **Appeals and fair hearings.** (a) A caregiver has the right to appeal to the
159.25 commissioner under section 256.045 when eligibility for Northstar Care for Children is
159.26 denied, and when payment or the agreement for an eligible child is modified or terminated.

159.27 (b) A relative custodian or adoptive parent has additional rights to appeal to the
159.28 commissioner pursuant to section 256.045. These rights include when the commissioner
159.29 terminates or modifies the guardianship assistance or adoption assistance agreement or
159.30 when the commissioner denies an application for guardianship assistance or adoption
159.31 assistance. A prospective relative custodian or adoptive parent who disagrees with a
159.32 decision by the commissioner before transfer of permanent legal and physical custody or
159.33 finalization of the adoption may request review of the decision by the commissioner or
159.34 may appeal the decision under section 256.045. A guardianship assistance or adoption
159.35 assistance agreement must be signed and in effect before the court order that transfers
159.36 permanent legal and physical custody or the adoption finalization; however in some cases,

160.1 there may be extenuating circumstances as to why an agreement was not entered into
160.2 before finalization of permanency for the child. Caregivers who believe that extenuating
160.3 circumstances exist in the case of their child may request a fair hearing. Caregivers have the
160.4 responsibility of proving that extenuating circumstances exist. Caregivers must be required
160.5 to provide written documentation of each eligibility criterion at the fair hearing. Examples
160.6 of extenuating circumstances include: relevant facts regarding the child were known by
160.7 the placing agency and not presented to the caregivers before transfer of permanent legal
160.8 and physical custody or finalization of the adoption, or failure by the commissioner or a
160.9 designee to advise potential caregivers about the availability of guardianship assistance or
160.10 adoption assistance for children in the state foster care system. If an appeals judge finds
160.11 through the fair hearing process that extenuating circumstances existed and that the child
160.12 met all eligibility criteria at the time the transfer of permanent legal and physical custody
160.13 was ordered or the adoption was finalized, the effective date and any associated federal
160.14 financial participation shall be retroactive from the date of the request for a fair hearing.

160.15 Subd. 7. **Transitions from pre-Northstar Care for Children programs.** (a) A child
160.16 in foster care who remains with the same caregiver shall continue to receive benefits under
160.17 the pre-Northstar Care for Children foster care program under section 256.82. Transitions
160.18 to Northstar Care for Children must occur as provided in section 256N.21, subdivision 6.

160.19 (b) The commissioner may seek to transition into Northstar Care for Children a child
160.20 who is in pre-Northstar Care for Children relative custody assistance under section 257.85
160.21 or pre-Northstar Care for Children adoption assistance under chapter 259A, in accordance
160.22 with these priorities, in order of priority:

160.23 (1) financial and budgetary constraints;

160.24 (2) complying with federal regulations;

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

160.27 (4) improving permanency for a child or children;

160.28 (5) maintaining permanency for a child or children;

160.29 (6) accessing additional federal funds; and

160.30 (7) administrative simplification.

160.31 (c) Transitions shall be accomplished according to procedures, deadlines, and
160.32 requirements specified by the commissioner under subdivision 2.

160.33 (d) The commissioner may accomplish a transition of a child from pre-Northstar
160.34 Care for Children relative custody assistance under section 257.85 to the guardianship
160.35 assistance component of Northstar Care for Children by declaration and appropriate notice
160.36 to the caregiver, provided that the benefit for a child under this paragraph is not reduced.

161.1 (e) The commissioner may offer a transition of a child from pre-Northstar Care for
161.2 Children adoption assistance under chapter 259A to the adoption assistance component
161.3 of Northstar Care for Children by contacting the caregiver with an offer. The transition
161.4 must be accomplished only when the caregiver agrees to the offer. The caregiver shall
161.5 have a maximum of 90 days to review and accept the commissioner's offer. If the
161.6 commissioner's offer is not accepted within 90 days, the pre-Northstar Care for Children
161.7 adoption assistance agreement remains in effect until it terminates or a subsequent offer is
161.8 made by the commissioner.

161.9 (f) For a child transitioning into Northstar Care for Children, the commissioner shall
161.10 assign an equivalent assessment level based on the most recently completed supplemental
161.11 difficulty of care level assessment, unless the commissioner determines that arranging
161.12 for a new assessment under section 256N.24 would be more appropriate based on the
161.13 priorities specified in paragraph (b).

161.14 (g) For a child transitioning into Northstar Care for Children, regardless of the age
161.15 of the child, the commissioner shall use the rates under section 256N.26, subdivision 5,
161.16 unless the rates under section 256N.26, subdivisions 3 and 4, are more appropriate based
161.17 on the priorities specified in paragraph (b), as determined by the commissioner.

161.18 Subd. 8. **Purchase of child-specific adoption services.** The commissioner may
161.19 reimburse the placing agency for appropriate adoption services for children eligible
161.20 under section 259A.75.

161.21 Sec. 45. Minnesota Statutes 2012, section 257.85, subdivision 2, is amended to read:

161.22 Subd. 2. **Scope.** The provisions of this section apply to those situations in which
161.23 the legal and physical custody of a child is established with a relative or important friend
161.24 with whom the child has resided or had significant contact according to section 260C.515,
161.25 subdivision 4, by a district court order issued on or after July 1, 1997, but on or before
161.26 November 26, 2014, or a tribal court order issued on or after July 1, 2005, but on or
161.27 before November 26, 2014, when the child has been removed from the care of the parent
161.28 by previous district or tribal court order.

161.29 Sec. 46. Minnesota Statutes 2012, section 257.85, subdivision 5, is amended to read:

161.30 Subd. 5. **Relative custody assistance agreement.** (a) A relative custody assistance
161.31 agreement will not be effective, unless it is signed by the local agency and the relative
161.32 custodian no later than 30 days after the date of the order establishing permanent legal and
161.33 physical custody, and on or before November 26, 2014, except that a local agency may
161.34 enter into a relative custody assistance agreement with a relative custodian more than 30

162.1 days after the date of the order if it certifies that the delay in entering the agreement was
162.2 through no fault of the relative custodian and the agreement is signed and in effect on or
162.3 before November 26, 2014. There must be a separate agreement for each child for whom
162.4 the relative custodian is receiving relative custody assistance.

162.5 (b) Regardless of when the relative custody assistance agreement is signed by the
162.6 local agency and relative custodian, the effective date of the agreement shall be the date of
162.7 the order establishing permanent legal and physical custody.

162.8 (c) If MFIP is not the applicable program for a child at the time that a relative
162.9 custody assistance agreement is entered on behalf of the child, when MFIP becomes
162.10 the applicable program, if the relative custodian had been receiving custody assistance
162.11 payments calculated based upon a different program, the amount of relative custody
162.12 assistance payment under subdivision 7 shall be recalculated under the Minnesota family
162.13 investment program.

162.14 (d) The relative custody assistance agreement shall be in a form specified by the
162.15 commissioner and shall include provisions relating to the following:

162.16 (1) the responsibilities of all parties to the agreement;

162.17 (2) the payment terms, including the financial circumstances of the relative
162.18 custodian, the needs of the child, the amount and calculation of the relative custody
162.19 assistance payments, and that the amount of the payments shall be reevaluated annually;

162.20 (3) the effective date of the agreement, which shall also be the anniversary date for
162.21 the purpose of submitting the annual affidavit under subdivision 8;

162.22 (4) that failure to submit the affidavit as required by subdivision 8 will be grounds
162.23 for terminating the agreement;

162.24 (5) the agreement's expected duration, which shall not extend beyond the child's
162.25 eighteenth birthday;

162.26 (6) any specific known circumstances that could cause the agreement or payments
162.27 to be modified, reduced, or terminated and the relative custodian's appeal rights under
162.28 subdivision 9;

162.29 (7) that the relative custodian must notify the local agency within 30 days of any of
162.30 the following:

162.31 (i) a change in the child's status;

162.32 (ii) a change in the relationship between the relative custodian and the child;

162.33 (iii) a change in composition or level of income of the relative custodian's family;

162.34 (iv) a change in eligibility or receipt of benefits under MFIP, or other assistance
162.35 program; and

163.1 (v) any other change that could affect eligibility for or amount of relative custody
163.2 assistance;

163.3 (8) that failure to provide notice of a change as required by clause (7) will be
163.4 grounds for terminating the agreement;

163.5 (9) that the amount of relative custody assistance is subject to the availability of state
163.6 funds to reimburse the local agency making the payments;

163.7 (10) that the relative custodian may choose to temporarily stop receiving payments
163.8 under the agreement at any time by providing 30 days' notice to the local agency and may
163.9 choose to begin receiving payments again by providing the same notice but any payments
163.10 the relative custodian chooses not to receive are forfeit; and

163.11 (11) that the local agency will continue to be responsible for making relative custody
163.12 assistance payments under the agreement regardless of the relative custodian's place of
163.13 residence.

163.14 Sec. 47. Minnesota Statutes 2012, section 257.85, subdivision 6, is amended to read:

163.15 Subd. 6. **Eligibility criteria.** (a) A local agency shall enter into a relative custody
163.16 assistance agreement under subdivision 5 if it certifies that the following criteria are met:

163.17 (1) the juvenile court has determined or is expected to determine that the child,
163.18 under the former or current custody of the local agency, cannot return to the home of
163.19 the child's parents;

163.20 (2) the court, upon determining that it is in the child's best interests, has issued
163.21 or is expected to issue an order transferring permanent legal and physical custody of
163.22 the child; and

163.23 (3) the child either:

163.24 (i) is a member of a sibling group to be placed together; or

163.25 (ii) has a physical, mental, emotional, or behavioral disability that will require
163.26 financial support.

163.27 When the local agency bases its certification that the criteria in clause (1) or (2) are
163.28 met upon the expectation that the juvenile court will take a certain action, the relative
163.29 custody assistance agreement does not become effective until and unless the court acts as
163.30 expected.

163.31 (b) After November 26, 2014, new relative custody assistance agreements must not
163.32 be executed. Agreements that were signed by all parties on or before November 26, 2014,
163.33 and were not in effect because the proposed transfer of permanent legal and physical
163.34 custody of the child did not occur on or before November 26, 2014, must be renegotiated
163.35 under the terms of Northstar Care for Children in chapter 256N.

164.1 Sec. 48. **[259A.12] NO NEW EXECUTION OF ADOPTION ASSISTANCE**
164.2 **AGREEMENTS.**
164.3 After November 26, 2014, new adoption assistance agreements must not be executed
164.4 under this section. Agreements that were signed on or before November 26, 2014, and
164.5 were not in effect because the adoption finalization of the child did not occur on or before
164.6 November 26, 2014, must be renegotiated according to the terms of Northstar Care for
164.7 Children under chapter 256N. Agreements signed and in effect on or before November 26,
164.8 2014, must continue according to the terms of this section and applicable rules for the
164.9 duration of the agreement, unless the commissioner and the adoptive parents choose to
164.10 renegotiated the agreements under Northstar Care for Children consistent with section
164.11 256N.28, subdivision 7. After November 26, 2014, this section and associated rules must
164.12 be referred to as the pre-Northstar Care for Children adoption assistance program and
164.13 shall apply to children whose adoption assistance agreements were in effect on or before
164.14 November 26, 2014, and whose adoptive parents have not renegotiated their agreements
164.15 according to the terms of Northstar Care for Children.

164.16 Sec. 49. **[260C.4411] PRE-NORTHSTAR CARE FOR CHILDREN FOSTER**
164.17 **CARE PROGRAM.**
164.18 Subdivision 1. **Pre-Northstar Care for Children foster care program.** (a) For a
164.19 child placed in family foster care on or before December 31, 2014, the county of financial
164.20 responsibility under section 256G.02 or tribal agency authorized under section 256.01,
164.21 subdivision 14b, shall pay the local share under section 256N.27, subdivision 3, for foster
164.22 care maintenance including any difficulty of care as defined in Minnesota Rules, part
164.23 9560.0521, subparts 7 and 10. Family foster care includes:
164.24 (1) emergency relative placement under section 245A.035;
164.25 (2) licensed foster family settings, foster residence settings, or treatment foster care
164.26 settings, licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, served by a public
164.27 or private child care agency authorized by Minnesota Rules, parts 9545.0755 to 9545.0845;
164.28 (3) family foster care homes approved by a tribal agency; and
164.29 (4) unlicensed supervised settings for foster youth ages 18 to 21.
164.30 (b) The county of financial responsibility under section 256G.02 or tribal social
164.31 services agency authorized in section 256.01, subdivision 14b, shall pay the entire cost of
164.32 any initial clothing allowance, administrative payments to child care agencies specified
164.33 in section 317A.907, or any other support services it authorizes, except as otherwise
164.34 provided by law.

165.1 (c) The rates for the pre-Northstar Care for Children foster care program remain
165.2 those in effect on January 1, 2013, continuing the preexisting rate structure for foster
165.3 children who remain with the same caregivers and do not transition into Northstar Care for
165.4 Children under section 256N.21, subdivision 6.

165.5 (d) Difficulty of care payments must be maintained consistent with Minnesota Rules,
165.6 parts 9560.0652 and 9560.0653, using the established reassessment tool in part 9560.0654.
165.7 The preexisting rate structure for the pre-Northstar Care for Children foster care program
165.8 must be maintained, provided that when the number of foster children in the program is
165.9 less than ten percent of the population in 2012, the commissioner may apply the same
165.10 assessment tool to both the pre-Northstar Care for Children foster care program and
165.11 Northstar Care for Children under the authority granted in section 256N.24, subdivision 2.

165.12 (e) The county of financial responsibility under section 256G.02 or tribal agency
165.13 authorized under section 256.01, subdivision 14b, shall document the determined
165.14 pre-Northstar Care for Children foster care rate in the case record, including a description
165.15 of each condition on which the difficulty of care assessment is based. The difficulty
165.16 of care rate is reassessed:

165.17 (1) every 12 months;

165.18 (2) at the request of the foster parent; or

165.19 (3) if the child's level of need changes in the current foster home.

165.20 (f) The pre-Northstar Care for Children foster care program must maintain the
165.21 following existing program features:

165.22 (1) monthly payments must be made to the family foster home provider;

165.23 (2) notice and appeal procedures must be consistent with Minnesota Rules, part
165.24 9560.0665; and

165.25 (3) medical assistance eligibility for foster children must continue to be determined
165.26 according to section 256B.055.

165.27 (g) The county of financial responsibility under section 256G.02 or tribal agency
165.28 authorized under section 256.01, subdivision 14b, may continue existing program features,
165.29 including:

165.30 (1) establishing a local fund of county money through which the agency may
165.31 reimburse foster parents for the cost of repairing damage done to the home and contents by
165.32 the foster child and the additional care insurance premium cost of a child who possesses a
165.33 permit or license to drive a car; and

165.34 (2) paying a fee for specific services provided by the foster parent, based on the
165.35 parent's skills, experience, or training. This fee must not be considered foster care
165.36 maintenance.

166.1 (h) The following events end the child's enrollment in the pre-Northstar Care for
166.2 Children foster care program:
166.3 (1) reunification with parent or other relative;
166.4 (2) adoption or transfer of permanent legal and physical custody;
166.5 (3) removal from the current foster home to a different foster home;
166.6 (4) another event that ends the current placement episode; or
166.7 (5) attaining the age of 21.
166.8 Subd. 2. **Consideration of other programs.** (a) When a child in foster care
166.9 is eligible to receive a grant of Retirement Survivors Disability Insurance (RSDI)
166.10 or Supplemental Security Income for the aged, blind, and disabled, or a foster care
166.11 maintenance payment under title IV-E of the Social Security Act, United States Code, title
166.12 42, sections 670 to 676, the child's needs must be met through these programs. Every
166.13 effort must be made to establish a child's eligibility for a title IV-E grant to reimburse the
166.14 county or tribe from the federal funds available for this purpose.
166.15 (b) When a child in foster care qualifies for home and community-based waivered
166.16 services under section 256B.49 for community alternative care (CAC), community
166.17 alternatives for disabled individuals (CADI), or traumatic brain injury (TBI) waivers,
166.18 this service does not substitute for the child foster care program. When a foster child is
166.19 receiving waivered services benefits, the county of financial responsibility under section
166.20 256G.02 or tribal agency authorized under section 256.01, subdivision 14b, assesses and
166.21 provides foster care maintenance including difficulty of care using the established tool in
166.22 Minnesota Rules, part 9560.0654. If it is determined that additional services are needed to
166.23 meet the child's needs in the home that are not or cannot be met by the foster care program,
166.24 the needs must be referred to the waivered service program.

166.25 Sec. 50. **[260C.4412] PAYMENT FOR RESIDENTIAL PLACEMENTS.**
166.26 When a child is placed in a foster care group residential setting under Minnesota
166.27 Rules, parts 2960.0020 to 2960.0710, foster care maintenance payments must be made on
166.28 behalf of the child to cover the cost of providing food, clothing, shelter, daily supervision,
166.29 school supplies, child's personal incidentals and supports, reasonable travel for visitation,
166.30 or other transportation needs associated with the items listed. Daily supervision in the
166.31 group residential setting includes routine day-to-day direction and arrangements to
166.32 ensure the well-being and safety of the child. It may also include reasonable costs of
166.33 administration and operation of the facility.

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

167.1 Sec. 51. **[260C.4413] INITIAL CLOTHING ALLOWANCE.**

167.2 (a) An initial clothing allowance must be available to a child eligible for:

167.3 (1) the pre-Northstar Care for Children foster care program under section 260C.4411,
167.4 subdivision 1; and

167.5 (2) the Northstar Care for Children benefits under section 256N.21.

167.6 (b) An initial clothing allowance must also be available for a foster child in a group
167.7 residential setting based on the child's individual needs during the first 60 days of the
167.8 child's initial placement. The agency must consider the parent's ability to provide for a
167.9 child's clothing needs and the residential facility contracts.

167.10 (c) The county of financial responsibility under section 256G.02 or tribal agency
167.11 authorized under section 256.01, subdivision 14b, shall approve an initial clothing
167.12 allowance consistent with the child's needs. The amount of the initial clothing allowance
167.13 must not exceed the monthly basic rate for the child's age group under section 256N.26,
167.14 subdivision 3.

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

167.16 Sec. 52. Minnesota Statutes 2012, section 260C.446, is amended to read:

167.17 **260C.446 DISTRIBUTION OF FUNDS RECOVERED FOR ASSISTANCE**
167.18 **FURNISHED.**

167.19 When any amount shall be recovered from any source for assistance furnished
167.20 under the provisions of sections 260C.001 to 260C.421 ~~and 260C.441~~, there shall be paid
167.21 into the treasury of the state or county in the proportion in which they have respectively
167.22 contributed toward the total assistance paid.

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

167.24 Sec. 53. **REPEALER.**

167.25 (a) Minnesota Statutes 2012, sections 256.82, subdivision 4; and 260C.441, are
167.26 repealed effective January 1, 2015.

167.27 (b) Minnesota Statutes 2012, section 256J.24, subdivision 10, is repealed effective
167.28 October 1, 2013, or upon approval from the United States Department of Agriculture,
167.29 whichever is later.

167.30 (c) Minnesota Rules, part 3400.0130, subpart 8, is repealed effective retroactively
167.31 from September 3, 2012.

167.32 (d) Minnesota Rules, parts 9560.0650, subparts 1, 3, and 6; 9560.0651; and
167.33 9560.0655, are repealed effective January 1, 2015.

168.1 (e) Minnesota Rules, part 9502.0355, subpart 4, is repealed.

168.2 ## ARTICLE 4

168.3 ## STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES

168.4 Section 1. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

168.5 Subd. 2. **General provisions.** (a) In the design and implementation of reforms to
168.6 the mental health system, the commissioner shall:

168.7 (1) consult with consumers, families, counties, tribes, advocates, providers, and
168.8 other stakeholders;

168.9 (2) bring to the legislature, and the State Advisory Council on Mental Health, by
168.10 January 15, 2008, recommendations for legislation to update the role of counties and to
168.11 clarify the case management roles, functions, and decision-making authority of health
168.12 plans and counties, and to clarify county retention of the responsibility for the delivery of
168.13 social services as required under subdivision 3, paragraph (a);

168.14 (3) withhold implementation of any recommended changes in case management
168.15 roles, functions, and decision-making authority until after the release of the report due
168.16 January 15, 2008;

168.17 (4) ensure continuity of care for persons affected by these reforms including
168.18 ensuring client choice of provider by requiring broad provider networks and developing
168.19 mechanisms to facilitate a smooth transition of service responsibilities;

168.20 (5) provide accountability for the efficient and effective use of public and private
168.21 resources in achieving positive outcomes for consumers;

168.22 (6) ensure client access to applicable protections and appeals; and

168.23 (7) make budget transfers necessary to implement the reallocation of services and
168.24 client responsibilities between counties and health care programs that do not increase the
168.25 state and county costs and efficiently allocate state funds.

168.26 (b) When making transfers under paragraph (a) necessary to implement movement
168.27 of responsibility for clients and services between counties and health care programs,
168.28 the commissioner, in consultation with counties, shall ensure that any transfer of state
168.29 grants to health care programs, including the value of case management transfer grants
168.30 under section 256B.0625, subdivision 20, does not exceed the value of the services being
168.31 transferred for the latest 12-month period for which data is available. The commissioner
168.32 may make quarterly adjustments based on the availability of additional data during the
168.33 first four quarters after the transfers first occur. If case management transfer grants under
168.34 section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior
168.35 to repeal, exceeds the value of the services being transferred, the difference becomes an

169.1 ongoing part of each county's adult ~~and children's~~ mental health grants under sections
169.2 245.4661~~, 245.4889,~~ and 256E.12.
169.3 (c) This appropriation is not authorized to be expended after December 31, 2010,
169.4 unless approved by the legislature.

169.5 Sec. 2. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:
169.6 Subd. 8. **State-operated services account.** (a) The state-operated services account is
169.7 established in the special revenue fund. Revenue generated by new state-operated services
169.8 listed under this section established after July 1, 2010, that are not enterprise activities must
169.9 be deposited into the state-operated services account, unless otherwise specified in law:
169.10 (1) intensive residential treatment services;
169.11 (2) foster care services; and
169.12 (3) psychiatric extensive recovery treatment services.
169.13 (b) Funds deposited in the state-operated services account are available to the
169.14 commissioner of human services for the purposes of:
169.15 (1) providing services needed to transition individuals from institutional settings
169.16 within state-operated services to the community when those services have no other
169.17 adequate funding source; and
169.18 (2) grants to providers participating in mental health specialty treatment services
169.19 under section 245.4661.

169.20 Sec. 3. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision
169.21 to read:
169.22 Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds
169.23 to the account in subdivision 8 for noncovered allowable costs of a provider certified and
169.24 licensed under section 256B.0622, and operating under section 246.014.

169.25 Sec. 4. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
169.26 subdivision to read:
169.27 Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon
169.28 federal approval, whichever is later, medical assistance covers family psychoeducation
169.29 services provided to a child up to age 21 with a diagnosed mental health condition when
169.30 identified in the child's individual treatment plan and provided by a licensed mental health
169.31 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a
169.32 clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who
169.33 has determined it medically necessary to involve family members in the child's care. For

170.1 the purposes of this subdivision, "family psychoeducation services" means information
170.2 or demonstration provided to an individual or family as part of an individual, family,
170.3 multifamily group, or peer group session to explain, educate, and support the child and
170.4 family in understanding a child's symptoms of mental illness, the impact on the child's
170.5 development, and needed components of treatment and skill development so that the
170.6 individual, family, or group can help the child to prevent relapse, prevent the acquisition
170.7 of comorbid disorders, and to achieve optimal mental health and long-term resilience.

170.8 Sec. 5. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
170.9 subdivision to read:

170.10 Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon
170.11 federal approval, whichever is later, medical assistance covers clinical care consultation
170.12 for a person up to age 21 who is diagnosed with a complex mental health condition or a
170.13 mental health condition that co-occurs with other complex and chronic conditions, when
170.14 described in the person's individual treatment plan and provided by a licensed mental
170.15 health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A. For
170.16 the purposes of this subdivision, "clinical care consultation" means communication from a
170.17 treating mental health professional to other providers not under the clinical supervision of
170.18 the treating mental health professional who are working with the same client to inform,
170.19 inquire, and instruct regarding the client's symptoms; strategies for effective engagement,
170.20 care, and intervention needs; and treatment expectations across service settings; and to
170.21 direct and coordinate clinical service components provided to the client and family.

170.22 Sec. 6. Minnesota Statutes 2012, section 256B.761, is amended to read:

170.23 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

170.24 (a) Effective for services rendered on or after July 1, 2001, payment for medication
170.25 management provided to psychiatric patients, outpatient mental health services, day
170.26 treatment services, home-based mental health services, and family community support
170.27 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
170.28 50th percentile of 1999 charges.

170.29 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
170.30 services provided by an entity that operates: (1) a Medicare-certified comprehensive
170.31 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
170.32 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
170.33 recent calendar year who are medical assistance recipients, will be increased by 38 percent,

171.1 when those services are provided within the comprehensive outpatient rehabilitation
171.2 facility and provided to residents of nursing facilities owned by the entity.

171.3 (c) The commissioner shall establish three levels of payment for mental health
171.4 diagnostic assessment, based on three levels of complexity. The aggregate payment under
171.5 the tiered rates must not exceed the projected aggregate payments for mental health
171.6 diagnostic assessment under the previous single rate. The new rate structure is effective
171.7 January 1, 2011, or upon federal approval, whichever is later.

171.8 (d) In addition to rate increases otherwise provided, the commissioner may
171.9 restructure coverage policy and rates to improve access to adult rehabilitative mental
171.10 health services under section 256B.0623 and related mental health support services under
171.11 section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and
171.12 2016, the projected state share of increased costs due to this paragraph is transferred
171.13 from adult mental health grants under sections 245.4661 and 256E.12. The transfer for
171.14 fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments
171.15 made to managed care plans and county-based purchasing plans under sections 256B.69,
171.16 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

171.17 ARTICLE 5

171.18 DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY

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

171.20 Subd. 7. **Use of data.** (a) Except as otherwise provided in subdivision 7a or sections
171.21 244.052 and 299C.093, the data provided under this section is private data on individuals
171.22 under section 13.02, subdivision 12.

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

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

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

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

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

171.32 Subd. 4a. **Agency background studies.** (a) The commissioner shall develop
171.33 and implement an electronic process for the regular transfer of new criminal history
171.34 information that is added to the Minnesota court information system. The commissioner's

172.1 system must include for review only information that relates to individuals who have been
172.2 the subject of a background study under this chapter that remain affiliated with the agency
172.3 that initiated the background study. For purposes of this paragraph, an individual remains
172.4 affiliated with an agency that initiated the background study until the agency informs the
172.5 commissioner that the individual is no longer affiliated. When any individual no longer
172.6 affiliated according to this paragraph returns to a position requiring a background study
172.7 under this chapter, the agency with whom the individual is again affiliated shall initiate
172.8 a new background study regardless of the length of time the individual was no longer
172.9 affiliated with the agency.

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

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

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

172.20 (1) information related to names of substantiated perpetrators of maltreatment of
172.21 vulnerable adults that has been received by the commissioner as required under section
172.22 626.557, subdivision 9c, paragraph (j);

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

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

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

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

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

173.1 (i) information from the child abuse and neglect registry for any state in which the
173.2 background study subject has resided for the past five years; and
173.3 (ii) information from national crime information databases, when the background
173.4 study subject is 18 years of age or older.
173.5 (b) Notwithstanding expungement by a court, the commissioner may consider
173.6 information obtained under paragraph (a), clauses (3) and (4), unless the commissioner
173.7 received notice of the petition for expungement and the court order for expungement is
173.8 directed specifically to the commissioner.
173.9 (c) The commissioner shall also review criminal history information received
173.10 according to section 245C.04, subdivision 4a, from the Minnesota court information
173.11 system that relates to individuals who have already been studied under this chapter and
173.12 who remain affiliated with the agency that initiated the background study.

173.13 Sec. 4. **[245E.01] CHILD CARE PROVIDER AND RECIPIENT FRAUD**
173.14 **INVESTIGATIONS WITHIN THE CHILD CARE ASSISTANCE PROGRAM.**
173.15 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this
173.16 subdivision have the meanings given them.
173.17 (b) "Applicant" has the meaning given in section 119B.011, subdivision 2.
173.18 (c) "Child care assistance program" means any of the assistance programs under
173.19 chapter 119B.
173.20 (d) "Commissioner" means the commissioner of human services.
173.21 (e) "Controlling individual" has the meaning given in section 245A.02, subdivision
173.22 5a.
173.23 (f) "County" means a local county child care assistance program staff or
173.24 subcontracted staff, or a county investigator acting on behalf of the commissioner.
173.25 (g) "Department" means the Department of Human Services.
173.26 (h) "Financial misconduct" or "misconduct" means an entity's or individual's acts or
173.27 omissions that result in fraud and abuse or error against the Department of Human Services.
173.28 (i) "Identify" means to furnish the full name, current or last known address, phone
173.29 number, and e-mail address of the individual or business entity.
173.30 (j) "License holder" has the meaning given in section 245A.02, subdivision 9.
173.31 (k) "Mail" means the use of any mail service with proof of delivery and receipt.
173.32 (l) "Provider" means either a provider as defined in section 119B.011, subdivision
173.33 19, or a legal unlicensed provider as defined in section 119B.011, subdivision 16.
173.34 (m) "Recipient" means a family receiving assistance as defined under section
173.35 119B.011, subdivision 13.

174.1 (n) "Terminate" means revocation of participation in the child care assistance
174.2 program.

174.3 Subd. 2. **Investigating provider or recipient financial misconduct.** The
174.4 department shall investigate alleged or suspected financial misconduct by providers and
174.5 errors related to payments issued by the child care assistance program under this chapter.
174.6 Recipients, employees, and staff persons may be investigated when the evidence shows
174.7 that their conduct is related to the financial misconduct of a provider, license holder,
174.8 or controlling individual.

174.9 Subd. 3. **Scope of investigations.** (a) The department may contact any person,
174.10 agency, organization, or other entity that is necessary to an investigation.

174.11 (b) The department may examine or interview any individual, document, or piece of
174.12 evidence that may lead to information that is relevant to child care assistance program
174.13 benefits, payments, and child care provider authorizations. This includes, but is not
174.14 limited to:

174.15 (1) child care assistance program payments;

174.16 (2) services provided by the program or related to child care assistance program
174.17 recipients;

174.18 (3) services provided to a provider;

174.19 (4) provider financial records of any type;

174.20 (5) daily attendance records of the children receiving services from the provider;

174.21 (6) billings; and

174.22 (7) verification of the credentials of a license holder, controlling individual, employee,
174.23 staff person, contractor, subcontractor, and entities under contract with the provider to
174.24 provide services or maintain service and financial records related to those services.

174.25 Subd. 4. **Determination of investigation.** After completing its investigation, the
174.26 department shall issue one of the following determinations:

174.27 (1) no violation of child care assistance requirements occurred;

174.28 (2) there is insufficient evidence to show that a violation of child care assistance
174.29 requirements occurred;

174.30 (3) a preponderance of evidence shows a violation of child care assistance program
174.31 law, rule, or policy; or

174.32 (4) there exists a credible allegation of fraud.

174.33 Subd. 5. **Actions or administrative sanctions.** (a) In addition to section 256.98,
174.34 after completing the determination under subdivision 4, the department may take one or
174.35 more of the actions or sanctions specified in this subdivision.

174.36 (b) The department may take the following actions:

175.1 (1) refer the investigation to law enforcement or a county attorney for possible
175.2 criminal prosecution;
175.3 (2) refer relevant information to the department's licensing division, the child care
175.4 assistance program, the Department of Education, the federal child and adult care food
175.5 program, or appropriate child or adult protection agency;
175.6 (3) enter into a settlement agreement with a provider, license holder, controlling
175.7 individual, or recipient; or
175.8 (4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction
175.9 for possible civil action under the Minnesota False Claims Act, chapter 15C.
175.10 (c) The department may impose sanctions by:
175.11 (1) pursuing administrative disqualification through hearings or waivers;
175.12 (2) establishing and seeking monetary recovery or recoupment; or
175.13 (3) issuing an order of corrective action that states the practices that are violations of
175.14 child care assistance program policies, laws, or regulations, and that they must be corrected.
175.15 Subd. 6. **Duty to provide access.** (a) A provider, license holder, controlling
175.16 individual, employee, staff person, or recipient has an affirmative duty to provide access
175.17 upon request to information specified under subdivision 8 or the program facility.
175.18 (b) Failure to provide access may result in denial or termination of authorizations for
175.19 or payments to a recipient, provider, license holder, or controlling individual in the child
175.20 care assistance program.
175.21 (c) When a provider fails to provide access, a 15-day notice of denial or termination
175.22 must be issued to the provider, which prohibits the provider from participating in the child
175.23 care assistance program. Notice must be sent to recipients whose children are under the
175.24 provider's care pursuant to Minnesota Rules, part 3400.0185.
175.25 (d) If the provider continues to fail to provide access at the expiration of the 15-day
175.26 notice period, child care assistance program payments to the provider must be denied
175.27 beginning the 16th day following notice of the initial failure or refusal to provide access.
175.28 The department may rescind the denial based upon good cause if the provider submits in
175.29 writing a good cause basis for having failed or refused to provide access. The writing must
175.30 be postmarked no later than the 15th day following the provider's notice of initial failure
175.31 to provide access. Additionally, the provider, license holder, or controlling individual
175.32 must immediately provide complete, ongoing access to the department. Repeated failures
175.33 to provide access must, after the initial failure or for any subsequent failure, result in
175.34 termination from participation in the child care assistance program.
175.35 (e) The department, at its own expense, may photocopy or otherwise duplicate
175.36 records referenced in subdivision 8. Photocopying must be done on the provider's

176.1 premises on the day of the request or other mutually agreeable time, unless removal of
176.2 records is specifically permitted by the provider. If requested, a provider, license holder,
176.3 or controlling individual, or a designee, must assist the investigator in duplicating any
176.4 record, including a hard copy or electronically stored data, on the day of the request.

176.5 (f) A provider, license holder, controlling individual, employee, or staff person must
176.6 grant the department access during the department's normal business hours, and any hours
176.7 that the program is operated, to examine the provider's program or the records listed in
176.8 subdivision 8. A provider shall make records available at the provider's place of business
176.9 on the day for which access is requested, unless the provider and the department both agree
176.10 otherwise. The department's normal business hours are 8:00 a.m. to 5:00 p.m., Monday
176.11 through Friday, excluding state holidays as defined in section 645.44, subdivision 5.

176.12 Subd. 7. **Honest and truthful statements.** It shall be unlawful for a provider
176.13 or recipient to:

176.14 (1) falsify, conceal, or cover up by any trick, scheme, or device a material fact;

176.15 (2) make any materially false, fictitious, or fraudulent statement or representation; or

176.16 (3) make or use any false writing or document knowing the same to contain
176.17 any materially false, fictitious, or fraudulent statement or entry related to any child
176.18 care assistance program services that the provider supplies or in relation to any child
176.19 care assistance payments received by a provider, or to any fraud investigator or law
176.20 enforcement officer conducting a financial misconduct investigation.

176.21 Subd. 8. **Record retention.** (a) The following records must be maintained,
176.22 controlled, and made immediately accessible to license holders, providers, and controlling
176.23 individuals. The records must be organized and labeled to correspond to categories that
176.24 make them easy to identify so that they can be made available immediately upon request
176.25 to an investigator acting on behalf of the commissioner at the provider's place of business:

176.26 (1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting
176.27 records;

176.28 (2) daily attendance records required by and that comply with section 119B.125,
176.29 subdivision 6;

176.30 (3) billing transmittal forms requesting payments from the child care assistance
176.31 program and billing adjustments related to child care assistance program payments;

176.32 (4) records identifying all persons, corporations, partnerships, and entities with an
176.33 ownership or controlling interest in the provider's child care business;

176.34 (5) employee records identifying those persons currently employed by the provider's
176.35 child care business or who have been employed by the business at any time within the
176.36 previous five years. The records must include each employee's name, hourly and annual

177.1 salary, qualifications, position description, job title, and dates of employment. In addition,
177.2 employee records that must be made available include the employee's time sheets, current
177.3 home address of the employee or last known address of any former employee, and
177.4 documentation of background studies required under chapter 119B or 245C;
177.5 (6) records related to transportation of children in care, including but not limited to:
177.6 (i) the dates and times that transportation is provided to children for transportation to
177.7 and from the provider's business location for any purpose. For transportation related to
177.8 field trips or locations away from the provider's business location, the names and addresses
177.9 of those field trips and locations must also be provided;
177.10 (ii) the name, business address, phone number, and Web site address, if any, of the
177.11 transportation service utilized; and
177.12 (iii) all billing or transportation records related to the transportation.
177.13 (b) A provider, license holder, or controlling individual must retain all records
177.14 in paragraph (a) for at least six years after the date the record is created. Microfilm or
177.15 electronically stored records satisfy the record keeping requirements of this subdivision.
177.16 (c) A provider, license holder, or controlling individual who withdraws or is
177.17 terminated from the child care assistance program must retain the records required under
177.18 this subdivision and make them available to the department on demand.
177.19 (d) If the ownership of a provider changes, the transferor, unless otherwise provided
177.20 by law or by written agreement with the transferee, is responsible for maintaining,
177.21 preserving, and upon request from the department, making available the records related to
177.22 the provider that were generated before the date of the transfer. Any written agreement
177.23 affecting this provision must be held in the possession of the transferor and transferee.
177.24 The written agreement must be provided to the department or county immediately upon
177.25 request, and the written agreement must be retained by the transferor and transferee for six
177.26 years after the agreement is fully executed.
177.27 (e) In the event of an appealed case, the provider must retain all records required in
177.28 this subdivision for the duration of the appeal or six years, whichever is longer.
177.29 (f) A provider's use of electronic record keeping or electronic signatures is governed
177.30 by chapter 325L.
177.31 Subd. 9. **Factors regarding imposition of administrative sanctions.** (a) The
177.32 department shall consider the following factors in determining the administrative sanctions
177.33 to be imposed:
177.34 (1) nature and extent of financial misconduct;
177.35 (2) history of financial misconduct;

178.1 (3) actions taken or recommended by other state agencies, other divisions of the
178.2 department, and court and administrative decisions;
178.3 (4) prior imposition of sanctions;
178.4 (5) size and type of provider;
178.5 (6) information obtained through an investigation from any source;
178.6 (7) convictions or pending criminal charges; and
178.7 (8) any other information relevant to the acts or omissions related to the financial
178.8 misconduct.
178.9 (b) Any single factor under paragraph (a) may be determinative of the department's
178.10 decision of whether and what sanctions are imposed.
178.11 Subd. 10. **Written notice of department sanction.** (a) The department shall give
178.12 notice in writing to a person of an administrative sanction that is to be imposed. The notice
178.13 shall be sent by mail as defined in subdivision 1, paragraph (k).
178.14 (b) The notice shall state:
178.15 (1) the factual basis for the department's determination;
178.16 (2) the sanction the department intends to take;
178.17 (3) the dollar amount of the monetary recovery or recoupment, if any;
178.18 (4) how the dollar amount was computed;
178.19 (5) the right to dispute the department's determination and to provide evidence;
178.20 (6) the right to appeal the department's proposed sanction; and
178.21 (7) the option to meet informally with department staff, and to bring additional
178.22 documentation or information, to resolve the issues.
178.23 (c) In cases of determinations resulting in denial or termination of payments, in
178.24 addition to the requirements of paragraph (b), the notice must state:
178.25 (1) the length of the denial or termination;
178.26 (2) the requirements and procedures for reinstatement; and
178.27 (3) the provider's right to submit documents and written arguments against the
178.28 denial or termination of payments for review by the department before the effective date
178.29 of denial or termination.
178.30 (d) The submission of documents and written argument for review by the department
178.31 under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the
178.32 deadline for filing an appeal.
178.33 (e) Unless appealed, the effective date of the proposed sanction shall be 30 days after
178.34 the license holder's, provider's, controlling individual's, or recipient's receipt of the notice.
178.35 If an appeal is made, the proposed sanction shall be delayed pending the final outcome of
178.36 the appeal. Implementation of a proposed sanction following the resolution of an appeal

179.1 may be postponed if, in the opinion of the department, the delay of sanction is necessary to
179.2 protect the health or safety of children in care. The department may consider the economic
179.3 hardship of a person in implementing the proposed sanction, but economic hardship shall
179.4 not be a determinative factor in implementing the proposed sanction.

179.5 (f) Requests for an informal meeting to attempt to resolve issues and requests
179.6 for appeals must be sent or delivered to the department's Office of Inspector General,
179.7 Financial Fraud and Abuse Division.

179.8 Subd. 11. **Appeal of department sanction under this section.** (a) If the department
179.9 does not pursue a criminal action against a provider, license holder, controlling individual,
179.10 or recipient for financial misconduct, but the department imposes an administrative
179.11 sanction, any individual or entity against whom the sanction was imposed may appeal the
179.12 department's administrative sanction under this section pursuant to section 119B.16 or
179.13 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:

179.14 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
179.15 amount involved for each disputed item, if appropriate;

179.16 (2) the computation that is believed to be correct, if appropriate;

179.17 (3) the authority in the statute or rule relied upon for each disputed item; and

179.18 (4) the name, address, and phone number of the person at the provider's place of
179.19 business with whom contact may be made regarding the appeal.

179.20 (b) An appeal is considered timely only if postmarked or received by the
179.21 department's Office of Inspector General, Financial Fraud and Abuse Division within 30
179.22 days after receiving a notice of department sanction.

179.23 (c) Before the appeal hearing, the department may deny or terminate authorizations
179.24 or payment to the entity or individual if the department determines that action is necessary
179.25 to protect the public welfare and the interests of the program.

179.26 Subd. 12. **Consolidated hearings with licensing sanction.** If an overpayment
179.27 recovery action has an appeal hearing right and it is timely appealed, and a licensing
179.28 sanction exists for which there is an appeal hearing right and the sanction is timely
179.29 appealed, and the overpayment recovery action and licensing sanction involve the same
179.30 set of facts, the overpayment recovery action and licensing sanction must be consolidated
179.31 in the contested case hearing related to the licensing sanction.

179.32 Subd. 13. **Grounds for and methods of monetary recovery.** (a) The department
179.33 may obtain monetary recovery from a provider who has been improperly paid by the
179.34 child care assistance program, regardless of whether the error was intentional or county
179.35 error. The department does not need to establish a pattern as a precondition of monetary

180.1 recovery of erroneous or false billing claims, duplicate billing claims, or billing claims
180.2 based on false statements or financial misconduct.

180.3 (b) The department shall obtain monetary recovery from providers by the following
180.4 means:

180.5 (1) permitting voluntary repayment of money, either in lump-sum payment or
180.6 installment payments;

180.7 (2) using any legal collection process;

180.8 (3) deducting or withholding program payments; or

180.9 (4) utilizing the means set forth in chapter 16D.

180.10 Subd. 14. **Reporting of suspected fraudulent activity.** (a) A person who, in
180.11 good faith, makes a report of or testifies in any action or proceeding in which financial
180.12 misconduct is alleged, and who is not involved in, has not participated in, or has not aided
180.13 and abetted, conspired, or colluded in the financial misconduct, shall have immunity from
180.14 any liability, civil or criminal, that results by reason of the person's report or testimony.
180.15 For the purpose of any proceeding, the good faith of any person reporting or testifying
180.16 under this provision shall be presumed.

180.17 (b) If a person that is or has been involved in, participated in, aided and abetted,
180.18 conspired, or colluded in the financial misconduct reports the financial misconduct,
180.19 the department may consider that person's report and assistance in investigating the
180.20 misconduct as a mitigating factor in the department's pursuit of civil, criminal, or
180.21 administrative remedies.

180.22 Subd. 15. **Data privacy.** Data of any kind obtained or created in relation to a provider
180.23 or recipient investigation under this section is defined, classified, and protected the same as
180.24 all other data under section 13.46, and this data has the same classification as licensing data.

180.25 Subd. 16. **Monetary recovery; random sample extrapolation.** The department is
180.26 authorized to calculate the amount of monetary recovery from a provider, license holder, or
180.27 controlling individual based upon extrapolation from a statistical random sample of claims
180.28 submitted by the provider, license holder, or controlling individual and paid by the child
180.29 care assistance program. The department's random sample extrapolation shall constitute a
180.30 rebuttable presumption of the accuracy of the calculation of monetary recovery. If the
180.31 presumption is not rebutted by the provider, license holder, or controlling individual in the
180.32 appeal process, the department shall use the extrapolation as the monetary recovery figure.
180.33 The department may use sampling and extrapolation to calculate the amount of monetary
180.34 recovery if the claims to be reviewed represent services to 50 or more children in care.

180.35 Subd. 17. **Effect of department's monetary penalty determination.** Unless
180.36 a timely and proper appeal is received by the department's Office of Inspector General,

181.1 Financial Fraud and Abuse Division, the department's administrative determination or
181.2 sanction shall be considered a final department determination.

181.3 Subd. 18. **Office of Inspector General recoveries.** Overpayment recoveries
181.4 resulting from child care provider fraud investigations initiated by the department's Office
181.5 of Inspector General's fraud investigations staff are excluded from the county recovery
181.6 provision in section 119B.11, subdivision 3.

181.7 Sec. 5. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

181.8 Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for
181.9 Medicare and Medicaid Services determines that a provider is designated "high-risk," the
181.10 commissioner may withhold payment from providers within that category upon initial
181.11 enrollment for a 90-day period. The withholding for each provider must begin on the date
181.12 of the first submission of a claim.

181.13 (b) An enrolled provider that is also licensed by the commissioner under chapter
181.14 245A must designate an individual as the entity's compliance officer. The compliance
181.15 officer must:

181.16 (1) develop policies and procedures to assure adherence to medical assistance laws
181.17 and regulations and to prevent inappropriate claims submissions;

181.18 (2) train the employees of the provider entity, and any agents or subcontractors of
181.19 the provider entity including billers, on the policies and procedures under clause (1);

181.20 (3) respond to allegations of improper conduct related to the provision or billing of
181.21 medical assistance services, and implement action to remediate any resulting problems;

181.22 (4) use evaluation techniques to monitor compliance with medical assistance laws
181.23 and regulations;

181.24 (5) promptly report to the commissioner any identified violations of medical
181.25 assistance laws or regulations; and

181.26 (6) within 60 days of discovery by the provider of a medical assistance
181.27 reimbursement overpayment, report the overpayment to the commissioner and make
181.28 arrangements with the commissioner for the commissioner's recovery of the overpayment.

181.29 The commissioner may require, as a condition of enrollment in medical assistance, that a
181.30 provider within a particular industry sector or category establish a compliance program that
181.31 contains the core elements established by the Centers for Medicare and Medicaid Services.

181.32 (c) The commissioner may revoke the enrollment of an ordering or rendering
181.33 provider for a period of not more than one year, if the provider fails to maintain and, upon
181.34 request from the commissioner, provide access to documentation relating to written orders
181.35 or requests for payment for durable medical equipment, certifications for home health

182.1 services, or referrals for other items or services written or ordered by such provider, when
182.2 the commissioner has identified a pattern of a lack of documentation. A pattern means a
182.3 failure to maintain documentation or provide access to documentation on more than one
182.4 occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a
182.5 provider under the provisions of section 256B.064.

182.6 (d) The commissioner shall terminate or deny the enrollment of any individual or
182.7 entity if the individual or entity has been terminated from participation in Medicare or
182.8 under the Medicaid program or Children's Health Insurance Program of any other state.

182.9 (e) As a condition of enrollment in medical assistance, the commissioner shall
182.10 require that a provider designated "moderate" or "high-risk" by the Centers for Medicare
182.11 and Medicaid Services or the ~~Minnesota Department of Human Services~~ commissioner
182.12 permit the Centers for Medicare and Medicaid Services, its agents, or its designated
182.13 contractors and the state agency, its agents, or its designated contractors to conduct
182.14 unannounced on-site inspections of any provider location. The commissioner shall publish
182.15 in the Minnesota Health Care Program Provider Manual a list of provider types designated
182.16 "limited," "moderate," or "high-risk," based on the criteria and standards used to designate
182.17 Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and
182.18 criteria are not subject to the requirements of chapter 14. The commissioner's designations
182.19 are not subject to administrative appeal.

182.20 (f) As a condition of enrollment in medical assistance, the commissioner shall
182.21 require that a high-risk provider, or a person with a direct or indirect ownership interest in
182.22 the provider of five percent or higher, consent to criminal background checks, including
182.23 fingerprinting, when required to do so under state law or by a determination by the
182.24 commissioner or the Centers for Medicare and Medicaid Services that a provider is
182.25 designated high-risk for fraud, waste, or abuse.

182.26 (g) As a condition of enrollment, all durable medical equipment, prosthetics,
182.27 orthotics, and supplies (DMEPOS) suppliers operating in Minnesota are required to name
182.28 the Department of Human Services, in addition to the Centers for Medicare and Medicaid
182.29 Services, as an obligee on all surety performance bonds required pursuant to section
182.30 4312(a) of the Balanced Budget Act of 1997, Public Law 105-33, amending Social
182.31 Security Act, section 1834(a). The performance bond must also allow for recovery of
182.32 costs and fees in pursuing a claim on the bond.

182.33 (h) The Department of Human Services may require a provider to purchase a
182.34 performance surety bond as a condition of initial enrollment, reenrollment, reinstatement,
182.35 or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the
182.36 department determines there is significant evidence of or potential for fraud and abuse by

183.1 the provider, or (3) the provider or category of providers is designated high-risk pursuant
183.2 to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450, or the
183.3 department otherwise finds it is in the best interest of the Medicaid program to do so. The
183.4 performance bond must be in an amount of $100,000 or ten percent of the provider's
183.5 payments from Medicaid during the immediately preceding 12 months, whichever is
183.6 greater. The performance bond must name the Department of Human Services as an
183.7 obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

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

183.9 Sec. 6. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
183.10 to read:

183.11 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
183.12 required nonrefundable application fees to pay for provider screening activities in
183.13 accordance with Code of Federal Regulations, title 42, section 455, subpart E. The
183.14 enrollment application must be made under the procedures specified by the commissioner,
183.15 in the form specified by the commissioner, and accompanied by an application fee
183.16 described in paragraph (b), or a request for a hardship exception as described in the
183.17 specified procedures. Application fees must be deposited in the provider screening account
183.18 in the special revenue fund. Amounts in the provider screening account are appropriated
183.19 to the commissioner for costs associated with the provider screening activities required
183.20 in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner
183.21 shall conduct screening activities as required by Code of Federal Regulations, title 42,
183.22 section 455, subpart E, and as otherwise provided by law, to include database checks,
183.23 unannounced pre- and postenrollment site visits, fingerprinting, and criminal background
183.24 studies. The commissioner must revalidate all providers under this subdivision at least
183.25 once every five years.

183.26 (b) The application fee under this subdivision is $532 for the calendar year 2013.
183.27 For calendar year 2014 and subsequent years, the fee:

183.28 (1) is adjusted by the percentage change to the consumer price index for all urban
183.29 consumers, United States city average, for the 12-month period ending with June of the
183.30 previous year. The resulting fee must be announced in the Federal Register;

183.31 (2) is effective from January 1 to December 31 of a calendar year;

183.32 (3) is required on the submission of an initial application, an application to establish
183.33 a new practice location, an application for re-enrollment when the provider is not enrolled
183.34 at the time of application of re-enrollment, or at revalidation when required by federal
183.35 regulation; and

184.1 (4) must be in the amount in effect for the calendar year during which the application
184.2 for enrollment, new practice location, or re-enrollment is being submitted.
184.3 (c) The application fee under this subdivision cannot be charged to:
184.4 (1) providers who are enrolled in Medicare or who provide documentation of
184.5 payment of the fee to, and enrollment with, another state;
184.6 (2) providers who are enrolled but are required to submit new applications for
184.7 purposes of re-enrollment; or
184.8 (3) a provider who enrolls as an individual.

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

184.10 Sec. 7. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to read:
184.11 Subd. 21. **Requirements for initial enrollment of personal care assistance**
184.12 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
184.13 time of enrollment as a personal care assistance provider agency in a format determined
184.14 by the commissioner, information and documentation that includes, but is not limited to,
184.15 the following:
184.16 (1) the personal care assistance provider agency's current contact information
184.17 including address, telephone number, and e-mail address;
184.18 (2) proof of surety bond coverage in the amount of ~~$50,000~~ $100,000 or ten percent
184.19 of the provider's payments from Medicaid in the previous year, whichever is ~~less~~ greater.
184.20 The performance bond must also allow for recovery of costs and fees in pursuing a
184.21 claim on the bond;
184.22 (3) proof of fidelity bond coverage in the amount of $20,000;
184.23 (4) proof of workers' compensation insurance coverage;
184.24 (5) proof of liability insurance;
184.25 (6) a description of the personal care assistance provider agency's organization
184.26 identifying the names of all owners, managing employees, staff, board of directors, and
184.27 the affiliations of the directors, owners, or staff to other service providers;
184.28 (7) a copy of the personal care assistance provider agency's written policies and
184.29 procedures including: hiring of employees; training requirements; service delivery;
184.30 and employee and consumer safety including process for notification and resolution
184.31 of consumer grievances, identification and prevention of communicable diseases, and
184.32 employee misconduct;
184.33 (8) copies of all other forms the personal care assistance provider agency uses in
184.34 the course of daily business including, but not limited to:

185.1 (i) a copy of the personal care assistance provider agency's time sheet if the time
185.2 sheet varies from the standard time sheet for personal care assistance services approved
185.3 by the commissioner, and a letter requesting approval of the personal care assistance
185.4 provider agency's nonstandard time sheet;
185.5 (ii) the personal care assistance provider agency's template for the personal care
185.6 assistance care plan; and
185.7 (iii) the personal care assistance provider agency's template for the written
185.8 agreement in subdivision 20 for recipients using the personal care assistance choice
185.9 option, if applicable;
185.10 (9) a list of all training and classes that the personal care assistance provider agency
185.11 requires of its staff providing personal care assistance services;
185.12 (10) documentation that the personal care assistance provider agency and staff have
185.13 successfully completed all the training required by this section;
185.14 (11) documentation of the agency's marketing practices;
185.15 (12) disclosure of ownership, leasing, or management of all residential properties
185.16 that is used or could be used for providing home care services;
185.17 (13) documentation that the agency will use the following percentages of revenue
185.18 generated from the medical assistance rate paid for personal care assistance services
185.19 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
185.20 personal care assistance choice option and 72.5 percent of revenue from other personal
185.21 care assistance providers. The revenue generated by the qualified professional and the
185.22 reasonable costs associated with the qualified professional shall not be used in making
185.23 this calculation; and
185.24 (14) effective May 15, 2010, documentation that the agency does not burden
185.25 recipients' free exercise of their right to choose service providers by requiring personal
185.26 care assistants to sign an agreement not to work with any particular personal care
185.27 assistance recipient or for another personal care assistance provider agency after leaving
185.28 the agency and that the agency is not taking action on any such agreements or requirements
185.29 regardless of the date signed.
185.30 (b) Personal care assistance provider agencies shall provide the information specified
185.31 in paragraph (a) to the commissioner at the time the personal care assistance provider
185.32 agency enrolls as a vendor or upon request from the commissioner. The commissioner
185.33 shall collect the information specified in paragraph (a) from all personal care assistance
185.34 providers beginning July 1, 2009.
185.35 (c) All personal care assistance provider agencies shall require all employees in
185.36 management and supervisory positions and owners of the agency who are active in the

186.1 day-to-day management and operations of the agency to complete mandatory training
186.2 as determined by the commissioner before enrollment of the agency as a provider.
186.3 Employees in management and supervisory positions and owners who are active in
186.4 the day-to-day operations of an agency who have completed the required training as
186.5 an employee with a personal care assistance provider agency do not need to repeat
186.6 the required training if they are hired by another agency, if they have completed the
186.7 training within the past three years. By September 1, 2010, the required training must
186.8 be available with meaningful access according to title VI of the Civil Rights Act and
186.9 federal regulations adopted under that law or any guidance from the United States Health
186.10 and Human Services Department. The required training must be available online or by
186.11 electronic remote connection. The required training must provide for competency testing.
186.12 Personal care assistance provider agency billing staff shall complete training about
186.13 personal care assistance program financial management. This training is effective July 1,
186.14 2009. Any personal care assistance provider agency enrolled before that date shall, if it
186.15 has not already, complete the provider training within 18 months of July 1, 2009. Any new
186.16 owners or employees in management and supervisory positions involved in the day-to-day
186.17 operations are required to complete mandatory training as a requisite of working for the
186.18 agency. Personal care assistance provider agencies certified for participation in Medicare
186.19 as home health agencies are exempt from the training required in this subdivision. When
186.20 available, Medicare-certified home health agency owners, supervisors, or managers must
186.21 successfully complete the competency test.

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

186.23 **ARTICLE 6**

186.24 **2013 MANAGED CARE ORGANIZATIONS RATE CONFORMITY**

186.25 Section 1. Minnesota Statutes 2012, section 256.969, subdivision 3a, is amended to read:
186.26 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
186.27 assistance program must not be submitted until the recipient is discharged. However,
186.28 the commissioner shall establish monthly interim payments for inpatient hospitals that
186.29 have individual patient lengths of stay over 30 days regardless of diagnostic category.
186.30 Except as provided in section 256.9693, medical assistance reimbursement for treatment
186.31 of mental illness shall be reimbursed based on diagnostic classifications. Individual
186.32 hospital payments established under this section and sections 256.9685, 256.9686, and
186.33 256.9695, in addition to third-party and recipient liability, for discharges occurring during
186.34 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered

187.1 inpatient services paid for the same period of time to the hospital. This payment limitation
187.2 shall be calculated separately for medical assistance and general assistance medical
187.3 care services. The limitation on general assistance medical care shall be effective for
187.4 admissions occurring on or after July 1, 1991. Services that have rates established under
187.5 subdivision 11 or 12, must be limited separately from other services. After consulting with
187.6 the affected hospitals, the commissioner may consider related hospitals one entity and
187.7 may merge the payment rates while maintaining separate provider numbers. The operating
187.8 and property base rates per admission or per day shall be derived from the best Medicare
187.9 and claims data available when rates are established. The commissioner shall determine
187.10 the best Medicare and claims data, taking into consideration variables of recency of the
187.11 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
187.12 The commissioner shall notify hospitals of payment rates by December 1 of the year
187.13 preceding the rate year. The rate setting data must reflect the admissions data used to
187.14 establish relative values. Base year changes from 1981 to the base year established for the
187.15 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
187.16 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
187.17 1. The commissioner may adjust base year cost, relative value, and case mix index data
187.18 to exclude the costs of services that have been discontinued by the October 1 of the year
187.19 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
187.20 that encompass portions of two or more rate years shall have payments established based
187.21 on payment rates in effect at the time of admission unless the date of admission preceded
187.22 the rate year in effect by six months or more. In this case, operating payment rates for
187.23 services rendered during the rate year in effect and established based on the date of
187.24 admission shall be adjusted to the rate year in effect by the hospital cost index.

187.25 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
187.26 payment, before third-party liability and spenddown, made to hospitals for inpatient
187.27 services is reduced by .5 percent from the current statutory rates.

187.28 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
187.29 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
187.30 before third-party liability and spenddown, is reduced five percent from the current
187.31 statutory rates. Mental health services within diagnosis related groups 424 to 432, and
187.32 facilities defined under subdivision 16 are excluded from this paragraph.

187.33 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
187.34 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
187.35 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
187.36 from the current statutory rates. Mental health services within diagnosis related groups

188.1 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
188.2 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
188.3 assistance does not include general assistance medical care. Payments made to managed
188.4 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
188.5 this reduction.

188.6 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
188.7 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
188.8 to hospitals for inpatient services before third-party liability and spenddown, is reduced
188.9 3.46 percent from the current statutory rates. Mental health services with diagnosis related
188.10 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
188.11 paragraph. Payments made to managed care plans shall be reduced for services provided
188.12 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

188.13 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
188.14 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
188.15 to hospitals for inpatient services before third-party liability and spenddown, is reduced
188.16 1.9 percent from the current statutory rates. Mental health services with diagnosis related
188.17 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
188.18 paragraph. Payments made to managed care plans shall be reduced for services provided
188.19 on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

188.20 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
188.21 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
188.22 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
188.23 from the current statutory rates. Mental health services with diagnosis related groups
188.24 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
188.25 Payments made to managed care plans shall be reduced for services provided on or after
188.26 July 1, 2011, to reflect this reduction.

188.27 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
188.28 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
188.29 hospitals for inpatient services before third-party liability and spenddown, is reduced
188.30 one percent from the current statutory rates. Facilities defined under subdivision 16 are
188.31 excluded from this paragraph. Payments made to managed care plans shall be reduced for
188.32 services provided on or after October 1, 2009, to reflect this reduction.

188.33 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
188.34 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
188.35 hospitals for inpatient services before third-party liability and spenddown, is reduced
188.36 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are

189.1 excluded from this paragraph. Payments made to managed care plans shall be reduced for
189.2 services provided on or after January 1, 2011, to reflect this reduction.
189.3 (j) For admissions occurring on or after January 1, 2014, the rate for inpatient
189.4 hospital services must be increased two percent from the rate in effect on December 31,
189.5 2013. Payments made to managed care plans shall not be adjusted to reflect payments
189.6 under this paragraph.

189.7 Sec. 2. Minnesota Statutes 2012, section 256B.0625, subdivision 17a, is amended to
189.8 read:
189.9 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers
189.10 ambulance services. Providers shall bill ambulance services according to Medicare
189.11 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
189.12 for services rendered on or after July 1, 2001, medical assistance payments for ambulance
189.13 services shall be paid at the Medicare reimbursement rate or at the medical assistance
189.14 payment rate in effect on July 1, 2000, whichever is greater.
189.15 (b) Effective for services provided on or after September 1, 2011, ambulance
189.16 services payment rates are reduced 4.5 percent. Payments made to managed care plans
189.17 and county-based purchasing plans must be reduced for services provided on or after
189.18 January 1, 2012, to reflect this reduction.
189.19 (c) Effective for services provided on or after January 1, 2014, ambulance services
189.20 payment rates are increased by three percent over the rates in effect on December 31,
189.21 2013. Payments made to managed care plans shall not be adjusted to reflect payments
189.22 under this paragraph.

189.23 Sec. 3. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:
189.24 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
189.25 services shall transfer each year to the medical education and research fund established
189.26 under section 62J.692, an amount specified in this subdivision. The commissioner shall
189.27 calculate the following:
189.28 (1) an amount equal to the reduction in the prepaid medical assistance payments as
189.29 specified in this clause. Until January 1, 2002, the county medical assistance capitation
189.30 base rate prior to plan specific adjustments and after the regional rate adjustments under
189.31 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
189.32 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
189.33 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
189.34 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining

metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and ~~$36,744,000~~ $49,552,000 in fiscal year 2014 and thereafter.

Sec. 4. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend ~~increases~~ changes to rates paid to managed care plans and county-based purchasing plans as follows:

(1) ~~7.5~~ 5.4 percent for medical assistance elderly basic care. This shall not apply to ~~Medicare cost-sharing, nursing facility, personal care assistance, and~~ elderly waiver services;

(2) ~~5.0~~ 0.0 percent for medical assistance special needs basic care;

(3) ~~2.0~~ 0.0 percent for medical assistance families and children;

(4) ~~3.0~~ -5.1 percent for medical assistance adults without children;

(5) ~~3.0~~ 2.7 percent for MinnesotaCare families and children; and

(6) ~~3.0~~ 11.4 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children.

The commissioner may limit trend increases to less than the maximum.

192.1 Sec. 5. Minnesota Statutes 2012, section 256B.76, subdivision 1, is amended to read:

192.2 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
192.3 or after October 1, 1992, the commissioner shall make payments for physician services
192.4 as follows:

192.5 (1) payment for level one Centers for Medicare and Medicaid Services' common
192.6 procedural coding system codes titled "office and other outpatient services," "preventive
192.7 medicine new and established patient," "delivery, antepartum, and postpartum care,"
192.8 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
192.9 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
192.10 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
192.11 30, 1992. If the rate on any procedure code within these categories is different than the
192.12 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
192.13 then the larger rate shall be paid;

192.14 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
192.15 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

192.16 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
192.17 percentile of 1989, less the percent in aggregate necessary to equal the above increases
192.18 except that payment rates for home health agency services shall be the rates in effect
192.19 on September 30, 1992.

192.20 (b) Effective for services rendered on or after January 1, 2000, payment rates for
192.21 physician and professional services shall be increased by three percent over the rates
192.22 in effect on December 31, 1999, except for home health agency and family planning
192.23 agency services. The increases in this paragraph shall be implemented January 1, 2000,
192.24 for managed care.

192.25 (c) Effective for services rendered on or after July 1, 2009, payment rates for
192.26 physician and professional services shall be reduced by five percent, except that for the
192.27 period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent
192.28 for the medical assistance and general assistance medical care programs, over the rates in
192.29 effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply
192.30 to office or other outpatient visits, preventive medicine visits and family planning visits
192.31 billed by physicians, advanced practice nurses, or physician assistants in a family planning
192.32 agency or in one of the following primary care practices: general practice, general internal
192.33 medicine, general pediatrics, general geriatrics, and family medicine. This reduction
192.34 and the reductions in paragraph (d) do not apply to federally qualified health centers,
192.35 rural health centers, and Indian health services. Effective October 1, 2009, payments

193.1 made to managed care plans and county-based purchasing plans under sections 256B.69,
193.2 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

193.3 (d) Effective for services rendered on or after July 1, 2010, payment rates for
193.4 physician and professional services shall be reduced an additional seven percent over
193.5 the five percent reduction in rates described in paragraph (c). This additional reduction
193.6 does not apply to physical therapy services, occupational therapy services, and speech
193.7 pathology and related services provided on or after July 1, 2010. This additional reduction
193.8 does not apply to physician services billed by a psychiatrist or an advanced practice nurse
193.9 with a specialty in mental health. Effective October 1, 2010, payments made to managed
193.10 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
193.11 256L.12 shall reflect the payment reduction described in this paragraph.

193.12 (e) Effective for services rendered on or after September 1, 2011, through June 30,
193.13 2013, payment rates for physician and professional services shall be reduced three percent
193.14 from the rates in effect on August 31, 2011. This reduction does not apply to physical
193.15 therapy services, occupational therapy services, and speech pathology and related services.

193.16 (f) Effective for services rendered on or after January 1, 2014, payment rates for
193.17 physician and professional services, including physical therapy, occupational therapy,
193.18 speech pathology, and mental health services shall be increased by five percent from the
193.19 rates in effect on December 31, 2013. This increase does not apply to federally qualified
193.20 health centers, rural health centers, and Indian health services. Payments made to managed
193.21 care plans shall not be adjusted to reflect payments under this paragraph.

193.22 Sec. 6. Minnesota Statutes 2012, section 256B.76, subdivision 2, is amended to read:

193.23 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after
193.24 October 1, 1992, the commissioner shall make payments for dental services as follows:

193.25 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
193.26 percent above the rate in effect on June 30, 1992; and

193.27 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
193.28 percentile of 1989, less the percent in aggregate necessary to equal the above increases.

193.29 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
193.30 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

193.31 (c) Effective for services rendered on or after January 1, 2000, payment rates for
193.32 dental services shall be increased by three percent over the rates in effect on December
193.33 31, 1999.

194.1 (d) Effective for services provided on or after January 1, 2002, payment for
194.2 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
194.3 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

194.4 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
194.5 2000, for managed care.

194.6 (f) Effective for dental services rendered on or after October 1, 2010, by a
194.7 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
194.8 on the Medicare principles of reimbursement. This payment shall be effective for services
194.9 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
194.10 county-based purchasing plans.

194.11 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
194.12 in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal
194.13 year, a supplemental state payment equal to the difference between the total payments
194.14 in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated
194.15 services for the operation of the dental clinics.

194.16 (h) If the cost-based payment system for state-operated dental clinics described in
194.17 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
194.18 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
194.19 receive the critical access dental reimbursement rate as described under subdivision 4,
194.20 paragraph (a).

194.21 (i) Effective for services rendered on or after September 1, 2011, through June 30,
194.22 2013, payment rates for dental services shall be reduced by three percent. This reduction
194.23 does not apply to state-operated dental clinics in paragraph (f).

194.24 <u>(j) Effective for services rendered on or after January 1, 2014, payment rates for</u>
194.25 <u>dental services shall be increased by five percent from the rates in effect on December</u>
194.26 <u>31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),</u>
194.27 <u>federally qualified health centers, rural health centers, and Indian health services. Effective</u>
194.28 <u>January 1, 2014, payments made to managed care plans and county-based purchasing</u>
194.29 <u>plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase</u>
194.30 <u>described in this paragraph.</u>

194.31 Sec. 7. Minnesota Statutes 2012, section 256B.761, is amended to read:

194.32 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

194.33 (a) Effective for services rendered on or after July 1, 2001, payment for medication
194.34 management provided to psychiatric patients, outpatient mental health services, day
194.35 treatment services, home-based mental health services, and family community support

195.1 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
195.2 50th percentile of 1999 charges.

195.3 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
195.4 services provided by an entity that operates: (1) a Medicare-certified comprehensive
195.5 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
195.6 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
195.7 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
195.8 when those services are provided within the comprehensive outpatient rehabilitation
195.9 facility and provided to residents of nursing facilities owned by the entity.

195.10 (c) The commissioner shall establish three levels of payment for mental health
195.11 diagnostic assessment, based on three levels of complexity. The aggregate payment under
195.12 the tiered rates must not exceed the projected aggregate payments for mental health
195.13 diagnostic assessment under the previous single rate. The new rate structure is effective
195.14 January 1, 2011, or upon federal approval, whichever is later.

195.15 (d) Effective for services rendered on or after January 1, 2014, payment rates for
195.16 outpatient mental health services shall be increased by five percent over the rates in effect
195.17 on December 31, 2013. Payments made to managed care plans shall not be adjusted
195.18 to reflect payments under this paragraph.

195.19 Sec. 8. Minnesota Statutes 2012, section 256B.766, is amended to read:

195.20 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

195.21 (a) Effective for services provided on or after July 1, 2009, total payments for basic
195.22 care services, shall be reduced by three percent, except that for the period July 1, 2009,
195.23 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
195.24 assistance and general assistance medical care programs, prior to third-party liability and
195.25 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
195.26 therapy services, occupational therapy services, and speech-language pathology and
195.27 related services as basic care services. The reduction in this paragraph shall apply to
195.28 physical therapy services, occupational therapy services, and speech-language pathology
195.29 and related services provided on or after July 1, 2010.

195.30 (b) Payments made to managed care plans and county-based purchasing plans shall
195.31 be reduced for services provided on or after October 1, 2009, to reflect the reduction
195.32 effective July 1, 2009, and payments made to the plans shall be reduced effective October
195.33 1, 2010, to reflect the reduction effective July 1, 2010.

196.1 (c) Effective for services provided on or after September 1, 2011, through June 30,
196.2 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
196.3 from the rates in effect on August 31, 2011.

196.4 (d) Effective for services provided on or after September 1, 2011, through June
196.5 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
196.6 and durable medical equipment not subject to a volume purchase contract, prosthetics
196.7 and orthotics, renal dialysis services, laboratory services, public health nursing services,
196.8 physical therapy services, occupational therapy services, speech therapy services,
196.9 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
196.10 purchase contract, and anesthesia services, and hospice services shall be reduced by three
196.11 percent from the rates in effect on August 31, 2011.

196.12 (e) Effective for services provided on or after January 1, 2014, payments for
196.13 ambulatory surgery centers facility fees, medical supplies and durable medical equipment
196.14 not subject to a volume purchase contract, prosthetics and orthotics, hospice services,
196.15 renal dialysis services, laboratory services, public health nursing services, eyeglasses not
196.16 subject to a volume purchase contract, and hearing aids not subject to a volume purchase
196.17 contract shall be increased by three percent and payments for outpatient hospital facility
196.18 fees shall be increased by five percent. Payments made to managed care plans shall not be
196.19 adjusted to reflect payments under this paragraph.

196.20 (e) (f) This section does not apply to physician and professional services, inpatient
196.21 hospital services, family planning services, mental health services, dental services,
196.22 prescription drugs, medical transportation, federally qualified health centers, rural health
196.23 centers, Indian health services, and Medicare cost-sharing.

196.24 **ARTICLE 7**

196.25 **HEALTH CARE**

196.26 Section 1. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

197.1 (2) admitted to the United States as a refugee according to United States Code,
197.2 title 8, section 1157;
197.3 (3) granted asylum according to United States Code, title 8, section 1158;
197.4 (4) granted withholding of deportation according to United States Code, title 8,
197.5 section 1253(h);
197.6 (5) paroled for a period of at least one year according to United States Code, title 8,
197.7 section 1182(d)(5);
197.8 (6) granted conditional entrant status according to United States Code, title 8,
197.9 section 1153(a)(7);
197.10 (7) determined to be a battered noncitizen by the United States Attorney General
197.11 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
197.12 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;
197.13 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
197.14 States Attorney General according to the Illegal Immigration Reform and Immigrant
197.15 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
197.16 Public Law 104-200; or
197.17 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
197.18 Law 96-422, the Refugee Education Assistance Act of 1980.
197.19 (c) All qualified noncitizens who were residing in the United States before August
197.20 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
197.21 medical assistance with federal financial participation.
197.22 (d) Beginning December 1, 1996, qualified noncitizens who entered the United
197.23 States on or after August 22, 1996, and who otherwise meet the eligibility requirements
197.24 of this chapter are eligible for medical assistance with federal participation for five years
197.25 if they meet one of the following criteria:
197.26 (1) refugees admitted to the United States according to United States Code, title 8,
197.27 section 1157;
197.28 (2) persons granted asylum according to United States Code, title 8, section 1158;
197.29 (3) persons granted withholding of deportation according to United States Code,
197.30 title 8, section 1253(h);
197.31 (4) veterans of the United States armed forces with an honorable discharge for
197.32 a reason other than noncitizen status, their spouses and unmarried minor dependent
197.33 children; or
197.34 (5) persons on active duty in the United States armed forces, other than for training,
197.35 their spouses and unmarried minor dependent children.

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

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

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

198.15 (g) For purposes of this subdivision, the term "emergency medical condition" means
198.16 a medical condition that meets the requirements of United States Code, title 42, section
198.17 1396b(v).

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

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

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

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

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

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

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

198.32 (iii) services for routine prenatal care;

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

198.35 (v) elective surgery;

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

(vii) preventative health care and family planning services;

~~(viii) dialysis;~~

~~(ix) chemotherapy or therapeutic radiation services;~~

~~(x)~~ (viii) rehabilitation services;

~~(xi)~~ (ix) physical, occupational, or speech therapy;

~~(xii)~~ (x) transportation services;

~~(xiii)~~ (xi) case management;

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

~~(xv)~~ (xiii) dental services;

~~(xvi)~~ (xiv) hospice care;

~~(xvii)~~ (xv) audiology services and hearing aids;

~~(xviii)~~ (xvi) podiatry services;

~~(xix)~~ (xvii) chiropractic services;

~~(xx)~~ (xviii) immunizations;

~~(xxi)~~ (xix) vision services and eyeglasses;

~~(xxii)~~ (xx) waiver services;

~~(xxiii)~~ (xxi) individualized education programs; or

~~(xxiv)~~ (xxii) chemical dependency treatment.

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

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

200.1 (k) Notwithstanding paragraph (h), clause (2), the following services are covered as
200.2 emergency medical conditions under paragraph (f) except where coverage is prohibited
200.3 under federal law:

200.4 (1) dialysis services provided in a hospital or freestanding dialysis facility; and

200.5 (2) surgery and the administration of chemotherapy, radiation, and related services
200.6 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission
200.7 and requires surgery, chemotherapy, or radiation treatment.

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

200.9 Sec. 2. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to
200.10 read:

200.11 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
200.12 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable
200.13 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
200.14 charged to the public. The amount of payment basis must be reduced to reflect all discount
200.15 amounts applied to the charge by any provider/insurer agreement or contract for submitted
200.16 charges to medical assistance programs. The net submitted charge may not be greater
200.17 than the patient liability for the service. The pharmacy dispensing fee shall be $3.65,
200.18 except that the dispensing fee for intravenous solutions which must be compounded by
200.19 the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and
200.20 $30 per bag for total parenteral nutritional products dispensed in one liter quantities,
200.21 or $44 per bag for total parenteral nutritional products dispensed in quantities greater
200.22 than one liter. Actual acquisition cost includes quantity and other special discounts
200.23 except time and cash discounts. The actual acquisition cost of a drug shall be estimated
200.24 by the commissioner at wholesale acquisition cost plus four percent for independently
200.25 owned pharmacies located in a designated rural area within Minnesota, and at wholesale
200.26 acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently
200.27 owned" if it is one of four or fewer pharmacies under the same ownership nationally.
200.28 A "designated rural area" means an area defined as a small rural area or isolated rural
200.29 area according to the four-category classification of the Rural Urban Commuting Area
200.30 system developed for the United States Health Resources and Services Administration.
200.31 The actual acquisition cost of a drug acquired through the federal 340B Drug Pricing
200.32 Program shall be estimated by the commissioner at wholesale acquisition cost minus 44
200.33 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or
200.34 biological to wholesalers or direct purchasers in the United States, not including prompt
200.35 pay or other discounts, rebates, or reductions in price, for the most recent month for which

201.1 information is available, as reported in wholesale price guides or other publications of
201.2 drug or biological pricing data. The maximum allowable cost of a multisource drug may
201.3 be set by the commissioner and it shall be comparable to, but no higher than, the maximum
201.4 amount paid by other third-party payors in this state who have maximum allowable cost
201.5 programs. Establishment of the amount of payment for drugs shall not be subject to the
201.6 requirements of the Administrative Procedure Act.

201.7 (b) An additional dispensing fee of $.30 may be added to the dispensing fee paid
201.8 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
201.9 facilities when a unit dose blister card system, approved by the department, is used. Under
201.10 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The
201.11 National Drug Code (NDC) from the drug container used to fill the blister card must be
201.12 identified on the claim to the department. The unit dose blister card containing the drug
201.13 must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that
201.14 govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will
201.15 be required to credit the department for the actual acquisition cost of all unused drugs that
201.16 are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in
201.17 a quantity that is less than a 30-day supply.

201.18 (c) Whenever a maximum allowable cost has been set for a multisource drug,
201.19 payment shall be the lower of the usual and customary price charged to the public or the
201.20 maximum allowable cost established by the commissioner unless prior authorization
201.21 for the brand name product has been granted according to the criteria established by
201.22 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the
201.23 prescriber has indicated "dispense as written" on the prescription in a manner consistent
201.24 with section 151.21, subdivision 2.

201.25 (d) The basis for determining the amount of payment for drugs administered in an
201.26 outpatient setting shall be the lower of the usual and customary cost submitted by the
201.27 provider ~~or~~, 106 percent of the average sales price as determined by the United States
201.28 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
201.29 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
201.30 set by the commissioner. If average sales price is unavailable, the amount of payment
201.31 must be lower of the usual and customary cost submitted by the provider ~~or~~, the wholesale
201.32 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the
201.33 commissioner. For drugs purchased through the federal 340B Drug Discount Program, the
201.34 amount of payment shall be the lower of the usual and customary cost, wholesale cost
201.35 minus 44 percent, the specialty pharmacy rate, or the maximum allowable cost set by the
201.36 commissioner. The payment for drugs administered in an outpatient setting shall be made

202.1 to the administering facility or practitioner. A retail or specialty pharmacy dispensing a
202.2 drug for administration in an outpatient setting is not eligible for direct reimbursement.
202.3 (e) The commissioner may negotiate lower reimbursement rates for specialty
202.4 pharmacy products than the rates specified in paragraph (a). The commissioner may
202.5 require individuals enrolled in the health care programs administered by the department
202.6 to obtain specialty pharmacy products from providers with whom the commissioner has
202.7 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
202.8 used by a small number of recipients or recipients with complex and chronic diseases
202.9 that require expensive and challenging drug regimens. Examples of these conditions
202.10 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
202.11 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
202.12 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
202.13 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
202.14 that require complex care. The commissioner shall consult with the formulary committee
202.15 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
202.16 with the formulary committee in developing this list, the commissioner shall take into
202.17 consideration the population served by specialty pharmacy products, the current delivery
202.18 system and standard of care in the state, and access to care issues. The commissioner shall
202.19 have the discretion to adjust the reimbursement rate to prevent access to care issues.
202.20 (f) Home infusion therapy services provided by home infusion therapy pharmacies
202.21 must be paid at rates according to subdivision 8d.

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

202.23 Sec. 3. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
202.24 subdivision to read:
202.25 Subd. 31b. **Preferred diabetic testing supply program.** (a) The commissioner
202.26 shall adopt and implement a point of sale preferred diabetic testing supply program by
202.27 January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform
202.28 to the limitations established under the program. The commissioner may enter into a
202.29 contract with a vendor for the purpose of participating in a preferred diabetic testing
202.30 supply list and supplemental rebate program. The commissioner shall ensure that any
202.31 contract meets all federal requirements and maximizes federal financial participation. The
202.32 commissioner shall maintain an accurate and up-to-date list on the agency Web site.
202.33 (b) The commissioner may add to, delete from, and otherwise modify the preferred
202.34 diabetic testing supply program drug list after consulting with the Drug Formulary

203.1 Committee and appropriate medial specialists and providing public notice and the
203.2 opportunity for public comment.
203.3 (c) The commissioner shall adopt and administer the preferred diabetic testing
203.4 supply program as part of the administration of the diabetic testing supply rebate program.
203.5 Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply
203.6 list may be subject to prior authorization.
203.7 (d) All claims for diabetic testing supplies in categories on the preferred diabetic
203.8 testing supply list must be submitted by enrolled pharmacy providers using the most
203.9 current National Council of Prescription Drug Providers electronic claims standard.
203.10 (e) For purposes of this subdivision, "preferred diabetic testing supply list" means a
203.11 list of diabetic testing supplies selected by the commissioner, for which prior authorization
203.12 is not required.
203.13 (f) The commissioner shall seek any federal waivers or approvals necessary to
203.14 implement this subdivision.

203.15 Sec. 4. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to read:
203.16 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**
203.17 Medical assistance covers early and periodic screening, diagnosis, and treatment services
203.18 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges
203.19 for vaccines that are available at no cost to the provider and shall not exceed the rate
203.20 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

203.21 **ARTICLE 8**

203.22 **CONTINUING CARE**

203.23 Section 1. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:
203.24 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
203.25 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
203.26 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
203.27 9555.6265, under this chapter for a physical location that will not be the primary residence
203.28 of the license holder for the entire period of licensure. If a license is issued during this
203.29 moratorium, and the license holder changes the license holder's primary residence away
203.30 from the physical location of the foster care license, the commissioner shall revoke the
203.31 license according to section 245A.07. Exceptions to the moratorium include:
203.32 (1) foster care settings that are required to be registered under chapter 144D;
203.33 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
203.34 and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities, or, allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

~~(c) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:~~

~~(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;~~

~~(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and~~

~~(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.~~

~~(d)~~ (c) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for foster care settings where the physical location is not the primary residence of the license holder, if the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term

care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county, and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

~~(e)~~ (d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph ~~(d)~~ (c) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or

(2) the license holder is certified under the requirements in subdivision 6a.

~~(f)~~ (e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph ~~(d)~~ (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1 of ~~each~~ 2013 and August 1 of 2014 and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

206.1 ~~(g)~~ (f) At the time of application and reapplication for licensure, the applicant and the
206.2 license holder that are subject to the moratorium or an exclusion established in paragraph
206.3 (a) are required to inform the commissioner whether the physical location where the foster
206.4 care will be provided is or will be the primary residence of the license holder for the entire
206.5 period of licensure. If the primary residence of the applicant or license holder changes, the
206.6 applicant or license holder must notify the commissioner immediately. The commissioner
206.7 shall print on the foster care license certificate whether or not the physical location is the
206.8 primary residence of the license holder.
206.9 ~~(h)~~ (g) License holders of foster care homes identified under paragraph ~~(g)~~ (f) that
206.10 are not the primary residence of the license holder and that also provide services in the
206.11 foster care home that are covered by a federally approved home and community-based
206.12 services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must
206.13 inform the human services licensing division that the license holder provides or intends to
206.14 provide these waiver-funded services. These license holders must be considered registered
206.15 under section 256B.092, subdivision 11, paragraph (c), and this registration status must
206.16 be identified on their license certificates.

206.17 Sec. 2. **[256.478] HOME AND COMMUNITY-BASED SERVICES**
206.18 **TRANSITIONS GRANTS.**
206.19 The commissioner shall make available home and community-based services
206.20 transition grants to serve individuals who do not meet eligibility criteria for the medical
206.21 assistance program under section 256B.056 or 256B.057, but who otherwise meet the
206.22 criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

206.23 Sec. 3. Minnesota Statutes 2012, section 256B.0911, subdivision 4d, is amended to read:
206.24 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a)
206.25 It is the policy of the state of Minnesota to ensure that individuals with disabilities or
206.26 chronic illness are served in the most integrated setting appropriate to their needs and have
206.27 the necessary information to make informed choices about home and community-based
206.28 service options.
206.29 (b) Individuals under 65 years of age who are admitted to a nursing facility from a
206.30 hospital must be screened prior to admission as outlined in subdivisions 4a through 4c.
206.31 (c) Individuals under 65 years of age who are admitted to nursing facilities with
206.32 only a telephone screening must receive a face-to-face assessment from the long-term
206.33 care consultation team member of the county in which the facility is located or from the
206.34 recipient's county case manager within 40 calendar days of admission.

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

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

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

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

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

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

207.27 (j) Notwithstanding the provisions of subdivision 6, the commissioner may pay
207.28 county agencies directly for face-to-face assessments for individuals under 65 years of
207.29 age who are being considered for placement or residing in a nursing facility. Until June
207.30 30, 2013, payments for individuals under 65 years of age shall be made as described
207.31 in this subdivision.

207.32 Sec. 4. Minnesota Statutes 2012, section 256B.0911, subdivision 6, is amended to read:

207.33 Subd. 6. **Payment for long-term care consultation services.** (a) Until June 30,
207.34 2013, payment for long-term care consultation face-to-face assessment shall be made
207.35 as described in this subdivision.

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

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

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

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

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

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

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

208.35 ~~(h)~~ (i) The commissioner shall develop an alternative payment methodology,
208.36 effective on July 1, 2013, for long-term care consultation services that includes the funding

209.1 available under this subdivision, and for assessments authorized under sections 256B.092
209.2 and 256B.0659. In developing the new payment methodology, the commissioner shall
209.3 consider the maximization of other funding sources, including federal administrative
209.4 reimbursement through federal financial participation funding, for all long-term care
209.5 consultation ~~and preadmission screening~~ activity. The alternative payment methodology
209.6 shall include the use of the appropriate time studies and the state financing of nonfederal
209.7 share as part of the state's medical assistance program.

209.8 Sec. 5. Minnesota Statutes 2012, section 256B.0916, is amended by adding a
209.9 subdivision to read:

209.10 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending
209.11 in excess of the allocation made by the commissioner. In the event a county or tribal
209.12 agency spends in excess of the allocation made by the commissioner for a given allocation
209.13 period, they must submit a corrective action plan to the commissioner. The plan must state
209.14 the actions the agency will take to correct their overspending for the year following the
209.15 period when the overspending occurred. Failure to correct overspending shall result in
209.16 recoupment of spending in excess of the allocation. Nothing in this subdivision shall be
209.17 construed as reducing the county's responsibility to offer and make available feasible
209.18 home and community-based options to eligible waiver recipients within the resources
209.19 allocated to them for that purpose.

209.20 Sec. 6. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

209.21 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
209.22 established a new service called residential support that is available on the community
209.23 alternative care, community alternatives for disabled individuals, developmental
209.24 disabilities, and brain injury waivers. Existing waiver service descriptions must be
209.25 modified to the extent necessary to ensure there is no duplication between other services.
209.26 Residential support services must be provided by vendors licensed as a community
209.27 residential setting as defined in section 245A.11, subdivision 8.

209.28 (b) Residential support services must meet the following criteria:

209.29 (1) providers of residential support services must own or control the residential site;

209.30 (2) the residential site must not be the primary residence of the license holder;

209.31 (3) the residential site must have a designated program supervisor responsible for
209.32 program oversight, development, and implementation of policies and procedures;

209.33 (4) the provider of residential support services must provide supervision, training,
209.34 and assistance as described in the person's coordinated service and support plan; and

210.1 (5) the provider of residential support services must meet the requirements of
210.2 licensure and additional requirements of the person's coordinated service and support plan.
210.3 (c) Providers of residential support services that meet the definition in paragraph
210.4 (a) must be registered using a process determined by the commissioner beginning July
210.5 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts
210.6 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts
210.7 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision
210.8 7, paragraph ~~(g)~~ (f), are considered registered under this section.

210.9 Sec. 7. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:
210.10 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall
210.11 establish statewide priorities for individuals on the waiting list for developmental
210.12 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must
210.13 include, but are not limited to, individuals who continue to have a need for waiver services
210.14 after they have maximized the use of state plan services and other funding resources,
210.15 including natural supports, prior to accessing waiver services, and who meet at least one
210.16 of the following criteria:
210.17 (1) no longer require the intensity of services provided where they are currently
210.18 living; or
210.19 (2) make a request to move from an institutional setting.
210.20 (b) After the priorities in paragraph (a) are met, priority must also be given to
210.21 individuals who meet at least one of the following criteria:
210.22 (1) have unstable living situations due to the age, incapacity, or sudden loss of
210.23 the primary caregivers;
210.24 (2) are moving from an institution due to bed closures;
210.25 (3) experience a sudden closure of their current living arrangement;
210.26 (4) require protection from confirmed abuse, neglect, or exploitation;
210.27 (5) experience a sudden change in need that can no longer be met through state plan
210.28 services or other funding resources alone; or
210.29 (6) meet other priorities established by the department.
210.30 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
210.31 consideration the number of individuals waiting who meet statewide priorities and the
210.32 lead agencies' current use of waiver funds and existing service options. The commissioner
210.33 has the authority to transfer funds between counties, groups of counties, and tribes to
210.34 accommodate statewide priorities and resource needs while accounting for a necessary
210.35 base level reserve amount for each county, group of counties, and tribe.

211.1 ~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and~~
211.2 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
211.3 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
211.4 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

211.5 Sec. 8. Minnesota Statutes 2012, section 256B.092, is amended by adding a
211.6 subdivision to read:

211.7 Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner
211.8 shall make available additional waiver allocations and additional necessary resources
211.9 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
211.10 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:
211.11 (1) are otherwise eligible for the developmental disabilities waiver under this section;
211.12 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
211.13 the Minnesota Security Hospital;
211.14 (3) whose discharge would be significantly delayed without the available waiver
211.15 allocation; and
211.16 (4) who have met treatment objectives and no longer meet hospital level of care.
211.17 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
211.18 requirements of the federal approved waiver plan.
211.19 (c) Any corporate foster care home developed under this subdivision must be
211.20 considered an exception under section 245A.03, subdivision 7, paragraph (a).

211.21 Sec. 9. **[256B.0949] AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**

211.22 Subdivision 1. **Purpose.** This section creates a new benefit available under the
211.23 medical assistance state plan 1915(i) option to provide early intensive intervention to a
211.24 child with an autism spectrum disorder diagnosis. This benefit must provide coverage for
211.25 the comprehensive, multidisciplinary diagnostic assessment, ongoing progress evaluation,
211.26 and medically necessary treatment of autism spectrum disorder. This option must be
211.27 available upon federal approval, but not earlier than March 1, 2014.

211.28 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in
211.29 this subdivision have the meanings given.
211.30 (b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the
211.31 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
211.32 (c) "Child" means a person under the age of 18.
211.33 (d) "Early intensive intervention benefit" means autism treatment options based in
211.34 behavioral and developmental science, which may include modalities such as applied

212.1 behavioral analysis, developmental treatment approaches, and naturalistic and parent
212.2 training models.
212.3 (e) "Commissioner" means the commissioner of human services, unless otherwise
212.4 specified.
212.5 (f) "Generalizable" means goals or gains that are observed in a variety of activities
212.6 with different people, such as providers, family members, other adults, and children and
212.7 in different environments including, but not limited to, clinics, homes, schools, and the
212.8 community.
212.9 Subd. 3. **Initial eligibility.** (a) This benefit is available to a child receiving medical
212.10 assistance who has an autism spectrum disorder diagnosis and who meets the criteria for
212.11 medically necessary early intensive intervention services.
212.12 (b) A comprehensive diagnosis must be based upon current DSM criteria including
212.13 direct observations and parental or caregiver reports. The comprehensive diagnosis
212.14 must reflect both medical and mental health input as provided by a licensed health care
212.15 professional and a licensed mental health professional.
212.16 (c) Additional diagnostic assessments may be provided as needed by professionals
212.17 who are licensed experts in the fields of medicine, speech and language, psychology,
212.18 occupational therapy, and physical therapy.
212.19 (d) Special education assessments may also be considered in the diagnostic
212.20 assessment.
212.21 (e) The multidisciplinary diagnostic assessment must lead to an individualized
212.22 treatment plan.
212.23 Subd. 4. **Treatment plan.** (a) Each child's treatment plan must be family centered,
212.24 culturally sensitive, and individualized based on the child's needs and developmental
212.25 status. The treatment plan must specify developmentally appropriate, functional,
212.26 generalizable goals, treatment modality, intensity, and setting. Treatment must be overseen
212.27 by a licensed health care or mental health professional with expertise and training in
212.28 autism and child development.
212.29 (b) A functional assessment must identify the child's developmental skills, needs,
212.30 and capacities based on direct observation of the child. It may include, but is not limited
212.31 to, input provided by the child's special education teacher.
212.32 (c) An assessment of parental or caregiver resilience and ability to participate in
212.33 therapy must be conducted to determine the nature and level of parental or caregiver
212.34 involvement and training.
212.35 (d) The treatment plan must be submitted to the commissioner for approval in a
212.36 manner determined by the commissioner for this purpose.

213.1 (e) The commissioner must authorize services consistent with approved treatment
213.2 plans.
213.3 Subd. 5. **Ongoing eligibility.** A child receiving this benefit must receive an
213.4 independent progress evaluation by a licensed mental health professional every six
213.5 months, or more frequently as determined by the commissioner, to determine if progress is
213.6 being made toward achieving generalizable gains and meeting functional goals contained
213.7 in the treatment plan. The progress evaluation must determine if the treatment plan
213.8 needs modification. This progress evaluation must include the treating provider's report,
213.9 parental or caregiver input, and an independent observation of the child. For children
213.10 participating in special education, the observation component of this progress evaluation
213.11 may be performed by the child's special education teacher. Progress evaluations must be
213.12 submitted to the commissioner in a manner determined by the commissioner for this
213.13 purpose. A child who continues to achieve generalizable gains and treatment goals as
213.14 contained in the treatment plan is eligible to continue receiving this benefit.
213.15 Subd. 6. **Refining the benefit with stakeholders.** The commissioner must develop
213.16 the implementation details of the benefit in consultation with stakeholders and consider
213.17 recommendations from the Health Services Advisory Council, the Autism Spectrum
213.18 Disorder Advisory Council, and the Interagency Task Force of the Departments of Health,
213.19 Education, and Human Services. The commissioner must release these details for a 30-day
213.20 public comment period prior to submission to the federal government for approval. The
213.21 implementation details include, but are not limited to, the following:
213.22 (1) defining the qualifications, standards, and roles of the treatment team;
213.23 (2) developing initial, uniform parameters for multidisciplinary diagnostic
213.24 assessment and progress evaluation standards;
213.25 (3) developing an effective and consistent process for assessing parent and caregiver
213.26 resilience and capacity to participate in the child's early intervention treatment;
213.27 (4) forming a collaborative process in which professionals have opportunities to
213.28 collectively inform diagnostic assessment and progress evaluation processes and standards
213.29 and to support quality improvement of early intensive intervention services;
213.30 (5) coordination with and interaction of this benefit with other services provided by
213.31 the Departments of Human Services and Education; and
213.32 (6) ongoing evaluation of and research regarding the program and treatment
213.33 modalities provided to children under this benefit.
213.34 Subd. 7. **Revision of treatment options.** The commissioner may revise covered
213.35 treatment options as needed to ensure consistency with evolving evidence.

214.1 Subd. 8. **Coordination between agencies.** The commissioners of human services
214.2 and education must coordinate diagnostic and educational assessment, service delivery,
214.3 and progress evaluations across health and education sectors.

214.4 Sec. 10. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:
214.5 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
214.6 have their payment rates determined under this section rather than section 256B.431, the
214.7 commissioner shall establish a rate under this subdivision. The nursing facility must enter
214.8 into a written contract with the commissioner.
214.9 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
214.10 contract under this section is the payment rate the facility would have received under
214.11 section 256B.431.
214.12 (c) A nursing facility's case mix payment rates for the second and subsequent years
214.13 of a facility's contract under this section are the previous rate year's contract payment
214.14 rates plus an inflation adjustment and, for facilities reimbursed under this section or
214.15 section 256B.431, an adjustment to include the cost of any increase in Health Department
214.16 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
214.17 inflation adjustment must be based on the change in the Consumer Price Index-All Items
214.18 (United States City average) (CPI-U) forecasted by the commissioner of management and
214.19 budget's national economic consultant, as forecasted in the fourth quarter of the calendar
214.20 year preceding the rate year. The inflation adjustment must be based on the 12-month
214.21 period from the midpoint of the previous rate year to the midpoint of the rate year for
214.22 which the rate is being determined. For the rate years beginning on July 1, 1999, July 1,
214.23 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006,
214.24 July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall
214.25 apply only to the property-related payment rate. For the rate years beginning on October
214.26 1, 2011, ~~and~~ October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and
214.27 October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning
214.28 in 2005, adjustment to the property payment rate under this section and section 256B.431
214.29 shall be effective on October 1. In determining the amount of the property-related payment
214.30 rate adjustment under this paragraph, the commissioner shall determine the proportion of
214.31 the facility's rates that are property-related based on the facility's most recent cost report.
214.32 (d) The commissioner shall develop additional incentive-based payments of up to
214.33 five percent above a facility's operating payment rate for achieving outcomes specified
214.34 in a contract. The commissioner may solicit contract amendments and implement those
214.35 which, on a competitive basis, best meet the state's policy objectives. The commissioner

215.1 shall limit the amount of any incentive payment and the number of contract amendments
215.2 under this paragraph to operate the incentive payments within funds appropriated for this
215.3 purpose. The contract amendments may specify various levels of payment for various
215.4 levels of performance. Incentive payments to facilities under this paragraph may be in the
215.5 form of time-limited rate adjustments or onetime supplemental payments. In establishing
215.6 the specified outcomes and related criteria, the commissioner shall consider the following
215.7 state policy objectives:

215.8 (1) successful diversion or discharge of residents to the residents' prior home or other
215.9 community-based alternatives;

215.10 (2) adoption of new technology to improve quality or efficiency;

215.11 (3) improved quality as measured in the Nursing Home Report Card;

215.12 (4) reduced acute care costs; and

215.13 (5) any additional outcomes proposed by a nursing facility that the commissioner
215.14 finds desirable.

215.15 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
215.16 take action to come into compliance with existing or pending requirements of the life
215.17 safety code provisions or federal regulations governing sprinkler systems must receive
215.18 reimbursement for the costs associated with compliance if all of the following conditions
215.19 are met:

215.20 (1) the expenses associated with compliance occurred on or after January 1, 2005,
215.21 and before December 31, 2008;

215.22 (2) the costs were not otherwise reimbursed under subdivision 4f or section
215.23 144A.071 or 144A.073; and

215.24 (3) the total allowable costs reported under this paragraph are less than the minimum
215.25 threshold established under section 256B.431, subdivision 15, paragraph (e), and
215.26 subdivision 16.

215.27 The commissioner shall use money appropriated for this purpose to provide to qualifying
215.28 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
215.29 2008. Nursing facilities that have spent money or anticipate the need to spend money
215.30 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
215.31 system or (2) replacing all or portions of an existing sprinkler system may submit to the
215.32 commissioner by June 30, 2007, on a form provided by the commissioner the actual
215.33 costs of a completed project or the estimated costs, based on a project bid, of a planned
215.34 project. The commissioner shall calculate a rate adjustment equal to the allowable
215.35 costs of the project divided by the resident days reported for the report year ending
215.36 September 30, 2006. If the costs from all projects exceed the appropriation for this

purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Sec. 11. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's ~~total operating~~ <u>external fixed</u> payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an ~~operating payment~~ <u>external fixed</u> rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(e) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

217.1 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
217.2 the commissioner shall recalculate planned closure rate adjustments for facilities that
217.3 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
217.4 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
217.5 from the date the per bed dollar amount is increased.

217.6 (g) For planned closures approved after June 30, 2009, the commissioner of human
217.7 services shall calculate the amount of the planned closure rate adjustment available under
217.8 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

217.9 (h) ~~Beginning~~ Between July 16, 2011, and June 30, 2013, the commissioner shall ~~no~~
217.10 ~~longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

217.11 Sec. 12. **[256B.4391] HOME AND COMMUNITY-BASED SERVICES QUALITY**
217.12 **PROFILES.**

217.13 Subdivision 1. **Development and implementation of quality profiles.** (a) The
217.14 commissioner of human services, in cooperation with the commissioner of health, shall
217.15 develop and implement quality profiles for home and community-based services (HCBS)
217.16 providers, except when the quality profiles would duplicate requirements under section
217.17 256B.5011, 256B.5012, or 256B.5013. For purposes of this section, HCBS providers
217.18 are defined as providers of HCBS under sections 256B.0915, 256B.092, and 256B.49,
217.19 and ICF/DD providers under section 256B.5013. To the extent possible, quality profiles
217.20 must be developed for providers of services to older adults and people with disabilities,
217.21 regardless of payor source, for the purposes of providing information to consumers.
217.22 The quality profiles shall be developed using existing data sets maintained by the
217.23 commissioners of health and human services to the extent possible. The profiles shall
217.24 incorporate or be coordinated with information on quality maintained by area agencies
217.25 on aging, long-term service and supports provider trade associations, the ombudsman
217.26 offices, counties, tribes, health plans, and other entities and the long-term services and
217.27 supports database maintained under section 256.975, subdivision 7. The profiles must be
217.28 designed to provide information on quality to:

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

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

217.32 (3) public and private purchasers of HCBS to enable them to purchase high-quality
217.33 services.

218.1 (b) The profiles must be developed in consultation with stakeholders and experts.
218.2 Within the limits of available appropriations, the commissioner may employ consultants
218.3 to assist with this project.

218.4 Subd. 2. **Quality measurement tools.** (a) The commissioners shall identify and
218.5 apply quality measurement tools to:

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

218.7 (2) address the needs of various users of HCBS.

218.8 (b) The tools must include, but not be limited to, surveys of consumers of HCBS. The
218.9 tools must be identified and applied, to the extent possible, without requiring providers to
218.10 supply information beyond state and federal requirements, for purposes of this subdivision.

218.11 Subd. 3. **Consumer surveys.** Following identification of the quality measurement
218.12 tool, the commissioner shall conduct surveys of HCBS consumers to develop quality
218.13 profiles of providers. To the extent possible, surveys must be conducted face-to-face by
218.14 state employees or contractors. At the discretion of the commissioner, surveys may be
218.15 conducted by an alternative method. Surveys must be conducted periodically to update
218.16 quality profiles of individual service providers.

218.17 Subd. 4. **Home and community-based services report card.** The profiles
218.18 developed shall be incorporated into a report card and maintained by the Minnesota
218.19 Board of Aging under section 256.975, subdivision 7, paragraph (b), clause (2), as data
218.20 becomes available. The commissioner shall use consumer choice, quality of life, service
218.21 delivery approaches, and cost or flexible purchasing categories to organize the consumer
218.22 information in the profiles. The profiles shall include consumer input and survey data to
218.23 the extent that is available through the state agencies. The commissioner shall develop and
218.24 disseminate quality profiles for a limited number of provider types initially, and develop
218.25 quality profiles for additional provider types as measurement tools are developed and
218.26 data becomes available. This includes providers of services to older adults and people
218.27 with disabilities, regardless of payor source.

218.28 Subd. 5. **Dissemination of quality profiles.** By July 1, 2014, the commissioner
218.29 shall implement a public awareness effort to disseminate the quality profiles. Profiles
218.30 may be disseminated through the Senior LinkAge Line and Disability Linkage Line to
218.31 consumers, providers, and purchasers of HCBS.

218.32 Subd. 6. **Implementation of home and community-based services**
218.33 **performance-based incentive payment program.** By July 1, 2014, the commissioner
218.34 shall develop incentive-based grants for HCBS providers for achieving outcomes specified
218.35 in a contract. The commissioner may solicit proposals from HCBS providers and
218.36 implement those which, on a competitive basis, best meet the state's policy objectives.

219.1 The commissioner shall determine the types of HCBS providers that will participate in the
219.2 program. The determination of participating provider types may be revised annually by
219.3 the commissioner. The commissioner shall limit the amount of any incentive-based grants
219.4 and the number of grants under this subdivision to operate the incentive payments within
219.5 funds appropriated for this purpose. The grant agreements may specify various levels of
219.6 payment for various levels of performance. In establishing the specified outcomes and
219.7 related criteria, the commissioner shall consider the following state policy objectives:

219.8 (1) provide more efficient, higher quality services;

219.9 (2) encourage HCBS providers to innovate;

219.10 (3) equip HCBS providers with organizational tools and expertise to improve their
219.11 quality;

219.12 (4) incentivize HCBS providers to invest in better services; and

219.13 (5) disseminate successful performance improvement strategies statewide.

219.14 Subd. 7. **Calculation of HCBS quality score.** (a) The commissioner shall
219.15 determine a quality score for each participating HCBS provider using quality measures
219.16 established in subdivisions 1 and 2, according to methods determined by the commissioner
219.17 in consultation with stakeholders and experts. These methods shall be exempt from the
219.18 rulemaking requirements under chapter 14.

219.19 (b) For each quality measure, a score shall be determined with a maximum number
219.20 of points available and number of points assigned as determined by the commissioner
219.21 using the methodology established according to this subdivision. The determination of
219.22 the quality measures to be used and the methods of calculating scores may be revised
219.23 annually be the commissioner.

219.24 Subd. 8. **Calculation of HCBS quality add-on.** Effective January 1, 2016, the
219.25 commissioner shall determine the quality add-on payment for participating HCBS
219.26 providers. The payment rate for the quality add-on shall be a variable amount based on
219.27 each provider's quality score as determined in subdivisions 1 and 2. The commissioner
219.28 shall limit the types of HCBS providers that may receive the quality add-on and the
219.29 amount of the quality add-on payments to operate the quality add-on within funds
219.30 appropriated for this purpose and based on the availability of the quality measures.

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

219.32 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to
219.33 the nursing home surcharge under section 256.9657, subdivision 1; licensure fees
219.34 under section 144.122; until June 30, 2013, long-term care consultation fees under
219.35 section 256B.0911, subdivision 6; family advisory council fee under section 144A.33;

220.1 scholarships under section 256B.431, subdivision 36; planned closure rate adjustments
220.2 under section 256B.437; or single bed room incentives under section 256B.431,
220.3 subdivision 42; property taxes and property insurance; and PERA.

220.4 Sec. 14. Minnesota Statutes 2012, section 256B.441, is amended by adding a
220.5 subdivision to read:

220.6 Subd. 46b. **Calculation of operating rate increase and quality add-on for the**
220.7 **October 1, 2013, rate year.** (a) Effective October 1, 2013, the commissioner shall
220.8 implement operating payment rate increases for each facility equal to the operating rates
220.9 in effect on September 30, 2013, multiplied by 1.09 percent.

220.10 (b) The commissioner shall determine quality add-ons to the operating payment
220.11 rates for each facility. The quality add-on amounts shall be based on rates in effect on
220.12 September 30, 2013. For each facility, the commissioner shall compute a quality factor by
220.13 subtracting 40 from the most recent quality score computed under subdivision 44, and
220.14 then dividing by 60. If the quality factor is less than zero, the commissioner shall use the
220.15 value zero. The quality add-ons shall be the operating payment rates multiplied by the
220.16 quality factor multiplied by 2.60 percent. The commissioner shall implement the quality
220.17 add-ons effective October 1, 2013.

220.18 (c) Facilities receiving rate adjustments under subdivision 55a must have rate
220.19 increases under paragraphs (a) and (b) computed based on rates in effect before the
220.20 increases given under subdivision 55a.

220.21 Sec. 15. Minnesota Statutes 2012, section 256B.441, is amended by adding a
220.22 subdivision to read:

220.23 Subd. 46c. **Calculation of operating rate increase and quality add-on for the**
220.24 **October 1, 2014, rate year.** (a) Effective October 1, 2014, the commissioner shall
220.25 implement operating payment rate increases for each facility equal to the operating rates
220.26 in effect on September 30, 2014, multiplied by 1.09 percent.

220.27 (b) The commissioner shall determine quality add-ons to the operating payment
220.28 rates for each facility. The quality add-on amounts shall be based on rates in effect on
220.29 September 30, 2014. For each facility, the commissioner shall compute a quality factor by
220.30 subtracting 40 from the most recent quality score computed under subdivision 44, and
220.31 then dividing by 60. If the quality factor is less than zero, the commissioner shall use the
220.32 value zero. The quality add-ons shall be the operating payment rates multiplied by the
220.33 quality factor multiplied by 2.60 percent. The commissioner shall implement the quality
220.34 add-ons effective October 1, 2014.

221.1 (c) Facilities receiving rate adjustments under subdivision 55a must have rate
221.2 increases under paragraphs (a) and (b) computed based on rates in effect before the
221.3 increases given under subdivision 55a and after the increases computed in subdivision 46b.

221.4 Sec. 16. Minnesota Statutes 2012, section 256B.441, is amended by adding a
221.5 subdivision to read:
221.6 Subd. 46d. **Calculation of quality add-on for the October 1, 2015, rate year.** (a)
221.7 The commissioner shall determine quality add-ons to the operating payment rates for each
221.8 facility. The quality add-on amounts shall be based on rates in effect on September 30,
221.9 2015. For each facility, the commissioner shall compute a quality factor by subtracting
221.10 40 from the most recent quality score computed under subdivision 44, and then dividing
221.11 by 60. If the quality factor is less than zero, the commissioner shall use the value zero.
221.12 The quality add-ons shall be the operating payment rates multiplied by the quality factor
221.13 multiplied by 5.40 percent. The commissioner shall implement the quality add-ons
221.14 effective October 1, 2015.
221.15 (b) Facilities receiving rate adjustments under subdivision 55a must have rate
221.16 increases under paragraph (a) computed based on rates in effect before the increases
221.17 given under subdivision 55a and after the sum of the increases computed in subdivisions
221.18 46b and 46c.

221.19 Sec. 17. Minnesota Statutes 2012, section 256B.441, is amended by adding a
221.20 subdivision to read:
221.21 Subd. 46e. **Calculation of quality add-on for the October 1, 2016, rate year.** (a)
221.22 The commissioner shall determine quality add-ons to the operating payment rates for each
221.23 facility. The quality add-on amounts shall be based on rates in effect on September 30,
221.24 2016. For each facility, the commissioner shall compute a quality factor by subtracting
221.25 40 from the most recent quality score computed under subdivision 44, and then dividing
221.26 by 60. If the quality factor is less than zero, the commissioner shall use the value zero.
221.27 The quality add-ons shall be the operating payment rates multiplied by the quality factor
221.28 multiplied by 5.40 percent. The commissioner shall implement the quality add-ons
221.29 effective October 1, 2016.
221.30 (b) Facilities receiving rate adjustments under subdivision 55a must have rate
221.31 increases under paragraph (a) computed based on rates in effect before the increases
221.32 given under subdivision 55a and after the sum of the increases computed in subdivisions
221.33 46b, 46c, and 46d.

222.1 Sec. 18. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:

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

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

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

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

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

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

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

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

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

222.28 (i) The single bed room incentives shall be as determined under section 256B.431,
222.29 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
222.30 no longer be included in the payment rate for external fixed costs beginning October 1,
222.31 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
222.32 longer be included in the payment rate for external fixed costs beginning on October 1 of
222.33 the first year not less than two years after their effective date.

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

223.1 Sec. 19. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:
223.2 Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall
223.3 establish statewide priorities for individuals on the waiting list for community alternative
223.4 care, community alternatives for disabled individuals, and brain injury waiver services,
223.5 as of January 1, 2010. The statewide priorities must include, but are not limited to,
223.6 individuals who continue to have a need for waiver services after they have maximized the
223.7 use of state plan services and other funding resources, including natural supports, prior to
223.8 accessing waiver services, and who meet at least one of the following criteria:
223.9 (1) no longer require the intensity of services provided where they are currently
223.10 living; or
223.11 (2) make a request to move from an institutional setting.
223.12 (b) After the priorities in paragraph (a) are met, priority must also be given to
223.13 individuals who meet at least one of the following criteria:
223.14 (1) have unstable living situations due to the age, incapacity, or sudden loss of
223.15 the primary caregivers;
223.16 (2) are moving from an institution due to bed closures;
223.17 (3) experience a sudden closure of their current living arrangement;
223.18 (4) require protection from confirmed abuse, neglect, or exploitation;
223.19 (5) experience a sudden change in need that can no longer be met through state plan
223.20 services or other funding resources alone; or
223.21 (6) meet other priorities established by the department.
223.22 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
223.23 consideration the number of individuals waiting who meet statewide priorities and the
223.24 lead agencies' current use of waiver funds and existing service options. The commissioner
223.25 has the authority to transfer funds between counties, groups of counties, and tribes to
223.26 accommodate statewide priorities and resource needs while accounting for a necessary
223.27 base level reserve amount for each county, group of counties, and tribe.
223.28 ~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and~~
223.29 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
223.30 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
223.31 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

223.32 Sec. 20. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:
223.33 Subd. 15. **Coordinated service and support plan; comprehensive transitional**
223.34 **service plan; maintenance service plan.** (a) Each recipient of home and community-based

224.1 waivered services shall be provided a copy of the written coordinated service and support
224.2 plan which meets the requirements in section 256B.092, subdivision 1b.

224.3 (b) In developing the comprehensive transitional service plan, the individual
224.4 receiving services, the case manager, and the guardian, if applicable, will identify the
224.5 transitional service plan fundamental service outcome and anticipated timeline to achieve
224.6 this outcome. Within the first 20 days following a recipient's request for an assessment or
224.7 reassessment, the transitional service planning team must be identified. A team leader must
224.8 be identified who will be responsible for assigning responsibility and communicating with
224.9 team members to ensure implementation of the transition plan and ongoing assessment and
224.10 communication process. The team leader should be an individual, such as the case manager
224.11 or guardian, who has the opportunity to follow the recipient to the next level of service.

224.12 Within ten days following an assessment, a comprehensive transitional service plan
224.13 must be developed incorporating elements of a comprehensive functional assessment and
224.14 including short-term measurable outcomes and timelines for achievement of and reporting
224.15 on these outcomes. Functional milestones must also be identified and reported according
224.16 to the timelines agreed upon by the transitional service planning team. In addition, the
224.17 comprehensive transitional service plan must identify additional supports that may assist
224.18 in the achievement of the fundamental service outcome such as the development of greater
224.19 natural community support, increased collaboration among agencies, and technological
224.20 supports.

224.21 The timelines for reporting on functional milestones will prompt a reassessment of
224.22 services provided, the units of services, rates, and appropriate service providers. It is
224.23 the responsibility of the transitional service planning team leader to review functional
224.24 milestone reporting to determine if the milestones are consistent with observable skills
224.25 and that milestone achievement prompts any needed changes to the comprehensive
224.26 transitional service plan.

224.27 For those whose fundamental transitional service outcome involves the need to
224.28 procure housing, a plan for the recipient to seek the resources necessary to secure the least
224.29 restrictive housing possible should be incorporated into the plan, including employment
224.30 and public supports such as housing access and shelter needy funding.

224.31 (c) Counties and other agencies responsible for funding community placement and
224.32 ongoing community supportive services are responsible for the implementation of the
224.33 comprehensive transitional service plans. Oversight responsibilities include both ensuring
224.34 effective transitional service delivery and efficient utilization of funding resources.

224.35 (d) Following one year of transitional services, the transitional services planning team
224.36 will make a determination as to whether or not the individual receiving services requires

225.1 the current level of continuous and consistent support in order to maintain the recipient's
225.2 current level of functioning. Recipients who are determined to have not had a significant
225.3 change in functioning for 12 months must move from a transitional to a maintenance
225.4 service plan. Recipients on a maintenance service plan must be reassessed to determine if
225.5 the recipient would benefit from a transitional service plan at least every 12 months and at
225.6 other times when there has been a significant change in the recipient's functioning. This
225.7 assessment should consider any changes to technological or natural community supports.

225.8 (e) When a county is evaluating denials, reductions, or terminations of home and
225.9 community-based services under section 256B.49 for an individual, the case manager
225.10 shall offer to meet with the individual or the individual's guardian in order to discuss
225.11 the prioritization of service needs within the coordinated service and support plan,
225.12 comprehensive transitional service plan, or maintenance service plan. The reduction in
225.13 the authorized services for an individual due to changes in funding for waivered services
225.14 may not exceed the amount needed to ensure medically necessary services to meet the
225.15 individual's health, safety, and welfare.

225.16 (f) At the time of reassessment, local agency case managers shall assess each recipient
225.17 of community alternatives for disabled individuals or brain injury waivered services
225.18 currently residing in a licensed adult foster home that is not the primary residence of the
225.19 license holder, or in which the license holder is not the primary caregiver, to determine if
225.20 that recipient could appropriately be served in a community-living setting. If appropriate
225.21 for the recipient, the case manager shall offer the recipient, through a person-centered
225.22 planning process, the option to receive alternative housing and service options. In the
225.23 event that the recipient chooses to transfer from the adult foster home, the vacated bed
225.24 shall not be filled with another recipient of waiver services and group residential housing
225.25 and the licensed capacity shall be reduced accordingly, unless the savings required by the
225.26 licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7,
225.27 sections 1 and 40, paragraph (f), for foster care settings where the physical location is not
225.28 the primary residence of the license holder are met through voluntary changes described
225.29 in section 245A.03, subdivision 7, paragraph ~~(f)~~ (e), or as provided under paragraph (a),
225.30 clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers,
225.31 the county agency, with the assistance of the department, shall facilitate a consolidation of
225.32 settings or closure. This reassessment process shall be completed by July 1, 2013.

225.33 Sec. 21. Minnesota Statutes 2012, section 256B.49, is amended by adding a
225.34 subdivision to read:

226.1 Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner
226.2 shall make available additional waiver allocations and additional necessary resources
226.3 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
226.4 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:
226.5 (1) are otherwise eligible for the developmental disabilities waiver under this section;
226.6 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
226.7 the Minnesota Security Hospital;
226.8 (3) whose discharge would be significantly delayed without the available waiver
226.9 allocation; and
226.10 (4) who have met treatment objectives and no longer meet hospital level of care.
226.11 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
226.12 requirements of the federal approved waiver plan.
226.13 (c) Any corporate foster care home developed under this subdivision must be
226.14 considered an exception under section 245A.03, subdivision 7, paragraph (a).

226.15 Sec. 22. Minnesota Statutes 2012, section 256B.49, is amended by adding a
226.16 subdivision to read:
226.17 Subd. 25. **Excess allocations.** County and tribal agencies will be responsible for
226.18 authorizations in excess of the allocation made by the commissioner. In the event a county
226.19 or tribal agency authorizes in excess of the allocation made by the commissioner for a
226.20 given allocation period, they must submit a corrective action plan to the commissioner.
226.21 The plan must state the actions the agency will take to correct their over-authorization
226.22 for the year following the period when the overspending occurred. Failure to correct
226.23 over-authorizations shall result in recoupment of authorizations in excess of the allocation.
226.24 Nothing in this subdivision shall be construed as reducing the county's responsibility to
226.25 offer and make available feasible home and community-based options to eligible waiver
226.26 recipients within the resources allocated to them for that purpose.

226.27 Sec. 23. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:
226.28 Subd. 2. **Planned closure process needs determination.** The commissioner shall
226.29 announce and implement a program for planned closure of adult foster care homes. Planned
226.30 closure shall be the preferred method for achieving necessary budgetary savings required by
226.31 the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph ~~(d)~~
226.32 (c). If additional closures are required to achieve the necessary savings, the commissioner
226.33 shall use the process and priorities in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c).

227.1 Sec. 24. **SAFETY NET FOR HOME AND COMMUNITY-BASED SERVICES**
227.2 **WAIVERS.**

227.3 The commissioner of human services shall submit a request by December 31, 2013,
227.4 to the federal government to amend the home and community-based services waivers for
227.5 individuals with disabilities authorized under Minnesota Statutes, section 256B.49, to
227.6 modify the financial management of the home and community-based services waivers
227.7 to provide a state-administered safety net when costs for an individual increase above
227.8 an identified threshold. The implementation of the safety net may result in a decreased
227.9 allocation for individual counties, tribes, or collaboratives of counties or tribes, but must
227.10 not result in a net decreased statewide allocation.

227.11 Sec. 25. **SHARED LIVING MODEL.**

227.12 The commissioner of human services shall develop and promote a shared living model
227.13 option for individuals receiving services through the home and community-based services
227.14 waivers for individuals with disabilities, authorized under Minnesota Statutes, section
227.15 256B.092 or 256B.49, as an option for individuals who require 24-hour assistance. The
227.16 option must be a companion model with a limit of one or two individuals receiving support
227.17 in the home, planned respite for the caregiver, and the availability of intensive training
227.18 and support on the needs of the individual or individuals. Any necessary amendments to
227.19 implement the model must be submitted to the federal government by December 31, 2013.

227.20 Sec. 26. **MONEY FOLLOWS THE PERSON GRANT.**

227.21 The commissioner of human services shall submit to the federal government all
227.22 necessary waiver amendments to implement the Money Follows the Person federal grant
227.23 by December 31, 2013.

227.24 **ARTICLE 9**

227.25 **WAIVER PROVIDER STANDARDS**

227.26 Section 1. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:

227.27 Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity
227.28 licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under
227.29 section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47,
227.30 an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts
227.31 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or
227.32 a hospice provider licensed under sections 144A.75 to 144A.755.

228.1 Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:
228.2 Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this
228.3 subdivision, "health care facility" means a facility:
228.4 (1) licensed by the commissioner of health as a hospital, boarding care home or
228.5 supervised living facility under sections 144.50 to 144.58, or a nursing home under
228.6 chapter 144A;
228.7 (2) registered by the commissioner of health as a housing with services establishment
228.8 as defined in section 144D.01; or
228.9 (3) licensed by the commissioner of human services as a residential facility under
228.10 chapter 245A to provide adult foster care, adult mental health treatment, chemical
228.11 dependency treatment to adults, or residential services to persons with ~~developmental~~
228.12 disabilities.
228.13 (b) Prior to admission to a health care facility, a person required to register under
228.14 this section shall disclose to:
228.15 (1) the health care facility employee processing the admission the person's status
228.16 as a registered predatory offender under this section; and
228.17 (2) the person's corrections agent, or if the person does not have an assigned
228.18 corrections agent, the law enforcement authority with whom the person is currently
228.19 required to register, that inpatient admission will occur.
228.20 (c) A law enforcement authority or corrections agent who receives notice under
228.21 paragraph (b) or who knows that a person required to register under this section is
228.22 planning to be admitted and receive, or has been admitted and is receiving health care
228.23 at a health care facility shall notify the administrator of the facility and deliver a fact
228.24 sheet to the administrator containing the following information: (1) name and physical
228.25 description of the offender; (2) the offender's conviction history, including the dates of
228.26 conviction; (3) the risk level classification assigned to the offender under section 244.052,
228.27 if any; and (4) the profile of likely victims.
228.28 (d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care
228.29 facility receives a fact sheet under paragraph (c) that includes a risk level classification for
228.30 the offender, and if the facility admits the offender, the facility shall distribute the fact
228.31 sheet to all residents at the facility. If the facility determines that distribution to a resident
228.32 is not appropriate given the resident's medical, emotional, or mental status, the facility
228.33 shall distribute the fact sheet to the patient's next of kin or emergency contact.

228.34 Sec. 3. **[245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY**
228.35 **MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**

229.1 Subdivision 1. **Rules.** The commissioner of human services shall, within 24 months
229.2 of enactment of this section, adopt rules governing the use of positive support strategies,
229.3 safety interventions, and emergency use of manual restraint in facilities and services
229.4 licensed under chapter 245D. The rules shall prohibit the application of aversive and
229.5 deprivation procedures except for the emergency use of manual restraint.

229.6 Subd. 2. **Data collection.** (a) The commissioner shall, with stakeholder input,
229.7 develop data collection elements specific to incidents on the use of aversive and controlled
229.8 procedures for providers identified to be licensed under chapter 245D effective January
229.9 1, 2014. Effective July 1, 2013, the providers shall report the data in a format and at a
229.10 frequency provided by the commissioner of human services.

229.11 (b) Within three months of the adoption of the new rule, the commissioner, with
229.12 stakeholder input, shall develop and initiate implementation of a transition plan to stage
229.13 the effective dates of the new rule.

229.14 Sec. 4. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:

229.15 Subd. 10. **Nonresidential program.** "Nonresidential program" means care,
229.16 supervision, rehabilitation, training or habilitation of a person provided outside the
229.17 person's own home and provided for fewer than 24 hours a day, including adult day
229.18 care programs; and chemical dependency or chemical abuse programs that are located
229.19 in a nursing home or hospital and receive public funds for providing chemical abuse or
229.20 chemical dependency treatment services under chapter 254B. Nonresidential programs
229.21 include home and community-based services ~~and semi-independent living services~~ for
229.22 persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in
229.23 or outside of a person's own home under chapter 245D.

229.24 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:

229.25 Subd. 14. **Residential program.** "Residential program" means a program
229.26 that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training,
229.27 education, habilitation, or treatment outside a person's own home, including a program
229.28 in an intermediate care facility for four or more persons with developmental disabilities;
229.29 and chemical dependency or chemical abuse programs that are located in a hospital
229.30 or nursing home and receive public funds for providing chemical abuse or chemical
229.31 dependency treatment services under chapter 254B. Residential programs include home
229.32 and community-based services for persons with ~~developmental~~ disabilities or persons age
229.33 65 and older that are provided in or outside of a person's own home under chapter 245D.

230.1 Sec. 6. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

230.2 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial
230.3 license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340,
230.4 or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under
230.5 this chapter for a physical location that will not be the primary residence of the license
230.6 holder for the entire period of licensure. If a license is issued during this moratorium, and
230.7 the license holder changes the license holder's primary residence away from the physical
230.8 location of the foster care license, the commissioner shall revoke the license according
230.9 to section 245A.07. The commissioner shall not issue an initial license for a community
230.10 residential setting licensed under chapter 245D. Exceptions to the moratorium include:

230.11 (1) foster care settings that are required to be registered under chapter 144D;

230.12 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
230.13 community residential setting licenses replacing adult foster care licenses in existence on
230.14 December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

230.15 (3) new foster care licenses or community residential setting licenses determined to
230.16 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
230.17 ICF/MR, or regional treatment center, or restructuring of state-operated services that
230.18 limits the capacity of state-operated facilities;

230.19 (4) new foster care licenses or community residential setting licenses determined
230.20 to be needed by the commissioner under paragraph (b) for persons requiring hospital
230.21 level care; or

230.22 (5) new foster care licenses or community residential setting licenses determined to
230.23 be needed by the commissioner for the transition of people from personal care assistance
230.24 to the home and community-based services.

230.25 (b) The commissioner shall determine the need for newly licensed foster care
230.26 homes or community residential settings as defined under this subdivision. As part of the
230.27 determination, the commissioner shall consider the availability of foster care capacity in
230.28 the area in which the licensee seeks to operate, and the recommendation of the local
230.29 county board. The determination by the commissioner must be final. A determination of
230.30 need is not required for a change in ownership at the same address.

230.31 (c) The commissioner shall study the effects of the license moratorium under this
230.32 subdivision and shall report back to the legislature by January 15, 2011. This study shall
230.33 include, but is not limited to the following:

230.34 (1) the overall capacity and utilization of foster care beds where the physical location
230.35 is not the primary residence of the license holder prior to and after implementation
230.36 of the moratorium;

231.1 (2) the overall capacity and utilization of foster care beds where the physical
231.2 location is the primary residence of the license holder prior to and after implementation
231.3 of the moratorium; and
231.4 (3) the number of licensed and occupied ICF/MR beds prior to and after
231.5 implementation of the moratorium.
231.6 (d) When a foster care recipient resident served by the program moves out of a
231.7 foster home that is not the primary residence of the license holder according to section
231.8 256B.49, subdivision 15, paragraph (f), or the community residential setting, the county
231.9 shall immediately inform the Department of Human Services Licensing Division.
231.10 The department shall decrease the statewide licensed capacity for foster care settings
231.11 where the physical location is not the primary residence of the license holder, or for
231.12 community residential settings, if the voluntary changes described in paragraph (f) are
231.13 not sufficient to meet the savings required by reductions in licensed bed capacity under
231.14 Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f),
231.15 and maintain statewide long-term care residential services capacity within budgetary
231.16 limits. Implementation of the statewide licensed capacity reduction shall begin on July
231.17 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the
231.18 needs determination process. Under this paragraph, the commissioner has the authority
231.19 to reduce unused licensed capacity of a current foster care program, or the community
231.20 residential settings, to accomplish the consolidation or closure of settings. A decreased
231.21 licensed capacity according to this paragraph is not subject to appeal under this chapter.
231.22 (e) Residential settings that would otherwise be subject to the decreased license
231.23 capacity established in paragraph (d) shall be exempt under the following circumstances:
231.24 (1) until August 1, 2013, the license holder's beds occupied by residents whose
231.25 primary diagnosis is mental illness and the license holder is:
231.26 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
231.27 health services (ARMHS) as defined in section 256B.0623;
231.28 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
231.29 9520.0870;
231.30 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
231.31 9520.0870; or
231.32 (iv) a provider of intensive residential treatment services (IRTS) licensed under
231.33 Minnesota Rules, parts 9520.0500 to 9520.0670; or
231.34 (2) the license holder is certified under the requirements in subdivision 6a or section
231.35 245D.33.

232.1 (f) A resource need determination process, managed at the state level, using the
232.2 available reports required by section 144A.351, and other data and information shall
232.3 be used to determine where the reduced capacity required under paragraph (d) will be
232.4 implemented. The commissioner shall consult with the stakeholders described in section
232.5 144A.351, and employ a variety of methods to improve the state's capacity to meet
232.6 long-term care service needs within budgetary limits, including seeking proposals from
232.7 service providers or lead agencies to change service type, capacity, or location to improve
232.8 services, increase the independence of residents, and better meet needs identified by the
232.9 long-term care services reports and statewide data and information. By February 1 of each
232.10 year, the commissioner shall provide information and data on the overall capacity of
232.11 licensed long-term care services, actions taken under this subdivision to manage statewide
232.12 long-term care services and supports resources, and any recommendations for change to
232.13 the legislative committees with jurisdiction over health and human services budget.

232.14 (g) At the time of application and reapplication for licensure, the applicant and the
232.15 license holder that are subject to the moratorium or an exclusion established in paragraph
232.16 (a) are required to inform the commissioner whether the physical location where the foster
232.17 care will be provided is or will be the primary residence of the license holder for the entire
232.18 period of licensure. If the primary residence of the applicant or license holder changes, the
232.19 applicant or license holder must notify the commissioner immediately. The commissioner
232.20 shall print on the foster care license certificate whether or not the physical location is the
232.21 primary residence of the license holder.

232.22 (h) License holders of foster care homes identified under paragraph (g) that are not
232.23 the primary residence of the license holder and that also provide services in the foster care
232.24 home that are covered by a federally approved home and community-based services
232.25 waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the
232.26 human services licensing division that the license holder provides or intends to provide
232.27 these waiver-funded services. ~~These license holders must be considered registered under~~
232.28 ~~section 256B.092, subdivision 11, paragraph (c), and this registration status must be~~
232.29 ~~identified on their license certificates.~~

232.30 Sec. 7. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:

232.31 Subd. 3. **Implementation.** (a) The commissioner shall implement the
232.32 responsibilities of this chapter according to the timelines in paragraphs (b) and (c)
232.33 only within the limits of available appropriations or other administrative cost recovery
232.34 methodology.

233.1 (b) The licensure of home and community-based services according to this section
233.2 shall be implemented January 1, 2014. License applications shall be received and
233.3 processed on a phased-in schedule as determined by the commissioner beginning July
233.4 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that
233.5 the application is complete according to section 245A.04.

233.6 (c) Within the limits of available appropriations or other administrative cost recovery
233.7 methodology, implementation of compliance monitoring must be phased in after January
233.8 1, 2014.

233.9 (1) Applicants who do not currently hold a license issued under ~~this~~ chapter 245B
233.10 must receive an initial compliance monitoring visit after 12 months of the effective date of
233.11 the initial license for the purpose of providing technical assistance on how to achieve and
233.12 maintain compliance with the applicable law or rules governing the provision of home and
233.13 community-based services under chapter 245D. If during the review the commissioner
233.14 finds that the license holder has failed to achieve compliance with an applicable law or
233.15 rule and this failure does not imminently endanger the health, safety, or rights of the
233.16 persons served by the program, the commissioner may issue a licensing review report with
233.17 recommendations for achieving and maintaining compliance.

233.18 (2) Applicants who do currently hold a license issued under this chapter must receive
233.19 a compliance monitoring visit after 24 months of the effective date of the initial license.

233.20 (d) Nothing in this subdivision shall be construed to limit the commissioner's
233.21 authority to suspend or revoke a license or issue a fine at any time under section 245A.07,
233.22 or ~~make~~ issue correction orders and make a license conditional for failure to comply with
233.23 applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity
233.24 of the violation of law or rule and the effect of the violation on the health, safety, or
233.25 rights of persons served by the program.

233.26 Sec. 8. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

233.27 Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license
233.28 under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is
233.29 based on a disqualification for which reconsideration was requested and which was not
233.30 set aside under section 245C.22, the scope of the contested case hearing shall include the
233.31 disqualification and the licensing sanction or denial of a license, unless otherwise specified
233.32 in this subdivision. When the licensing sanction or denial of a license is based on a
233.33 determination of maltreatment under section 626.556 or 626.557, or a disqualification for
233.34 serious or recurring maltreatment which was not set aside, the scope of the contested case
233.35 hearing shall include the maltreatment determination, disqualification, and the licensing

234.1 sanction or denial of a license, unless otherwise specified in this subdivision. In such
234.2 cases, a fair hearing under section 256.045 shall not be conducted as provided for in
234.3 sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.
234.4 (b) Except for family child care and child foster care, reconsideration of a
234.5 maltreatment determination under sections 626.556, subdivision 10i, and 626.557,
234.6 subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall
234.7 not be conducted when:
234.8 (1) a denial of a license under section 245A.05, or a licensing sanction under section
234.9 245A.07, is based on a determination that the license holder is responsible for maltreatment
234.10 or the disqualification of a license holder is based on serious or recurring maltreatment;
234.11 (2) the denial of a license or licensing sanction is issued at the same time as the
234.12 maltreatment determination or disqualification; and
234.13 (3) the license holder appeals the maltreatment determination or disqualification,
234.14 and denial of a license or licensing sanction. In these cases, a fair hearing shall not be
234.15 conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision
234.16 9d. The scope of the contested case hearing must include the maltreatment determination,
234.17 disqualification, and denial of a license or licensing sanction.
234.18 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
234.19 determination or disqualification, but does not appeal the denial of a license or a licensing
234.20 sanction, reconsideration of the maltreatment determination shall be conducted under
234.21 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
234.22 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
234.23 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
234.24 626.557, subdivision 9d.
234.25 (c) In consolidated contested case hearings regarding sanctions issued in family child
234.26 care, child foster care, family adult day services, ~~and~~ adult foster care, and community
234.27 residential settings, the county attorney shall defend the commissioner's orders in
234.28 accordance with section 245A.16, subdivision 4.
234.29 (d) The commissioner's final order under subdivision 5 is the final agency action
234.30 on the issue of maltreatment and disqualification, including for purposes of subsequent
234.31 background studies under chapter 245C and is the only administrative appeal of the final
234.32 agency determination, specifically, including a challenge to the accuracy and completeness
234.33 of data under section 13.04.
234.34 (e) When consolidated hearings under this subdivision involve a licensing sanction
234.35 based on a previous maltreatment determination for which the commissioner has issued
234.36 a final order in an appeal of that determination under section 256.045, or the individual

235.1 failed to exercise the right to appeal the previous maltreatment determination under
235.2 section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is
235.3 conclusive on the issue of maltreatment. In such cases, the scope of the administrative
235.4 law judge's review shall be limited to the disqualification and the licensing sanction or
235.5 denial of a license. In the case of a denial of a license or a licensing sanction issued to
235.6 a facility based on a maltreatment determination regarding an individual who is not the
235.7 license holder or a household member, the scope of the administrative law judge's review
235.8 includes the maltreatment determination.

235.9 (f) The hearings of all parties may be consolidated into a single contested case
235.10 hearing upon consent of all parties and the administrative law judge, if:

235.11 (1) a maltreatment determination or disqualification, which was not set aside under
235.12 section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing
235.13 sanction under section 245A.07;

235.14 (2) the disqualified subject is an individual other than the license holder and upon
235.15 whom a background study must be conducted under section 245C.03; and

235.16 (3) the individual has a hearing right under section 245C.27.

235.17 (g) When a denial of a license under section 245A.05 or a licensing sanction under
235.18 section 245A.07 is based on a disqualification for which reconsideration was requested
235.19 and was not set aside under section 245C.22, and the individual otherwise has no hearing
235.20 right under section 245C.27, the scope of the administrative law judge's review shall
235.21 include the denial or sanction and a determination whether the disqualification should
235.22 be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In
235.23 determining whether the disqualification should be set aside, the administrative law judge
235.24 shall consider the factors under section 245C.22, subdivision 4, to determine whether the
235.25 individual poses a risk of harm to any person receiving services from the license holder.

235.26 (h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction
235.27 under section 245A.07 is based on the termination of a variance under section 245C.30,
235.28 subdivision 4, the scope of the administrative law judge's review shall include the sanction
235.29 and a determination whether the disqualification should be set aside, unless section
235.30 245C.24 prohibits the set-aside of the disqualification. In determining whether the
235.31 disqualification should be set aside, the administrative law judge shall consider the factors
235.32 under section 245C.22, subdivision 4, to determine whether the individual poses a risk of
235.33 harm to any person receiving services from the license holder.

235.34 Sec. 9. Minnesota Statutes 2012, section 245A.10, is amended to read:

235.35 **245A.10 FEES.**

236.1 Subdivision 1. **Application or license fee required, programs exempt from fee.**
236.2 (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation
236.3 of applications and inspection of programs which are licensed under this chapter.
236.4 (b) Except as provided under subdivision 2, no application or license fee shall be
236.5 charged for child foster care, adult foster care, or family and group family child care, or
236.6 a community residential setting.
236.7 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
236.8 purposes of family and group family child care licensing under this chapter, a county
236.9 agency may charge a fee to an applicant or license holder to recover the actual cost of
236.10 background studies, but in any case not to exceed $100 annually. A county agency may
236.11 also charge a license fee to an applicant or license holder not to exceed $50 for a one-year
236.12 license or $100 for a two-year license.
236.13 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
236.14 applicant for authorization to recover the actual cost of background studies completed
236.15 under section 119B.125, but in any case not to exceed $100 annually.
236.16 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):
236.17 (1) in cases of financial hardship;
236.18 (2) if the county has a shortage of providers in the county's area;
236.19 (3) for new providers; or
236.20 (4) for providers who have attained at least 16 hours of training before seeking
236.21 initial licensure.
236.22 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
236.23 an installment basis for up to one year. If the provider is receiving child care assistance
236.24 payments from the state, the provider may have the fees under paragraph (a) or (b)
236.25 deducted from the child care assistance payments for up to one year and the state shall
236.26 reimburse the county for the county fees collected in this manner.
236.27 (e) For purposes of adult foster care and child foster care licensing, and licensing
236.28 the physical plant of a community residential setting, under this chapter, a county agency
236.29 may charge a fee to a corporate applicant or corporate license holder to recover the actual
236.30 cost of licensing inspections, not to exceed $500 annually.
236.31 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the
236.32 following circumstances:
236.33 (1) in cases of financial hardship;
236.34 (2) if the county has a shortage of providers in the county's area; or
236.35 (3) for new providers.

237.1 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
237.2 under subdivision 1, an applicant for an initial license or certification issued by the
237.3 commissioner shall submit a $500 application fee with each new application required
237.4 under this subdivision. An applicant for an initial day services facility license under
237.5 chapter 245D shall submit a $250 application fee with each new application. The
237.6 application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license
237.7 or certification fee that expires on December 31. The commissioner shall not process an
237.8 application until the application fee is paid.

237.9 (b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license
237.10 to provide services at a specific location.

237.11 (1) ~~For a license to provide residential-based habilitation services to persons with~~
237.12 ~~developmental disabilities under chapter 245B, an applicant shall submit an application~~
237.13 ~~for each county in which the services will be provided. Upon licensure, the license~~
237.14 ~~holder may provide services to persons in that county plus no more than three persons~~
237.15 ~~at any one time in each of up to ten additional counties. A license holder in one county~~
237.16 ~~may not provide services under the home and community-based waiver for persons with~~
237.17 ~~developmental disabilities to more than three people in a second county without holding~~
237.18 ~~a separate license for that second county. Applicants or licensees providing services~~
237.19 ~~under this clause to not more than three persons remain subject to the inspection fees~~
237.20 ~~established in section 245A.10, subdivision 2, for each location. The license issued by~~
237.21 ~~the commissioner must state the name of each additional county where services are being~~
237.22 ~~provided to persons with developmental disabilities. A license holder must notify the~~
237.23 ~~commissioner before making any changes that would alter the license information listed~~
237.24 ~~under section 245A.04, subdivision 7, paragraph (a), including any additional counties~~
237.25 ~~where persons with developmental disabilities are being served.~~ For a license to provide
237.26 home and community-based services to persons with disabilities or age 65 and older under
237.27 chapter 245D, an applicant shall submit an application to provide services statewide.

237.28 (2) ~~For a license to provide supported employment, crisis respite, or~~
237.29 ~~semi-independent living services to persons with developmental disabilities under chapter~~
237.30 ~~245B, an applicant shall submit a single application to provide services statewide.~~

237.31 ~~(3)~~ For a license to provide independent living assistance for youth under section
237.32 245A.22, an applicant shall submit a single application to provide services statewide.

237.33 ~~(4)~~ (3) For a license for a private agency to provide foster care or adoption services
237.34 under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single
237.35 application to provide services statewide.

238.1 (c) The initial application fee charged under this subdivision does not include the
238.2 temporary license surcharge under section 16E.22.

238.3 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers
238.4 shall pay an annual nonrefundable license fee based on the following schedule:

	Licensed Capacity	Child Care Center License Fee
238.5–238.6	Licensed Capacity	Child Care Center License Fee
238.7	1 to 24 persons	$200
238.8	25 to 49 persons	$300
238.9	50 to 74 persons	$400
238.10	75 to 99 persons	$500
238.11	100 to 124 persons	$600
238.12	125 to 149 persons	$700
238.13	150 to 174 persons	$800
238.14	175 to 199 persons	$900
238.15	200 to 224 persons	$1,000
238.16	225 or more persons	$1,100

238.17 ~~(b) A day training and habilitation program serving persons with developmental~~
238.18 ~~disabilities or related conditions shall pay an annual nonrefundable license fee based on~~
238.19 ~~the following schedule:~~

238.20	~~Licensed Capacity~~	~~License Fee~~
238.21	~~1 to 24 persons~~	~~$800~~
238.22	~~25 to 49 persons~~	~~$1,000~~
238.23	~~50 to 74 persons~~	~~$1,200~~
238.24	~~75 to 99 persons~~	~~$1,400~~
238.25	~~100 to 124 persons~~	~~$1,600~~
238.26	~~125 to 149 persons~~	~~$1,800~~
238.27	~~150 or more persons~~	~~$2,000~~

238.28 ~~Except as provided in paragraph (c), when a day training and habilitation program~~
238.29 ~~serves more than 50 percent of the same persons in two or more locations in a community,~~
238.30 ~~the day training and habilitation program shall pay a license fee based on the licensed~~
238.31 ~~capacity of the largest facility and the other facility or facilities shall be charged a license~~
238.32 ~~fee based on a licensed capacity of a residential program serving one to 24 persons.~~
238.33 ~~(c) When a day training and habilitation program serving persons with developmental~~
238.34 ~~disabilities or related conditions seeks a single license allowed under section 245B.07,~~
238.35 ~~subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed~~
238.36 ~~capacity for each location.~~
238.37 ~~(d) A program licensed to provide supported employment services to persons~~
238.38 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
238.39 ~~license fee of $650.~~

~~(e) A program licensed to provide crisis respite services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of $700.~~

~~(f) A program licensed to provide semi-independent living services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of $700.~~

~~(g) A program licensed to provide residential-based habilitation services under the home and community-based waiver for persons with developmental disabilities shall pay an annual license fee that includes a base rate of $690 plus $60 times the number of clients served on the first day of July of the current license year.~~

~~(h) A residential program certified by the Department of Health as an intermediate care facility for persons with developmental disabilities (ICF/MR) and a noncertified residential program licensed to provide health or rehabilitative services for persons with developmental disabilities shall pay an annual nonrefundable license fee based on the following schedule:~~

~~Licensed Capacity~~	~~License Fee~~
~~1 to 24 persons~~	~~$535~~
~~25 to 49 persons~~	~~$735~~
~~50 or more persons~~	~~$935~~

(b) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee that includes a base rate of $1,125, plus $92 times the number of persons served on the last day of June of the current license year for programs serving ten or more persons. The fee is limited to a maximum of 200 persons, regardless of the actual number of persons served. Programs serving nine or fewer persons pay only the base rate.

(c) A facility licensed under chapter 245D to provide day services shall pay an annual nonrefundable license fee of $100.

~~(i)~~ (d) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

240.1 ~~(j)~~ (e) A chemical dependency program licensed under Minnesota Rules, parts
240.2 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual
240.3 nonrefundable license fee based on the following schedule:

	Licensed Capacity	License Fee
240.4		
240.5	1 to 24 persons	$760
240.6	25 to 49 persons	$960
240.7	50 or more persons	$1,160

240.8 ~~(k)~~ (f) Except for child foster care, a residential facility licensed under Minnesota
240.9 Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee
240.10 based on the following schedule:

	Licensed Capacity	License Fee
240.11		
240.12	1 to 24 persons	$1,000
240.13	25 to 49 persons	$1,100
240.14	50 to 74 persons	$1,200
240.15	75 to 99 persons	$1,300
240.16	100 or more persons	$1,400

240.17 ~~(l)~~ (g) A residential facility licensed under Minnesota Rules, parts 9520.0500 to
240.18 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license
240.19 fee based on the following schedule:

	Licensed Capacity	License Fee
240.20		
240.21	1 to 24 persons	$2,525
240.22	25 or more persons	$2,725

240.23 ~~(m)~~ (h) A residential facility licensed under Minnesota Rules, parts 9570.2000 to
240.24 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
240.25 license fee based on the following schedule:

	Licensed Capacity	License Fee
240.26		
240.27	1 to 24 persons	$450
240.28	25 to 49 persons	$650
240.29	50 to 74 persons	$850
240.30	75 to 99 persons	$1,050
240.31	100 or more persons	$1,250

240.32 ~~(n)~~ (i) A program licensed to provide independent living assistance for youth under
240.33 section 245A.22 shall pay an annual nonrefundable license fee of $1,500.
240.34 ~~(o)~~ (j) A private agency licensed to provide foster care and adoption services under
240.35 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable
240.36 license fee of $875.

241.1 ~~(p)~~ (k) A program licensed as an adult day care center licensed under Minnesota
241.2 Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based
241.3 on the following schedule:

	Licensed Capacity	License Fee
241.5	1 to 24 persons	$500
241.6	25 to 49 persons	$700
241.7	50 to 74 persons	$900
241.8	75 to 99 persons	$1,100
241.9	100 or more persons	$1,300

241.10 ~~(q)~~ (l) A program licensed to provide treatment services to persons with sexual
241.11 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
241.12 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.
241.13 ~~(r)~~ (m) A mental health center or mental health clinic requesting certification for
241.14 purposes of insurance and subscriber contract reimbursement under Minnesota Rules,
241.15 parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the
241.16 mental health center or mental health clinic provides services at a primary location with
241.17 satellite facilities, the satellite facilities shall be certified with the primary location without
241.18 an additional charge.
241.19 Subd. 6. **License not issued until license or certification fee is paid.** The
241.20 commissioner shall not issue a license or certification until the license or certification fee
241.21 is paid. The commissioner shall send a bill for the license or certification fee to the billing
241.22 address identified by the license holder. If the license holder does not submit the license or
241.23 certification fee payment by the due date, the commissioner shall send the license holder
241.24 a past due notice. If the license holder fails to pay the license or certification fee by the
241.25 due date on the past due notice, the commissioner shall send a final notice to the license
241.26 holder informing the license holder that the program license will expire on December 31
241.27 unless the license fee is paid before December 31. If a license expires, the program is no
241.28 longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2,
241.29 must not operate after the expiration date. After a license expires, if the former license
241.30 holder wishes to provide licensed services, the former license holder must submit a new
241.31 license application and application fee under subdivision 3.
241.32 Subd. 7. **Human services licensing fees to recover expenditures.** Notwithstanding
241.33 section 16A.1285, subdivision 2, related to activities for which the commissioner charges
241.34 a fee, the commissioner must plan to fully recover direct expenditures for licensing
241.35 activities under this chapter over a five-year period. The commissioner may have
241.36 anticipated expenditures in excess of anticipated revenues in a biennium by using surplus
241.37 revenues accumulated in previous bienniums.

242.1 Subd. 8. **Deposit of license fees.** A human services licensing account is created in
242.2 the state government special revenue fund. Fees collected under subdivisions 3 and 4 must
242.3 be deposited in the human services licensing account and are annually appropriated to the
242.4 commissioner for licensing activities authorized under this chapter.

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

242.6 Sec. 10. Minnesota Statutes 2012, section 245A.11, subdivision 2a, is amended to read:
242.7 Subd. 2a. **Adult foster care and community residential setting license capacity.**
242.8 (a) The commissioner shall issue adult foster care and community residential setting
242.9 licenses with a maximum licensed capacity of four beds, including nonstaff roomers and
242.10 boarders, except that the commissioner may issue a license with a capacity of five beds,
242.11 including roomers and boarders, according to paragraphs (b) to (f).
242.12 (b) An adult foster care The license holder may have a maximum license capacity
242.13 of five if all persons in care are age 55 or over and do not have a serious and persistent
242.14 mental illness or a developmental disability.
242.15 (c) The commissioner may grant variances to paragraph (b) to allow a foster care
242.16 provider facility with a licensed capacity of five persons to admit an individual under the
242.17 age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of
242.18 the variance is recommended by the county in which the licensed foster care provider
242.19 facility is located.
242.20 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
242.21 bed for emergency crisis services for a person with serious and persistent mental illness
242.22 or a developmental disability, regardless of age, if the variance complies with section
242.23 245A.04, subdivision 9, and approval of the variance is recommended by the county in
242.24 which the licensed foster care provider facility is located.
242.25 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of a
242.26 fifth bed for respite services, as defined in section 245A.02, for persons with disabilities,
242.27 regardless of age, if the variance complies with sections 245A.03, subdivision 7, and
242.28 245A.04, subdivision 9, and approval of the variance is recommended by the county in
242.29 which the licensed foster care provider facility is licensed located. Respite care may be
242.30 provided under the following conditions:
242.31 (1) staffing ratios cannot be reduced below the approved level for the individuals
242.32 being served in the home on a permanent basis;
242.33 (2) no more than two different individuals can be accepted for respite services in
242.34 any calendar month and the total respite days may not exceed 120 days per program in
242.35 any calendar year;

243.1 (3) the person receiving respite services must have his or her own bedroom, which
243.2 could be used for alternative purposes when not used as a respite bedroom, and cannot be
243.3 the room of another person who lives in the ~~foster care home~~ facility; and

243.4 (4) individuals living in the ~~foster care home~~ facility must be notified when the
243.5 variance is approved. The provider must give 60 days' notice in writing to the residents
243.6 and their legal representatives prior to accepting the first respite placement. Notice must
243.7 be given to residents at least two days prior to service initiation, or as soon as the license
243.8 holder is able if they receive notice of the need for respite less than two days prior to
243.9 initiation, each time a respite client will be served, unless the requirement for this notice is
243.10 waived by the resident or legal guardian.

243.11 (f) The commissioner may issue an adult foster care or community residential setting
243.12 license with a capacity of five adults if the fifth bed does not increase the overall statewide
243.13 capacity of licensed adult foster care or community residential setting beds in homes that
243.14 are not the primary residence of the license holder, as identified in a plan submitted to the
243.15 commissioner by the county, when the capacity is recommended by the county licensing
243.16 agency of the county in which the facility is located and if the recommendation verifies that:

243.17 (1) the facility meets the physical environment requirements in the adult foster
243.18 care licensing rule;

243.19 (2) the five-bed living arrangement is specified for each resident in the resident's:

243.20 (i) individualized plan of care;

243.21 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

243.22 (iii) individual resident placement agreement under Minnesota Rules, part
243.23 9555.5105, subpart 19, if required;

243.24 (3) the license holder obtains written and signed informed consent from each
243.25 resident or resident's legal representative documenting the resident's informed choice
243.26 to remain living in the home and that the resident's refusal to consent would not have
243.27 resulted in service termination; and

243.28 (4) the facility was licensed for adult foster care before March 1, 2011.

243.29 (g) The commissioner shall not issue a new adult foster care license under paragraph
243.30 (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care
243.31 license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five
243.32 adults if the license holder continues to comply with the requirements in paragraph (f).

243.33 Sec. 11. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

243.34 Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The
243.35 commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts

244.1 requiring a caregiver to be present in an adult foster care home during normal sleeping
244.2 hours to allow for alternative methods of overnight supervision. The commissioner may
244.3 grant the variance if the local county licensing agency recommends the variance and the
244.4 county recommendation includes documentation verifying that:

244.5 (1) the county has approved the license holder's plan for alternative methods of
244.6 providing overnight supervision and determined the plan protects the residents' health,
244.7 safety, and rights;

244.8 (2) the license holder has obtained written and signed informed consent from
244.9 each resident or each resident's legal representative documenting the resident's or legal
244.10 representative's agreement with the alternative method of overnight supervision; and

244.11 (3) the alternative method of providing overnight supervision, which may include
244.12 the use of technology, is specified for each resident in the resident's: (i) individualized
244.13 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if
244.14 required; or (iii) individual resident placement agreement under Minnesota Rules, part
244.15 9555.5105, subpart 19, if required.

244.16 (b) To be eligible for a variance under paragraph (a), the adult foster care license
244.17 holder must not have had a conditional license issued under section 245A.06, or any
244.18 other licensing sanction issued under section 245A.07 during the prior 24 months based
244.19 on failure to provide adequate supervision, health care services, or resident safety in
244.20 the adult foster care home.

244.21 (c) A license holder requesting a variance under this subdivision to utilize
244.22 technology as a component of a plan for alternative overnight supervision may request
244.23 the commissioner's review in the absence of a county recommendation. Upon receipt of
244.24 such a request from a license holder, the commissioner shall review the variance request
244.25 with the county.

244.26 (d) A variance granted by the commissioner according to this subdivision before
244.27 January 1, 2014, to a license holder for an adult foster care home must transfer with the
244.28 license when the license converts to a community residential setting license under chapter
244.29 245D. The terms and conditions of the variance remain in effect as approved at the time
244.30 the variance was granted.

244.31 Sec. 12. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:

244.32 Subd. 7a. **Alternate overnight supervision technology; adult foster care ~~license~~**
244.33 **and community residential setting licenses.** (a) The commissioner may grant an
244.34 applicant or license holder an adult foster care or community residential setting license
244.35 for a residence that does not have a caregiver in the residence during normal sleeping

245.1 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section
245.2 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder
245.3 when an incident occurs that may jeopardize the health, safety, or rights of a foster
245.4 care recipient. The applicant or license holder must comply with all other requirements
245.5 under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under
245.6 chapter 245D, and the requirements under this subdivision. The license printed by the
245.7 commissioner must state in bold and large font:

245.8 (1) that the facility is under electronic monitoring; and

245.9 (2) the telephone number of the county's common entry point for making reports of
245.10 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

245.11 (b) Applications for a license under this section must be submitted directly to
245.12 the Department of Human Services licensing division. The licensing division must
245.13 immediately notify the ~~host county and lead county contract agency and the host~~ county
245.14 licensing agency. The licensing division must collaborate with the county licensing
245.15 agency in the review of the application and the licensing of the program.

245.16 (c) Before a license is issued by the commissioner, and for the duration of the
245.17 license, the applicant or license holder must establish, maintain, and document the
245.18 implementation of written policies and procedures addressing the requirements in
245.19 paragraphs (d) through (f).

245.20 (d) The applicant or license holder must have policies and procedures that:

245.21 (1) establish characteristics of target populations that will be admitted into the home,
245.22 and characteristics of populations that will not be accepted into the home;

245.23 (2) explain the discharge process when a ~~foster care recipient~~ resident served by the
245.24 program requires overnight supervision or other services that cannot be provided by the
245.25 license holder due to the limited hours that the license holder is on site;

245.26 (3) describe the types of events to which the program will respond with a physical
245.27 presence when those events occur in the home during time when staff are not on site, and
245.28 how the license holder's response plan meets the requirements in paragraph (e), clause
245.29 (1) or (2);

245.30 (4) establish a process for documenting a review of the implementation and
245.31 effectiveness of the response protocol for the response required under paragraph (e),
245.32 clause (1) or (2). The documentation must include:

245.33 (i) a description of the triggering incident;

245.34 (ii) the date and time of the triggering incident;

245.35 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);

245.36 (iv) whether the response met the resident's needs;

246.1 (v) whether the existing policies and response protocols were followed; and
246.2 (vi) whether the existing policies and protocols are adequate or need modification.
246.3 When no physical presence response is completed for a three-month period, the
246.4 license holder's written policies and procedures must require a physical presence response
246.5 drill to be conducted for which the effectiveness of the response protocol under paragraph
246.6 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and
246.7 (5) establish that emergency and nonemergency phone numbers are posted in a
246.8 prominent location in a common area of the home where they can be easily observed by a
246.9 person responding to an incident who is not otherwise affiliated with the home.
246.10 (e) The license holder must document and include in the license application which
246.11 response alternative under clause (1) or (2) is in place for responding to situations that
246.12 present a serious risk to the health, safety, or rights of ~~people receiving foster care services~~
246.13 ~~in the home~~ residents served by the program:
246.14 (1) response alternative (1) requires only the technology to provide an electronic
246.15 notification or alert to the license holder that an event is underway that requires a response.
246.16 Under this alternative, no more than ten minutes will pass before the license holder will be
246.17 physically present on site to respond to the situation; or
246.18 (2) response alternative (2) requires the electronic notification and alert system under
246.19 alternative (1), but more than ten minutes may pass before the license holder is present on
246.20 site to respond to the situation. Under alternative (2), all of the following conditions are met:
246.21 (i) the license holder has a written description of the interactive technological
246.22 applications that will assist the license holder in communicating with and assessing the
246.23 needs related to the care, health, and safety of the foster care recipients. This interactive
246.24 technology must permit the license holder to remotely assess the well being of the ~~foster~~
246.25 ~~care recipient~~ resident served by the program without requiring the initiation of the
246.26 foster care recipient. Requiring the foster care recipient to initiate a telephone call does
246.27 not meet this requirement;
246.28 (ii) the license holder documents how the remote license holder is qualified and
246.29 capable of meeting the needs of the foster care recipients and assessing foster care
246.30 recipients' needs under item (i) during the absence of the license holder on site;
246.31 (iii) the license holder maintains written procedures to dispatch emergency response
246.32 personnel to the site in the event of an identified emergency; and
246.33 (iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual~~
246.34 ~~service plan~~ coordinated service and support plan under ~~section~~ sections 256B.0913,
246.35 subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49,
246.36 subdivision 15, if required, or individual resident placement agreement under Minnesota

Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time, which may be greater than ten minutes, for the license holder to be on site for that ~~foster care recipient~~ resident.

(f) Each ~~foster care recipient's~~ resident's placement agreement, individual service agreement, and plan must clearly state that the adult foster care or community residential setting license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents served by the program under paragraph (e), clause (1) or (2); and a signed informed consent from each ~~foster care recipient~~ resident served by the program or the person's legal representative documenting the person's or legal representative's agreement with placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

(1) how any electronic monitoring is incorporated into the alternative supervision system;

(2) the backup system for any electronic monitoring in times of electrical outages or other equipment malfunctions;

(3) how the caregivers or direct support staff are trained on the use of the technology;

(4) the event types and license holder response times established under paragraph (e);

(5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy related to electronic monitoring and related to any electronically recorded data generated by the monitoring system. A ~~foster care recipient~~ resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring. The consent form must explain where and how the electronically recorded data is stored, with whom it will be shared, and how long it is retained; and

(6) the risks and benefits of the alternative overnight supervision system.

The written explanations under clauses (1) to (6) may be accomplished through cross-references to other policies and procedures as long as they are explained to the person giving consent, and the person giving consent is offered a copy.

(g) Nothing in this section requires the applicant or license holder to develop or maintain separate or duplicative policies, procedures, documentation, consent forms, or individual plans that may be required for other licensing standards, if the requirements of this section are incorporated into those documents.

(h) The commissioner may grant variances to the requirements of this section according to section 245A.04, subdivision 9.

248.1 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning
248.2 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
248.3 contractors affiliated with the license holder.

248.4 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
248.5 remotely determine what action the license holder needs to take to protect the well-being
248.6 of the foster care recipient.

248.7 (k) The commissioner shall evaluate license applications using the requirements
248.8 in paragraphs (d) to (f). The commissioner shall provide detailed application forms,
248.9 including a checklist of criteria needed for approval.

248.10 (l) To be eligible for a license under paragraph (a), the adult foster care or community
248.11 residential setting license holder must not have had a conditional license issued under
248.12 section 245A.06 or any licensing sanction under section 245A.07 during the prior 24
248.13 months based on failure to provide adequate supervision, health care services, or resident
248.14 safety in the adult foster care home or community residential setting.

248.15 (m) The commissioner shall review an application for an alternative overnight
248.16 supervision license within 60 days of receipt of the application. When the commissioner
248.17 receives an application that is incomplete because the applicant failed to submit required
248.18 documents or that is substantially deficient because the documents submitted do not meet
248.19 licensing requirements, the commissioner shall provide the applicant written notice
248.20 that the application is incomplete or substantially deficient. In the written notice to the
248.21 applicant, the commissioner shall identify documents that are missing or deficient and
248.22 give the applicant 45 days to resubmit a second application that is substantially complete.
248.23 An applicant's failure to submit a substantially complete application after receiving
248.24 notice from the commissioner is a basis for license denial under section 245A.05. The
248.25 commissioner shall complete subsequent review within 30 days.

248.26 (n) Once the application is considered complete under paragraph (m), the
248.27 commissioner will approve or deny an application for an alternative overnight supervision
248.28 license within 60 days.

248.29 (o) For the purposes of this subdivision, "supervision" means:

248.30 (1) oversight by a caregiver or direct support staff as specified in the individual
248.31 resident's place agreement or coordinated service and support plan and awareness of the
248.32 resident's needs and activities; and

248.33 (2) the presence of a caregiver or direct support staff in a residence during normal
248.34 sleeping hours, unless a determination has been made and documented in the individual's
248.35 coordinated service and support plan that the individual does not require the presence of a
248.36 caregiver or direct support staff during normal sleeping hours.

249.1 Sec. 13. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:
249.2 Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care
249.3 <u>or community residential setting</u> license holder who creates, collects, records, maintains,
249.4 stores, or discloses any individually identifiable recipient data, whether in an electronic
249.5 or any other format, must comply with the privacy and security provisions of applicable
249.6 privacy laws and regulations, including:
249.7 (1) the federal Health Insurance Portability and Accountability Act of 1996
249.8 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
249.9 title 45, part 160, and subparts A and E of part 164; and
249.10 (2) the Minnesota Government Data Practices Act as codified in chapter 13.
249.11 (b) For purposes of licensure, the license holder shall be monitored for compliance
249.12 with the following data privacy and security provisions:
249.13 (1) the license holder must control access to data on ~~foster care recipients~~ <u>residents</u>
249.14 <u>served by the program</u> according to the definitions of public and private data on individuals
249.15 under section 13.02; classification of the data on individuals as private under section
249.16 13.46, subdivision 2; and control over the collection, storage, use, access, protection,
249.17 and contracting related to data according to section 13.05, in which the license holder is
249.18 assigned the duties of a government entity;
249.19 (2) the license holder must provide each ~~foster care recipient~~ <u>resident served by</u>
249.20 <u>the program</u> with a notice that meets the requirements under section 13.04, in which
249.21 the license holder is assigned the duties of the government entity, and that meets the
249.22 requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall
249.23 describe the purpose for collection of the data, and to whom and why it may be disclosed
249.24 pursuant to law. The notice must inform the ~~recipient~~ <u>individual</u> that the license holder
249.25 uses electronic monitoring and, if applicable, that recording technology is used;
249.26 (3) the license holder must not install monitoring cameras in bathrooms;
249.27 (4) electronic monitoring cameras must not be concealed from the ~~foster care~~
249.28 ~~recipients~~ <u>residents served by the program</u>; and
249.29 (5) electronic video and audio recordings of ~~foster care recipients~~ <u>residents served</u>
249.30 <u>by the program</u> shall be stored by the license holder for five days unless: (i) a ~~foster care~~
249.31 ~~recipient~~ <u>resident served by the program</u> or legal representative requests that the recording
249.32 be held longer based on a specific report of alleged maltreatment; or (ii) the recording
249.33 captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or
249.34 a crime under chapter 609. When requested by a ~~recipient~~ <u>resident served by the program</u>
249.35 or when a recording captures an incident or event of alleged maltreatment or a crime, the
249.36 license holder must maintain the recording in a secured area for no longer than 30 days

to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in section 626.557, subdivision 12b.

(c) The commissioner shall develop, and make available to license holders and county licensing workers, a checklist of the data privacy provisions to be monitored for purposes of licensure.

Sec. 14. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, 2012, as a component of the quality outcome standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

(b) Providers licensed under chapter 245B, and providing, contracting, or arranging for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105 to 9555.6265~~, or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340~~; and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b)~~ section 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

Sec. 15. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06, or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

251.1 (5) variances regarding disqualified individuals except that county agencies may
251.2 issue variances under section 245C.30 regarding disqualified individuals when the county
251.3 is responsible for conducting a consolidated reconsideration according to sections 245C.25
251.4 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
251.5 and a disqualification based on serious or recurring maltreatment; ~~and~~
251.6 (6) the required presence of a caregiver in the adult foster care residence during
251.7 normal sleeping hours; and
251.8 (7) variances for community residential setting licenses under chapter 245D.
251.9 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency
251.10 must not grant a license holder a variance to exceed the maximum allowable family child
251.11 care license capacity of 14 children.
251.12 (b) County agencies must report information about disqualification reconsiderations
251.13 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances
251.14 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
251.15 prescribed by the commissioner.
251.16 (c) For family day care programs, the commissioner may authorize licensing reviews
251.17 every two years after a licensee has had at least one annual review.
251.18 (d) For family adult day services programs, the commissioner may authorize
251.19 licensing reviews every two years after a licensee has had at least one annual review.
251.20 (e) A license issued under this section may be issued for up to two years.

251.21 Sec. 16. Minnesota Statutes 2012, section 245D.02, is amended to read:

251.22 **245D.02 DEFINITIONS.**
251.23 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given
251.24 them in this section.
251.25 Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given
251.26 in section 245A.02, subdivision 2b.
251.27 Subd. 3. **Case manager.** "Case manager" means the individual designated
251.28 to provide waiver case management services, care coordination, or long-term care
251.29 consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,
251.30 or successor provisions.
251.31 Subd. 3a. **Certification.** "Certification" means the commissioner's written
251.32 authorization for a license holder to provide specialized services based on certification
251.33 standards in section 245D.33. The term certification and its derivatives have the same
251.34 meaning and may be substituted for the term licensure and its derivatives in this chapter
251.35 and chapter 245A.

252.1 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the
252.2 Department of Human Services or the commissioner's designated representative.
252.3 Subd. 4a. **Community residential setting.** "Community residential setting" means
252.4 a residential program as identified in section 245A.11, subdivision 8, where residential
252.5 supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause
252.6 (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant
252.7 of the facility licensed according to this chapter, and the license holder does not reside
252.8 in the facility.
252.9 Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support
252.10 plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision
252.11 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.
252.12 Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated
252.13 service and support plan addendum" means the documentation that this chapter requires
252.14 of the license holder for each person receiving services.
252.15 Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster
252.16 residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340,
252.17 or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to
252.18 9555.6265, where the license holder does not live in the home.
252.19 Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence"
252.20 or "culturally competent" means the ability and the will to respond to the unique needs of
252.21 a person that arise from the person's culture and the ability to use the person's culture as a
252.22 resource or tool to assist with the intervention and help meet the person's needs.
252.23 Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed
252.24 according to this chapter at which persons receive day services licensed under this chapter
252.25 from the license holder's direct support staff for a cumulative total of more than 30 days
252.26 within any 12-month period and the license holder is the owner, lessor, or tenant of the
252.27 facility.
252.28 Subd. 5. **Department.** "Department" means the Department of Human Services.
252.29 Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
252.30 subdivision 11, and is used interchangeably with the term "direct support service."
252.31 Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means
252.32 employees of the license holder who have direct contact with persons served by the
252.33 program and includes temporary staff or subcontractors, regardless of employer, providing
252.34 program services for hire under the control of the license holder who have direct contact
252.35 with persons served by the program.
252.36 Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

253.1 Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary
253.2 daily operation of the program including, but not limited to, fires, severe weather, natural
253.3 disasters, power failures, or other events that threaten the immediate health and safety of
253.4 a person receiving services and that require calling 911, emergency evacuation, moving
253.5 to an emergency shelter, or temporary closure or relocation of the program to another
253.6 facility or service site for more than 24 hours.

253.7 Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual
253.8 restraint" means using a manual restraint when a person's conduct poses an imminent risk
253.9 of physical harm to self or others and less restrictive strategies would not achieve safety.
253.10 Property damage, verbal aggression, or a person's refusal to receive or participate in
253.11 treatment or programming on their own, do not constitute an emergency.

253.12 Subd. 8b. **Expanded support team.** "Expanded support team" means the members
253.13 of the support team defined in subdivision 46, and a licensed health professional or other
253.14 licensed, certified, or qualified professionals or consultants working with the person and
253.15 included in the team at the request of the person or the person's legal representative.

253.16 Subd. 8c. **Family foster care.** "Family foster care" means a child foster family
253.17 setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult
253.18 foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265,
253.19 where the license holder lives in the home.

253.20 Subd. 9. **Health services.** "Health services" means any service or treatment
253.21 consistent with the physical and mental health needs of the person, such as medication
253.22 administration and monitoring, medical, dental, nutritional, health monitoring, wellness
253.23 education, and exercise.

253.24 Subd. 10. **Home and community-based services.** "Home and community-based
253.25 services" means the services ~~subject to the provisions of this chapter~~ identified in section
253.26 245D.03, subdivision 1, and as defined in:

253.27 (1) the ~~federal~~ federally approved waiver plans governed by United States Code,
253.28 title 42, sections 1396 et seq., ~~or the state's alternative care program according to section~~
253.29 ~~256B.0913,~~ including the waivers for persons with disabilities under section 256B.49,
253.30 subdivision 11, including the brain injury (BI) waiver~~,~~ plan; the community alternative
253.31 care (CAC) waiver~~,~~ plan; the community alternatives for disabled individuals (CADI)
253.32 waiver~~,~~ plan; the developmental disability (DD) waiver~~,~~ plan under section 256B.092,
253.33 subdivision 5; the elderly waiver (EW)~~, and~~ plan under section 256B.0915, subdivision 1;
253.34 or successor plans respective to each waiver; or

253.35 (2) the alternative care (AC) program under section 256B.0913.

254.1 Subd. 11. **Incident.** "Incident" means an occurrence ~~that affects the~~ which involves
254.2 a person and requires the program to make a response that is not a part of the program's
254.3 ordinary provision of services to ~~a~~ that person, and includes ~~any of the following~~:
254.4 (1) serious injury of a person as determined by section 245.91, subdivision 6;
254.5 (2) a person's death;
254.6 (3) any medical emergency, unexpected serious illness, or significant unexpected
254.7 change in an illness or medical condition~~, or the mental health status~~ of a person that
254.8 requires ~~calling~~ the program to call 911 ~~or a mental health crisis intervention team~~,
254.9 physician treatment, or hospitalization;
254.10 (4) any mental health crisis that requires the program to call 911 or a mental health
254.11 crisis intervention team;
254.12 (5) an act or situation involving a person that requires the program to call 911,
254.13 law enforcement, or the fire department;
254.14 ~~(4)~~ (6) a person's unauthorized or unexplained absence from a program;
254.15 ~~(5)~~ (7) ~~physical aggression~~ conduct by a person receiving services against another
254.16 person receiving services that ~~causes physical pain, injury, or persistent emotional distress,~~
254.17 ~~including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting,~~
254.18 ~~pushing, and spitting;~~:
254.19 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with
254.20 a person's opportunities to participate in or receive service or support;
254.21 (ii) places the person in actual and reasonable fear of harm;
254.22 (iii) places the person in actual and reasonable fear of damage to property of the
254.23 person; or
254.24 (iv) substantially disrupts the orderly operation of the program;
254.25 ~~(6)~~ (8) any sexual activity between persons receiving services involving force or
254.26 coercion as defined under section 609.341, subdivisions 3 and 14; ~~or~~
254.27 (9) any emergency use of manual restraint as identified in section 245D.061; or
254.28 ~~(7)~~ (10) a report of alleged or suspected child or vulnerable adult maltreatment
254.29 under section 626.556 or 626.557.
254.30 Subd. 11a. **Intermediate care facility for persons with developmental disabilities**
254.31 **or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or
254.32 "ICF/DD" means a residential program licensed to serve four or more persons with
254.33 developmental disabilities under section 252.28 and chapter 245A and licensed as a
254.34 supervised living facility under chapter 144, which together are certified by the Department
254.35 of Health as an intermediate care facility for persons with developmental disabilities.

255.1 Subd. 11b. **Least restrictive alternative.** "Least restrictive alternative" means
255.2 the alternative method for providing supports and services that is the least intrusive and
255.3 most normalized given the level of supervision and protection required for the person.
255.4 This level of supervision and protection allows risk taking to the extent that there is no
255.5 reasonable likelihood that serious harm will happen to the person or others.

255.6 Subd. 12. **Legal representative.** "Legal representative" means the parent of a
255.7 person who is under 18 years of age, a court-appointed guardian, or other representative
255.8 with legal authority to make decisions about services for a person. A person who is a
255.9 competent adult may authorize another competent adult to represent their rights as allowed
255.10 in section 245D.04, subdivision 3, paragraph (a), clause (11), when the person provides
255.11 written informed consent for a release of information.

255.12 Subd. 13. **License.** "License" has the meaning given in section 245A.02,
255.13 subdivision 8.

255.14 Subd. 14. **Licensed health professional.** "Licensed health professional" means a
255.15 person licensed in Minnesota to practice those professions described in section 214.01,
255.16 subdivision 2.

255.17 Subd. 15. **License holder.** "License holder" has the meaning given in section
255.18 245A.02, subdivision 9.

255.19 Subd. 16. **Medication.** "Medication" means a prescription drug or over-the-counter
255.20 drug. For purposes of this chapter, "medication" includes dietary supplements.

255.21 ~~Subd. 17.~~ ~~**Medication administration.**~~ ~~"Medication administration" means~~
255.22 ~~performing the following set of tasks to ensure a person takes both prescription and~~
255.23 ~~over-the-counter medications and treatments according to orders issued by appropriately~~
255.24 ~~licensed professionals, and includes the following:~~

255.25 ~~(1) checking the person's medication record;~~

255.26 ~~(2) preparing the medication for administration;~~

255.27 ~~(3) administering the medication to the person;~~

255.28 ~~(4) documenting the administration of the medication or the reason for not~~
255.29 ~~administering the medication; and~~

255.30 ~~(5) reporting to the prescriber or a nurse any concerns about the medication,~~
255.31 ~~including side effects, adverse reactions, effectiveness, or the person's refusal to take the~~
255.32 ~~medication or the person's self-administration of the medication.~~

255.33 ~~Subd. 18.~~ ~~**Medication assistance.**~~ ~~"Medication assistance" means providing verbal~~
255.34 ~~or visual reminders to take regularly scheduled medication, which includes either of~~
255.35 ~~the following:~~

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

~~(2) providing verbal or visual reminders to perform regularly scheduled treatments and exercises.~~

~~Subd. 19.~~ ~~**Medication management.**~~ ~~"Medication management" means the provision of any of the following:~~

~~(1) medication-related services to a person;~~

~~(2) medication setup;~~

~~(3) medication administration;~~

~~(4) medication storage and security;~~

~~(5) medication documentation and charting;~~

~~(6) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;~~

~~(7) coordination of medication refills;~~

~~(8) handling changes to prescriptions and implementation of those changes;~~

~~(9) communicating with the pharmacy; or~~

~~(10) coordination and communication with prescriber.~~

~~For the purposes of this chapter, medication management does not mean "medication therapy management services" as identified in section 256B.0625, subdivision 13h.~~

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response ~~providers~~ provider as identified in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children.

Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.

Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription."

Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by the person that can be observed, measured, and determined reliable and valid.

Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision 11.

257.1 Subd. 23. **Person with a disability.** "Person with a disability" means a person
257.2 determined to have a disability by the commissioner's state medical review team as
257.3 identified in section 256B.055, subdivision 7, the Social Security Administration, or
257.4 the person is determined to have a developmental disability as defined in Minnesota
257.5 Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section
257.6 252.27, subdivision 1a.

257.7 Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter
257.8 147.

257.9 Subd. 24. **Prescriber.** "Prescriber" means a ~~licensed practitioner as defined in~~
257.10 ~~section 151.01, subdivision 23,~~ person who is authorized under ~~section~~ sections 148.235;
257.11 151.01, subdivision 23; or 151.37 to prescribe drugs. ~~For the purposes of this chapter, the~~
257.12 ~~term "prescriber" is used interchangeably with "physician."~~

257.13 Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section
257.14 151.01, subdivision ~~17~~ 16.

257.15 Subd. 26. **Program.** "Program" means either the nonresidential or residential
257.16 program as defined in section 245A.02, subdivisions 10 and 14.

257.17 Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any
257.18 medication prescribed to treat the symptoms of mental illness that affect thought processes,
257.19 mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic
257.20 (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and
257.21 stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder.
257.22 Other miscellaneous medications are considered to be a psychotropic medication when
257.23 they are specifically prescribed to treat a mental illness or to control or alter behavior.

257.24 Subd. 28. **Restraint.** "Restraint" means physical or mechanical limiting of the free
257.25 and normal movement of body or limbs.

257.26 Subd. 29. **Seclusion.** "Seclusion" means ~~separating a person from others in a way~~
257.27 ~~that prevents social contact and prevents the person from leaving the situation if he or she~~
257.28 ~~chooses~~ the placement of a person alone in a room from which exit is prohibited by a staff
257.29 person or a mechanism such as a lock, a device, or an object positioned to hold the door
257.30 closed or otherwise prevent the person from leaving the room.

257.31 Subd. 29a. **Self-determination.** "Self-determination" means the person makes
257.32 decisions independently, plans for the person's own future, determines how money is spent
257.33 for the person's supports, and takes responsibility for making these decisions. If a person
257.34 has a legal representative, the legal representative's decision-making authority is limited to
257.35 the scope of authority granted by the court or allowed in the document authorizing the
257.36 legal representative to act.

258.1 Subd. 29b. **Semi-independent living services.** "Semi-independent living services"
258.2 has the meaning given in section 252.275.
258.3 Subd. 30. **Service.** "Service" means care, training, supervision, counseling,
258.4 consultation, or medication assistance assigned to the license holder in the coordinated
258.5 service and support plan.
258.6 ~~Subd. 31. **Service plan.** "Service plan" means the individual service plan or~~
258.7 ~~individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,~~
258.8 ~~or successor provisions, and includes any support plans or service needs identified as~~
258.9 ~~a result of long-term care consultation, or a support team meeting that includes the~~
258.10 ~~participation of the person, the person's legal representative, and case manager, or assigned~~
258.11 ~~to a license holder through an authorized service agreement.~~
258.12 Subd. 32. **Service site.** "Service site" means the location where the service is
258.13 provided to the person, including, but not limited to, a facility licensed according to
258.14 chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's
258.15 own home; or a community-based location.
258.16 ~~Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a~~
258.17 ~~person served by the facility, agency, or program.~~
258.18 Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning
258.19 given in Minnesota Rules, part 4665.0100, subpart 10.
258.20 Subd. 33b. **Supervision.** (a) "Supervision" means:
258.21 (1) oversight by direct support staff as specified in the person's coordinated service
258.22 and support plan and awareness of the person's needs and activities;
258.23 (2) responding to situations that present a serious risk to the health, safety, or rights
258.24 of the person while services are being provided; and
258.25 (3) the presence of direct support staff at a service site while services are being
258.26 provided, unless a determination has been made and documented in the person's
258.27 coordinated service and support plan that the person does not require the presence of direct
258.28 support staff while services are being provided.
258.29 (b) For the purposes of this definition, "while services are being provided," means
258.30 any period of time during which the license holder will seek reimbursement for services.
258.31 Subd. 34. **Support team.** "Support team" means the service planning team
258.32 identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in
258.33 Minnesota Rules, part 9525.0004, subpart 14.
258.34 Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an
258.35 ongoing activity to a room, either locked or unlocked, or otherwise separating a person

259.1 from others in a way that prevents social contact and prevents the person from leaving the
259.2 situation if the person chooses.

259.3 Subd. 35. **Unit of government.** "Unit of government" means every city, county,
259.4 town, school district, other political subdivisions of the state, and any agency of the state
259.5 or the United States, and includes any instrumentality of a unit of government.

259.6 Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than
259.7 medications, ordered or prescribed by a licensed health professional, provided to a person
259.8 to cure, rehabilitate, or ease symptoms.

259.9 Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the
259.10 license holder, provides direct services without pay to a person served by the license holder.

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

259.12 Sec. 17. Minnesota Statutes 2012, section 245D.03, is amended to read:

259.13 **245D.03 APPLICABILITY AND EFFECT.**

259.14 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of
259.15 home and community-based services to persons with disabilities and persons age 65 and
259.16 older pursuant to this chapter. The licensing standards in this chapter govern the provision
259.17 of the following basic support services: and intensive support services.

259.18 (1) housing access coordination as defined under the current BI, CADI, and DD
259.19 waiver plans or successor plans;

259.20 (2) respite services as defined under the current CADI, BI, CAC, DD, and EW
259.21 waiver plans or successor plans when the provider is an individual who is not an employee
259.22 of a residential or nonresidential program licensed by the Department of Human Services
259.23 or the Department of Health that is otherwise providing the respite service;

259.24 (3) behavioral programming as defined under the current BI and CADI waiver
259.25 plans or successor plans;

259.26 (4) specialist services as defined under the current DD waiver plan or successor plans;

259.27 (5) companion services as defined under the current BI, CADI, and EW waiver
259.28 plans or successor plans, excluding companion services provided under the Corporation
259.29 for National and Community Services Senior Companion Program established under the
259.30 Domestic Volunteer Service Act of 1973, Public Law 98-288;

259.31 (6) personal support as defined under the current DD waiver plan or successor plans;

259.32 (7) 24-hour emergency assistance, on-call and personal emergency response as
259.33 defined under the current CADI and DD waiver plans or successor plans;

~~(8) night supervision services as defined under the current BI waiver plan or successor plans;~~

~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW waiver plans or successor plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only;~~

~~(10) independent living skills training as defined under the current BI and CADI waiver plans or successor plans;~~

~~(11) prevocational services as defined under the current BI and CADI waiver plans or successor plans;~~

~~(12) structured day services as defined under the current BI waiver plan or successor plans; or~~

~~(13) supported employment as defined under the current BI and CADI waiver plans or successor plans.~~

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and safety of the person and do not include services that are specifically directed toward the training, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community alternatives for disabled individuals, developmental disability, and elderly waiver plans;

(2) companion services as defined under the brain injury, community alternatives for disabled individuals, and elderly waiver plans, excluding companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community alternatives for disabled individuals and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan; and

(6) homemaker services as defined under the community alternatives for disabled individuals, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and safety of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

261.1 (1) intervention services, including:
261.2 (i) behavioral support services as defined under the brain injury and community
261.3 alternatives for disabled individuals waiver plans;
261.4 (ii) in-home or out-of-home crisis respite services as defined under the developmental
261.5 disability waiver plan; and
261.6 (iii) specialist services as defined under the current developmental disability waiver
261.7 plan;
261.8 (2) in-home support services, including:
261.9 (i) in-home family support and supported living services as defined under the
261.10 developmental disability waiver plan;
261.11 (ii) independent living services training as defined under the brain injury and
261.12 community alternatives for disabled individuals waiver plans; and
261.13 (iii) semi-independent living services;
261.14 (3) residential supports and services, including:
261.15 (i) supported living services as defined under the developmental disability waiver
261.16 plan provided in a family or corporate child foster care residence, a family adult foster
261.17 care residence, a community residential setting, or a supervised living facility;
261.18 (ii) foster care services as defined in the brain injury, community alternative care,
261.19 and community alternatives for disabled individuals waiver plans provided in a family or
261.20 corporate child foster care residence, a family adult foster care residence, or a community
261.21 residential setting; and
261.22 (iii) residential services provided in a supervised living facility that is certified by
261.23 the Department of Health as an ICF/DD;
261.24 (4) day services, including:
261.25 (i) structured day services as defined under the brain injury waiver plan;
261.26 (ii) day training and habilitation services under sections 252.40 to 252.46, and as
261.27 defined under the developmental disability waiver plan; and
261.28 (iii) prevocational services as defined under the brain injury and community
261.29 alternatives for disabled individuals waiver plans; and
261.30 (5) supported employment as defined under the brain injury, developmental
261.31 disability, and community alternatives for disabled individuals waiver plans.
261.32 Subd. 2. **Relationship to other standards governing home and community-based**
261.33 **services.** (a) A license holder governed by this chapter is also subject to the licensure
261.34 requirements under chapter 245A.
261.35 (b) ~~A license holder concurrently providing child foster care services licensed~~
261.36 ~~according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed~~

262.1 under this chapter is exempt from section 245D.04 as it applies to the person. A corporate
262.2 or family child foster care site controlled by a license holder and providing services
262.3 governed by this chapter is exempt from compliance with section 245D.04. This exemption
262.4 applies to foster care homes where at least one resident is receiving residential supports
262.5 and services licensed according to this chapter. This chapter does not apply to corporate or
262.6 family child foster care homes that do not provide services licensed under this chapter.

262.7 (c) A family adult foster care site controlled by a license holder and providing
262.8 services governed by this chapter is exempt from compliance with Minnesota Rules, parts
262.9 9555.6185; 9555.6225, subpart 8; 9555.6235, item C; 9555.6245; 9555.6255, subpart
262.10 2; and 9555.6265. These exemptions apply to family adult foster care homes where at
262.11 least one resident is receiving residential supports and services licensed according to this
262.12 chapter. This chapter does not apply to family adult foster care homes that do not provide
262.13 services licensed under this chapter.

262.14 (d) A license holder providing services licensed according to this chapter in a
262.15 supervised living facility is exempt from compliance with sections 245D.04; 245D.05,
262.16 subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).

262.17 (e) A license holder providing residential services to persons in an ICF/DD is exempt
262.18 from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision
262.19 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09,
262.20 subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

262.21 (c) (f) A license holder concurrently providing home care homemaker services
262.22 registered licensed according to sections 144A.43 to 144A.49 to the same person receiving
262.23 home management services licensed under this chapter and registered according to chapter
262.24 144A is exempt from compliance with section 245D.04 as it applies to the person.

262.25 (d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt
262.26 from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557,
262.27 subdivision 14, paragraph (b).

262.28 (e) Notwithstanding section 245D.06, subdivision 5, a license holder providing
262.29 structured day, prevocational, or supported employment services under this chapter
262.30 and day training and habilitation or supported employment services licensed under
262.31 chapter 245B within the same program is exempt from compliance with this chapter
262.32 when the license holder notifies the commissioner in writing that the requirements under
262.33 chapter 245B will be met for all persons receiving these services from the program. For
262.34 the purposes of this paragraph, if the license holder has obtained approval from the
262.35 commissioner for an alternative inspection status according to section 245B.031, that
262.36 approval will apply to all persons receiving services in the program.

263.1 (g) Nothing in this chapter prohibits a license holder from concurrently serving
263.2 persons without disabilities or people who are or are not age 65 and older, provided this
263.3 chapter's standards are met as well as other relevant standards.
263.4 (h) The documentation required under sections 245D.07 and 245D.071 must meet
263.5 the individual program plan requirements identified in section 256B.092 or successor
263.6 provisions.
263.7 Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met,
263.8 the commissioner may grant a variance to any of the requirements in this chapter, except
263.9 sections 245D.04, ~~and 245D.10, subdivision 4, paragraph (b)~~ 245D.06, subdivision 4,
263.10 paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and
263.11 information rights of persons.
263.12 ~~Subd. 4.~~ ~~**License holders with multiple 245D licenses.**~~ ~~(a) When a person changes~~
263.13 ~~service from one license to a different license held by the same license holder, the license~~
263.14 ~~holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).~~
263.15 ~~(b) When a staff person begins providing direct service under one or more licenses~~
263.16 ~~held by the same license holder, other than the license for which staff orientation was~~
263.17 ~~initially provided according to section 245D.09, subdivision 4, the license holder is~~
263.18 ~~exempt from those staff orientation requirements, except the staff person must review each~~
263.19 ~~person's service plan and medication administration procedures in accordance with section~~
263.20 ~~245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.~~

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

263.22 Sec. 18. **[245D.031] LICENSURE REQUIREMENTS.**
263.23 Subdivision 1. **Registering the license.** Within 30 days of licensure, license holders
263.24 must register their service online at the Web site containing the service information
263.25 developed by the Minnesota Board on Aging under section 256.975, subdivision 7,
263.26 paragraph (b), clause (1). Providers entering information under this section shall ensure that
263.27 current service information, rates, and vacancies are maintained. Registration must ensure
263.28 that information about the license holder's agency and services will be available to persons
263.29 seeking services and county agencies where services are provided. The license holder must
263.30 ensure that current information is maintained. If the information required in subdivision 2
263.31 changes, the license holder must update the information within 30 days of the change.
263.32 Subd. 2. **Information required for registration.** The license holder must provide
263.33 the following information in the format specified by the Minnesota Board on Aging:

264.1 (1) populations served with consideration of at least the following characteristics
264.2 of the persons: cultural background, gender, age, disability or medical condition, and
264.3 legal status;

264.4 (2) the primary support and service needs of persons to be served that the license
264.5 holder will meet in the licensed program or service;

264.6 (3) the license holder's expertise and qualifications to provide the services noted in
264.7 the program description;

264.8 (4) a description of the specific extent and limitations of the program, including the
264.9 county or counties where services will be provided;

264.10 (5) a description of how the license holder will involve the person's cultural or ethnic
264.11 community to ensure culturally appropriate care;

264.12 (6) a description of those services provided directly by the license holder or the
264.13 license holder's direct support staff and those services to be provided by subcontractors
264.14 including, but not limited to, transportation services; and

264.15 (7) daily service availability such as vacancies or units of service that can be
264.16 accessed by persons served.

264.17 Subd. 3. **Program certification.** An applicant or a license holder may apply for
264.18 program certification as identified in section 245D.33.

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

264.20 Sec. 19. Minnesota Statutes 2012, section 245D.04, is amended to read:

264.21 **245D.04 SERVICE RECIPIENT RIGHTS.**

264.22 Subdivision 1. **License holder responsibility for individual rights of persons**
264.23 **served by the program.** The license holder must:

264.24 (1) provide each person or each person's legal representative with a written notice
264.25 that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of
264.26 those rights within five working days of service initiation and annually thereafter;

264.27 (2) make reasonable accommodations to provide this information in other formats
264.28 or languages as needed to facilitate understanding of the rights by the person and the
264.29 person's legal representative, if any;

264.30 (3) maintain documentation of the person's or the person's legal representative's
264.31 receipt of a copy and an explanation of the rights; and

264.32 (4) ensure the exercise and protection of the person's rights in the services provided
264.33 by the license holder and as authorized in the coordinated service and support plan.

264.34 Subd. 2. **Service-related rights.** A person's service-related rights include the right to:

265.1 (1) participate in the development and evaluation of the services provided to the
265.2 person;
265.3 (2) have services and supports identified in the coordinated service and support plan
265.4 and the coordinated service and support plan addendum provided in a manner that respects
265.5 and takes into consideration the person's preferences according to the requirements in
265.6 sections 245D.07 and 245D.071;
265.7 (3) refuse or terminate services and be informed of the consequences of refusing
265.8 or terminating services;
265.9 (4) know, in advance, limits to the services available from the license holder,
265.10 including the license holder's knowledge, skill, and ability to meet the person's service and
265.11 support needs based on the information required in section 245D.031, subdivision 2;
265.12 (5) know conditions and terms governing the provision of services, including the
265.13 license holder's admission criteria and policies and procedures related to temporary
265.14 service suspension and service termination;
265.15 (6) a coordinated transfer to ensure continuity of care when there will be a change
265.16 in the provider;
265.17 (7) know what the charges are for services, regardless of who will be paying for the
265.18 services, and be notified of changes in those charges;
265.19 ~~(7)~~ (8) know, in advance, whether services are covered by insurance, government
265.20 funding, or other sources, and be told of any charges the person or other private party
265.21 may have to pay; and
265.22 ~~(8)~~ (9) receive services from an individual who is competent and trained, who has
265.23 professional certification or licensure, as required, and who meets additional qualifications
265.24 identified in the person's coordinated service and support plan~~.~~ or coordinated service and
265.25 support plan addendum.
265.26 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include
265.27 the right to:
265.28 (1) have personal, financial, service, health, and medical information kept private,
265.29 and be advised of disclosure of this information by the license holder;
265.30 (2) access records and recorded information about the person in accordance with
265.31 applicable state and federal law, regulation, or rule;
265.32 (3) be free from maltreatment;
265.33 (4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except
265.34 for emergency use of manual restraint to protect the person from imminent danger to self
265.35 or others according to the requirements in section 245D.06;

266.1 (5) receive services in a clean and safe environment when the license holder is the
266.2 owner, lessor, or tenant of the service site;
266.3 (6) be treated with courtesy and respect and receive respectful treatment of the
266.4 person's property;
266.5 (7) reasonable observance of cultural and ethnic practice and religion;
266.6 (8) be free from bias and harassment regarding race, gender, age, disability,
266.7 spirituality, and sexual orientation;
266.8 (9) be informed of and use the license holder's grievance policy and procedures,
266.9 including knowing how to contact persons responsible for addressing problems and to
266.10 appeal under section 256.045;
266.11 (10) know the name, telephone number, and the Web site, e-mail, and street
266.12 addresses of protection and advocacy services, including the appropriate state-appointed
266.13 ombudsman, and a brief description of how to file a complaint with these offices;
266.14 (11) assert these rights personally, or have them asserted by the person's family,
266.15 authorized representative, or legal representative, without retaliation;
266.16 (12) give or withhold written informed consent to participate in any research or
266.17 experimental treatment;
266.18 (13) associate with other persons of the person's choice;
266.19 (14) personal privacy; and
266.20 (15) engage in chosen activities.
266.21 (b) For a person residing in a residential site licensed according to chapter 245A,
266.22 or where the license holder is the owner, lessor, or tenant of the residential service site,
266.23 protection-related rights also include the right to:
266.24 (1) have daily, private access to and use of a non-coin-operated telephone for local
266.25 calls and long-distance calls made collect or paid for by the person;
266.26 (2) receive and send, without interference, uncensored, unopened mail or electronic
266.27 correspondence or communication; ~~and~~
266.28 (3) have use of and free access to common areas in the residence; and
266.29 (4) privacy for visits with the person's spouse, next of kin, legal counsel, religious
266.30 advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including
266.31 privacy in the person's bedroom.
266.32 (c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a),
266.33 clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure
266.34 the health, safety, and well-being of the person. Any restriction of those rights must be
266.35 documented in the person's coordinated service and support plan ~~for the person and~~ or
266.36 coordinated service and support plan addendum. The restriction must be implemented

267.1 in the least restrictive alternative manner necessary to protect the person and provide
267.2 support to reduce or eliminate the need for the restriction in the most integrated setting
267.3 and inclusive manner. The documentation must include the following information:
267.4 (1) the justification for the restriction based on an assessment of the person's
267.5 vulnerability related to exercising the right without restriction;
267.6 (2) the objective measures set as conditions for ending the restriction;
267.7 (3) a schedule for reviewing the need for the restriction based on the conditions for
267.8 ending the restriction to occur, at a minimum, every three months for persons who do not
267.9 have a legal representative and annually for persons who do have a legal representative
267.10 semiannually from the date of initial approval, at a minimum, or more frequently if
267.11 requested by the person, the person's legal representative, if any, and case manager; and
267.12 (4) signed and dated approval for the restriction from the person, or the person's
267.13 legal representative, if any. A restriction may be implemented only when the required
267.14 approval has been obtained. Approval may be withdrawn at any time. If approval is
267.15 withdrawn, the right must be immediately and fully restored.

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

267.17 Sec. 20. Minnesota Statutes 2012, section 245D.05, is amended to read:

267.18 **245D.05 HEALTH SERVICES.**

267.19 Subdivision 1. **Health needs.** (a) The license holder is responsible for providing
267.20 meeting health services service needs assigned in the coordinated service and support plan
267.21 and or the coordinated service and support plan addendum, consistent with the person's
267.22 health needs. The license holder is responsible for promptly notifying the person or
267.23 the person's legal representative, if any, and the case manager of changes in a person's
267.24 physical and mental health needs affecting assigned health services service needs assigned
267.25 to the license holder in the coordinated service and support plan or the coordinated service
267.26 and support plan addendum, when discovered by the license holder, unless the license
267.27 holder has reason to know the change has already been reported. The license holder
267.28 must document when the notice is provided.
267.29 (b) When assigned in the service plan, If responsibility for meeting the person's
267.30 health service needs has been assigned to the license holder in the coordinated service and
267.31 support plan or the coordinated service and support plan addendum, the license holder is
267.32 required to must maintain documentation on how the person's health needs will be met,
267.33 including a description of the procedures the license holder will follow in order to:

268.1 (1) provide medication ~~administration,~~ assistance or medication ~~assistance, or~~
268.2 ~~medication management~~ administration according to this chapter;
268.3 (2) monitor health conditions according to written instructions from ~~the person's~~
268.4 ~~physician or~~ a licensed health professional;
268.5 (3) assist with or coordinate medical, dental, and other health service appointments; or
268.6 (4) use medical equipment, devices, or adaptive aides or technology safely and
268.7 correctly according to written instructions from ~~the person's physician or~~ a licensed
268.8 health professional.
268.9 Subd. 1a. **Medication setup.** For the purposes of this subdivision, "medication
268.10 setup" means the arranging of medications according to instructions from the pharmacy,
268.11 the prescriber, or a licensed nurse, for later administration when the license holder
268.12 is assigned responsibility for medication assistance or medication administration in
268.13 the coordinated service and support plan or the coordinated service and support plan
268.14 addendum. A prescription label or the prescriber's written or electronically recorded order
268.15 for the prescription is sufficient to constitute written instructions from the prescriber. The
268.16 license holder must document in the person's medication administration record: dates
268.17 of setup, name of medication, quantity of dose, times to be administered, and route of
268.18 administration at time of setup; and, when the person will be away from home, to whom
268.19 the medications were given.
268.20 Subd. 1b. **Medication assistance.** If responsibility for medication assistance
268.21 is assigned to the license holder in the coordinated service and support plan or the
268.22 coordinated service and support plan addendum, the license holder must ensure that
268.23 the requirements of subdivision 2, paragraph (b), have been met when staff provides
268.24 medication assistance to enable a person to self-administer medication or treatment when
268.25 the person is capable of directing the person's own care, or when the person's legal
268.26 representative is present and able to direct care for the person. For the purposes of this
268.27 subdivision, "medication assistance" means any of the following:
268.28 (1) bringing to the person and opening a container of previously set up medications,
268.29 emptying the container into the person's hand, or opening and giving the medications in
268.30 the original container to the person;
268.31 (2) bringing to the person liquids or food to accompany the medication; or
268.32 (3) providing reminders to take regularly scheduled medication or perform regularly
268.33 scheduled treatments and exercises.
268.34 Subd. 2. **Medication administration.** (a) If responsibility for medication
268.35 administration is assigned to the license holder in the coordinated service and support plan
268.36 or the coordinated service and support plan addendum, the license holder must implement

269.1 the following medication administration procedures to ensure a person takes medications
269.2 and treatments as prescribed:
269.3 (1) checking the person's medication record;
269.4 (2) preparing the medication as necessary;
269.5 (3) administering the medication or treatment to the person;
269.6 (4) documenting the administration of the medication or treatment or the reason for
269.7 not administering the medication or treatment; and
269.8 (5) reporting to the prescriber or a nurse any concerns about the medication or
269.9 treatment, including side effects, effectiveness, or a pattern of the person refusing to
269.10 take the medication or treatment as prescribed. Adverse reactions must be immediately
269.11 reported to the prescriber or a nurse.
269.12 (b)(1) The license holder must ensure that the following criteria requirements in
269.13 clauses (2) to (4) have been met before staff that is not a licensed health professional
269.14 administers administering medication or treatment:.
269.15 (1) (2) The license holder must obtain written authorization has been obtained from
269.16 the person or the person's legal representative to administer medication or treatment
269.17 orders; and must obtain reauthorization annually as needed. If the person or the person's
269.18 legal representative refuses to authorize the license holder to administer medication, the
269.19 medication must not be administered. The refusal to authorize medication administration
269.20 must be reported to the prescriber as expediently as possible.
269.21 (2) (3) The staff person has completed responsible for administering the medication
269.22 or treatment must complete medication administration training according to section
269.23 245D.09, subdivision 4, paragraph 4a, paragraphs (a) and (c), clause (2); and, as applicable
269.24 to the person, paragraph (d).
269.25 (3) The medication or treatment will be administered under administration
269.26 procedures established for the person in consultation with a licensed health professional.
269.27 written instruction from the person's physician may constitute the medication
269.28 administration procedures. A prescription label or the prescriber's order for the
269.29 prescription is sufficient to constitute written instructions from the prescriber. A licensed
269.30 health professional may delegate medication administration procedures.
269.31 (4) For a license holder providing intensive support services, the medication or
269.32 treatment must be administered according to the license holder's medication administration
269.33 policy and procedures as required under section 245D.11, subdivision 2, clause (3).
269.34 (b) (c) The license holder must ensure the following information is documented in
269.35 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~~

271.1 ~~legal representative and case manager as they occur or following timelines established~~
271.2 ~~in the person's service plan or as requested in writing by the person or the person's legal~~
271.3 ~~representative, or the case manager:~~ (a) When assigned responsibility for medication
271.4 administration, the license holder must ensure that the information maintained in
271.5 the medication administration record is current and is regularly reviewed to identify
271.6 medication administration errors. At a minimum, the review must be conducted every
271.7 three months, or more frequently as directed in the coordinated service and support plan
271.8 or coordinated service and support plan addendum or as requested by the person or the
271.9 person's legal representative. Based on the review, the license holder must develop and
271.10 implement a plan to correct patterns of medication administration errors when identified.

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

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

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

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

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

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

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

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

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

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

272.1 Sec. 21. **[245D.051] PSYCHOTROPIC MEDICATION USE AND**
272.2 **MONITORING.**

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

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

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

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

272.17 (2) documentation methods the license holder will use to monitor and measure
272.18 changes in the target symptoms that are to be alleviated by the psychotropic medication if
272.19 required by the prescriber. The license holder must collect and report on medication and
272.20 symptom-related data as instructed by the prescriber. The license holder must provide
272.21 the monitoring data to the expanded support team for review every three months, or as
272.22 otherwise requested by the person or the person's legal representative.

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

272.27 (d) If a person is prescribed a psychotropic medication and monitoring the use of
272.28 the psychotropic medication has not been assigned in the coordinated service and support
272.29 plan, and the person lives in a licensed residential site controlled by the license holder, the
272.30 license holder must monitor the psychotropic medication as required by this section.

272.31 Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the
272.32 person's legal representative refuses to authorize the administration of a psychotropic
272.33 medication as ordered by the prescriber, the license holder must follow the requirement
272.34 in section 245D.05, subdivision 2, paragraph (b), clause (2). After reporting the refusal
272.35 to the prescriber, the license holder must follow any directives or orders given by the
272.36 prescriber. A court order must be obtained to override the refusal. Refusal to authorize

administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A decision to terminate services must be reached in compliance with section 245D.10, subdivision 3.

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

Sec. 22. Minnesota Statutes 2012, section 245D.06, is amended to read:

245D.06 PROTECTION STANDARDS.

Subdivision 1. **Incident response and reporting.** (a) The license holder must respond to ~~all~~ incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person. Responses to incidents involving the emergency use of manual restraints must comply with the requirements in section 245D.061.

(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) 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.

(g) The license holder must report the emergency use of manual restraint of a person as required in paragraph (b), and to the Department of Human Services Licensing Division within 24 hours of the occurrence. The license holder must conduct an internal review of all incident reports of the emergency use of manual restraints 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

275.1 license holder must document an assessment of the physical plant, the environment and
275.2 the population served, identifying the risk factors which require the use of locked doors,
275.3 and a statement of specific measures to be taken to minimize the safety risk to persons
275.4 receiving services at the service site; and

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

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

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

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

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

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

275.24 Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person
275.25 with the safekeeping of funds or other property according to section 245A.04, subdivision
275.26 13, the license holder must have obtain written authorization to do so from the person or
275.27 the person's legal representative and the case manager. Authorization must be obtained
275.28 within five working days of service initiation and renewed annually thereafter. At the time
275.29 initial authorization is obtained, the license holder must survey, document, and implement
275.30 the preferences of the person or the person's legal representative and the case manager
275.31 for frequency of receiving a statement that itemizes receipts and disbursements of funds
275.32 or other property. The license holder must document changes to these preferences when
275.33 they are requested.

275.34 (b) A license holder or staff person may not accept powers-of-attorney from a
275.35 person receiving services from the license holder for any purpose, and may not accept an
275.36 appointment as guardian or conservator of a person receiving services from the license

276.1 ~~holder~~. This does not apply to license holders that are Minnesota counties or other
276.2 units of government or to staff persons employed by license holders who were acting
276.3 as ~~power-of-attorney, guardian, or conservator~~ attorney-in-fact for specific individuals
276.4 prior to ~~April 23, 2012~~ implementation of this chapter. The license holder must maintain
276.5 documentation of the power-of-attorney~~, guardianship, or conservatorship~~ in the service
276.6 recipient record.

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

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

276.15 ~~(b) The license holder is prohibited from using restraints or seclusion under any~~
276.16 ~~circumstance, unless the commissioner has approved a variance request from the license~~
276.17 ~~holder that allows for the emergency use of restraints and seclusion according to terms~~
276.18 ~~and conditions approved in the variance. Applicants and license holders who have~~
276.19 ~~reason to believe they may be serving an individual who will need emergency use of~~
276.20 ~~restraints or seclusion may request a variance on the application or reapplication, and~~
276.21 ~~the commissioner shall automatically review the request for a variance as part of the~~
276.22 ~~application or reapplication process. License holders may also request the variance any~~
276.23 ~~time after issuance of a license. In the event a license holder uses restraint or seclusion for~~
276.24 ~~any reason without first obtaining a variance as required, the license holder must report~~
276.25 ~~the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the~~
276.26 ~~occurrence and request the required variance.~~

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

276.31 (c) For the purposes of this subdivision, "mechanical restraint practice" means the
276.32 use of any adaptive equipment or safety device to control the person's behavior or restrict
276.33 the person's freedom of movement and not as ordered by a licensed health professional.
276.34 Mechanical restraint practices include, but are not limited to, the use of bed rails or similar
276.35 devices on a bed to prevent the person from getting out of bed, chairs that prevent a person
276.36 from rising, or placing a person in a wheelchair so close to a wall that the wall prevents

277.1 the person from rising. Wrist bands or devices on clothing that trigger electronic alarms to
277.2 warn staff that a person is leaving a room or area do not, in and of themselves, restrict
277.3 freedom of movement and should not be considered restraints.

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

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

277.14 Sec. 23. **[245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

277.15 Subdivision 1. **Standards for emergency use of manual restraints.** Except
277.16 for the emergency use of controlled procedures with a person with a developmental
277.17 disability as governed by Minnesota Rules, part 9525.2770, or its successor provisions,
277.18 the license holder must ensure that emergency use of manual restraints complies with the
277.19 requirements of this chapter and the license holder's policy and procedures as required
277.20 under subdivision 10.

277.21 Subd. 2. **Definitions.** (a) The terms used in this section have the meaning given
277.22 them in this subdivision.

277.23 (b) "Manual restraint" means physical intervention intended to hold a person
277.24 immobile or limit a person's voluntary movement by using body contact as the only source
277.25 of physical restraint.

277.26 (c) "Mechanical restraint" means the use of devices, materials, or equipment attached
277.27 or adjacent to the person's body, or the use of practices which restrict freedom of movement
277.28 or normal access to one's body or body parts, or limits a person's voluntary movement
277.29 or holds a person immobile as an intervention precipitated by a person's behavior. The
277.30 term does apply to mechanical restraint used to prevent injury with persons who engage in
277.31 self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue
277.32 damage that have caused or could cause medical problems resulting from the self-injury.

277.33 Subd. 3. **Conditions for emergency use of manual restraint.** Emergency use of
277.34 manual restraint must meet the following conditions:

278.1 (1) immediate intervention must be needed to protect the person or others from
278.2 imminent risk of physical harm; and
278.3 (2) manual restraint must be the least restrictive intervention possible to eliminate
278.4 the immediate risk of harm and effectively achieve safety in the situation after positive
278.5 support strategies and less restrictive interventions have been tried and failed.
278.6 Subd. 4. **Permitted instructional techniques and therapeutic conduct.** (a) Use of
278.7 physical contact as therapeutic conduct or as an instructional technique as identified in
278.8 paragraphs (b) and (c), is permitted and is not subject to the requirements of this section
278.9 when such use is addressed in a person's coordinated service and support plan addendum
278.10 and the required conditions have been met. For the purposes of this subdivision,
278.11 "therapeutic conduct" has the meaning given in section 626.5572, subdivision 20.
278.12 (b) Physical contact or instructional techniques must use the least restrictive
278.13 alternative possible to meet the needs of the person and may be used:
278.14 (1) to calm or comfort a person by holding that person with no resistance from
278.15 that person;
278.16 (2) to protect a person known to be at risk of injury due to frequent falls as a result of
278.17 a medical condition; or
278.18 (3) to position a person with physical disabilities in a manner specified in the
278.19 person's coordinated service and support plan.
278.20 (c) Restraint may be used as therapeutic conduct:
278.21 (1) to allow a licensed health care professional to safely conduct a medical
278.22 examination or to provide medical treatment ordered by a licensed health care professional
278.23 to a person necessary to promote healing or recovery from an acute, meaning short-term,
278.24 medical condition;
278.25 (2) to facilitate the person's completion of a task or response when the person does
278.26 not resist or the person's resistance is minimal in intensity and duration;
278.27 (3) to briefly block or redirect a person's limbs or body without holding the person
278.28 or limiting the person's movement to interrupt the person's behavior that may result in
278.29 injury to self or others; or
278.30 (4) to assist in the safe evacuation of a person in the event of an emergency or to
278.31 redirect a person who is at imminent risk of harm in a dangerous situation.
278.32 (d) A plan for using restraint as therapeutic conduct must be developed according to
278.33 the requirements in sections 245D.07 and 245D.071, and must include methods to reduce
278.34 or eliminate the use of and need for restraint.
278.35 Subd. 5. **Restrictions when implementing emergency use of manual restraint.**
278.36 (a) Emergency use of manual restraint procedures must not:

279.1 (1) be implemented with a child in a manner that constitutes sexual abuse, neglect,
279.2 physical abuse, or mental injury, as defined in section 626.556, subdivision 2;
279.3 (2) be implemented with an adult in a manner that constitutes abuse or neglect as
279.4 defined in section 626.5572, subdivisions 2 and 17;
279.5 (3) be implemented in a manner that violates a person's rights and protections
279.6 identified in section 245D.04;
279.7 (4) restrict a person's normal access to a nutritious diet, drinking water, adequate
279.8 ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping
279.9 conditions, or necessary clothing, or to any protection required by state licensing standards
279.10 and federal regulations governing the program;
279.11 (5) deny the person visitation or ordinary contact with legal counsel, a legal
279.12 representative, or next of kin;
279.13 (6) be used as a substitute for adequate staffing, for the convenience of staff, as
279.14 punishment, or as a consequence if the person refuses to participate in the treatment
279.15 or services provided by the program; or
279.16 (7) use prone restraint. For the purposes of this section, "prone restraint" means use
279.17 of manual restraint that places a person in a face-down position. This does not include
279.18 brief physical holding of a person who, during an emergency use of manual restraint, rolls
279.19 into a prone position, and the person is restored to a standing, sitting, or side-lying position
279.20 as quickly as possible. Applying back or chest pressure while a person is in the prone or
279.21 supine position or face-up is prohibited.
279.22 Subd. 6. **Monitoring emergency use of manual restraint.** The license holder shall
279.23 monitor a person's health and safety during an emergency use of a manual restraint. Staff
279.24 monitoring the procedure must not be the staff implementing the procedure when possible.
279.25 The license holder shall complete a monitoring form, approved by the commissioner, for
279.26 each incident involving the emergency use of a manual restraint.
279.27 Subd. 7. **Reporting emergency use of manual restraint incident.** (a) The license
279.28 holder must report each incident involving the emergency use of manual restraint in
279.29 compliance with section 245D.06, subdivision 1, paragraph (g). At a minimum, the
279.30 incident report must include the following information:
279.31 (1) the staff and persons receiving services who were involved in the incident
279.32 leading up to the emergency use of manual restraint;
279.33 (2) a description of the physical and social environment, including who was present
279.34 before and during the incident leading up to the emergency use of manual restraint;
279.35 (3) a description of what less restrictive alternative measures were attempted to
279.36 de-escalate the incident and maintain safety before the manual restraint was implemented

280.1 that identifies when, how, and how long the alternative measures were attempted before
280.2 manual restraint was implemented;

280.3 (4) a description of the mental, physical, and emotional condition of the person who
280.4 was restrained, and other persons involved in the incident leading up to, during, and
280.5 following the manual restraint;

280.6 (5) whether there was any injury to the person who was restrained or other persons
280.7 involved in the incident, including staff, before or as a result of the use of manual
280.8 restraint; and

280.9 (6) whether there was an attempt to debrief with the staff, and, if not contraindicated,
280.10 with the person who was restrained and other persons who were involved in or who
280.11 witnessed the restraint, following the incident and the outcome of the debriefing. If the
280.12 debriefing was not conducted at the time the incident report was made, the report should
280.13 identify whether a debriefing is planned.

280.14 (b) Each single incident of emergency use of manual restraint must be reported
280.15 separately. For the purposes of this subdivision, an incident of emergency use of manual
280.16 restraint is a single incident when the following conditions have been met:

280.17 (1) after implementing the manual restraint, staff attempt to release the person at the
280.18 moment staff believe the person's conduct no longer poses an imminent risk of physical
280.19 harm to self or others and less restrictive strategies can be implemented to maintain safety;

280.20 (2) upon the attempt to release the restraint, the person's behavior immediately
280.21 re-escalates; and

280.22 (3) staff must immediately reimplement the restraint in order to maintain safety.

280.23 Subd. 8. **Internal review of emergency use of manual restraint.** (a) Within five
280.24 working days of the emergency use of manual restraint, the license holder must complete
280.25 an internal review of each report of emergency use of manual restraint. The review must
280.26 include an evaluation of whether:

280.27 (1) the person's service and support strategies developed according to sections
280.28 245D.07 and 245D.071 need to be revised;

280.29 (2) related policies and procedures were followed;

280.30 (3) the policies and procedures were adequate;

280.31 (4) there is a need for additional staff training;

280.32 (5) the reported event is similar to past events with the persons, staff, or the services
280.33 involved; and

280.34 (6) there is a need for corrective action by the license holder to protect the health
280.35 and safety of persons.

281.1 (b) Based on the results of the internal review, the license holder must develop,
281.2 document, and implement a corrective action plan for the program designed to correct
281.3 current lapses and prevent future lapses in performance by individuals or the license
281.4 holder, if any. The corrective action plan, if any, must be implemented within 30 days of
281.5 the internal review being completed.

281.6 Subd. 9. **Expanded support team review.** (a) Within five working days after the
281.7 completion of the internal review required in subdivision 8, the license holder must consult
281.8 with the expanded support team following the emergency use of manual restraint to:

281.9 (1) discuss the incident reported in subdivision 7, to define the antecedent or event
281.10 that gave rise to the behavior resulting in the manual restraint and identify the perceived
281.11 function the behavior served; and

281.12 (2) determine whether the person's coordinated service and support plan addendum
281.13 needs to be revised according to sections 245D.07 and 245D.071 to positively and
281.14 effectively help the person maintain stability and to reduce or eliminate future occurrences
281.15 requiring emergency use of manual restraint.

281.16 Subd. 10. **Emergency use of manual restraints policy and procedures.** The
281.17 license holder must develop, document, and implement a policy and procedures that
281.18 promote service recipient rights and protect health and safety during the emergency use of
281.19 manual restraints. The policy and procedures must comply with the requirements of this
281.20 section and must specify the following:

281.21 (1) a description of the positive support strategies and techniques staff must use to
281.22 attempt to de-escalate a person's behavior before it poses an imminent risk of physical
281.23 harm to self or others;

281.24 (2) a description of the types of manual restraints the license holder allows staff to
281.25 use on an emergency basis, if any. If the license holder will not allow the emergency use
281.26 of manual restraint, the policy and procedure must identify the alternative measures the
281.27 license holder will require staff to use when a person's conduct poses an imminent risk of
281.28 physical harm to self or others and less restrictive strategies would not achieve safety;

281.29 (3) instructions for safe and correct implementation of the allowed manual restraint
281.30 procedures;

281.31 (4) the training that staff must complete and the timelines for completion, before they
281.32 may implement an emergency use of manual restraint. In addition to the training on this
281.33 policy and procedure and the orientation and annual training required in section 245D.09,
281.34 subdivision 4, the training for emergency use of manual restraint must incorporate the
281.35 following subjects:

282.1 (i) alternatives to manual restraint procedures, including techniques to identify
282.2 events and environmental factors that may escalate conduct that poses an imminent risk of
282.3 physical harm to self or others;
282.4 (ii) de-escalation methods, positive support strategies, and how to avoid power
282.5 struggles;
282.6 (iii) simulated experiences of administering and receiving manual restraint
282.7 procedures allowed by the license holder on an emergency basis;
282.8 (iv) how to properly identify thresholds for implementing and ceasing restrictive
282.9 procedures;
282.10 (v) how to recognize, monitor, and respond to the person's physical signs of distress,
282.11 including positional asphyxia; and
282.12 (vi) the physiological and psychological impact on the person and the staff when
282.13 restrictive procedures are used;
282.14 (5) the procedures and forms to be used to monitor the emergency use of manual
282.15 restraints, including what must be monitored and the frequency of monitoring per
282.16 each incident of emergency use of manual restraint, and the person or position who is
282.17 responsible for monitoring the use;
282.18 (6) the instructions, forms, and timelines required for completing and submitting an
282.19 incident report by the person or persons who implemented the manual restraint; and
282.20 (7) the procedures and timelines for conducting the internal review and the expanded
282.21 support team review, and the person or position responsible for completing the reviews and
282.22 who is responsible for ensuring that corrective action is taken or the person's coordinated
282.23 service and support plan addendum is revised, when determined necessary.

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

282.25 Sec. 24. Minnesota Statutes 2012, section 245D.07, is amended to read:

282.26 **245D.07 SERVICE ~~NEEDS~~ PLANNING AND DELIVERY.**

282.27 Subdivision 1. **Provision of services.** The license holder must provide services as
282.28 ~~specified~~ assigned in the coordinated service and support plan ~~and assigned to the license~~
282.29 ~~holder~~. The provision of services must comply with the requirements of this chapter and
282.30 the federal waiver plans.

282.31 Subd. 1a. **Person-centered planning and service delivery.** (a) The license holder
282.32 must provide services in response to the person's identified needs, interests, preferences,
282.33 and desired outcomes as specified in the coordinated service and support plan, the
282.34 coordinated service and support plan addendum, and in compliance with the requirements

283.1 of this chapter. License holders providing intensive support services must also provide
283.2 outcome-based services according to the requirements in section 245D.071.
283.3 (b) Services must be provided in a manner that supports the person's preferences,
283.4 daily needs, and activities and accomplishment of the person's personal goals and service
283.5 outcomes, consistent with the principles of:
283.6 (1) person-centered service planning and delivery that:
283.7 (i) identifies and supports what is important to the person as well as what is
283.8 important for the person, including preferences for when, how, and by whom direct
283.9 support service is provided;
283.10 (ii) uses that information to identify outcomes the person desires; and
283.11 (iii) respects each person's history, dignity, and cultural background;
283.12 (2) self-determination that supports and provides:
283.13 (i) opportunities for the development and exercise of functional and age-appropriate
283.14 skills, decision making and choice, personal advocacy, and communication; and
283.15 (ii) the affirmation and protection of each person's civil and legal rights;
283.16 (3) providing the most integrated setting and inclusive service delivery that supports,
283.17 promotes, and allows:
283.18 (i) inclusion and participation in the person's community as desired by the person
283.19 in a manner that enables the person to interact with nondisabled persons to the fullest
283.20 extent possible and supports the person in developing and maintaining a role as a valued
283.21 community member;
283.22 (ii) opportunities for self-sufficiency as well as developing and maintaining social
283.23 relationships and natural supports; and
283.24 (iii) a balance between risk and opportunity, meaning the least restrictive supports or
283.25 interventions necessary are provided in the most integrated settings in the most inclusive
283.26 manner possible to support the person to engage in activities of the person's own choosing
283.27 that may otherwise present a risk to the person's health, safety, or rights.
283.28 Subd. 2. **Service planning.** (a) License holders providing basic support services
283.29 must meet the requirements of this subdivision.
283.30 (b) Within 15 days of service initiation the license holder must complete a
283.31 preliminary service plan based on the coordinated service and support plan.
283.32 (c) Within 60 days of service initiation the license holder must develop and
283.33 document the coordinated service and support plan addendum that identifies what services
283.34 will be provided including how, when, and by whom services will be provided, and the
283.35 person responsible for overseeing the delivery and coordination of services.

284.1 (d) The license holder must participate in service planning and support team
284.2 meetings ~~related to~~ for the person following stated timelines established in the person's
284.3 coordinated service and support plan or as requested by ~~the support team,~~ the person~~,~~ or
284.4 the person's legal representative, the support team or the expanded support team.

284.5 Subd. 3. **Reports.** The license holder must provide written reports regarding the
284.6 person's progress or status as requested by the person, the person's legal representative, the
284.7 case manager, or the team.

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

284.9 Sec. 25. **[245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE**
284.10 **SUPPORT SERVICES.**

284.11 Subdivision 1. **Requirements for intensive support services.** A license holder
284.12 providing intensive support services identified in section 245D.03, subdivision 1,
284.13 paragraph (c), must comply with the requirements in section 245D.07 and this section.

284.14 Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder
284.15 must develop, document, and implement an abuse prevention plan according to section
284.16 245A.65, subdivision 2.

284.17 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service
284.18 initiation the license holder must complete a preliminary service plan based on the
284.19 coordinated service and support plan.

284.20 (b) Within 45 days of service initiation the license holder must meet with the person,
284.21 the person's legal representative, the case manager, and other members of the support team
284.22 or expanded support team to assess and determine the following based on the person's
284.23 coordinated service and support plan and the requirements in subdivision 4 and section
284.24 245D.07, subdivision 1a:

284.25 (1) the scope of the services to be provided to support the person's daily needs
284.26 and activities;

284.27 (2) the person's desired outcomes and the supports necessary to accomplish the
284.28 person's desired outcomes;

284.29 (3) the person's preferences for how services and supports are provided;

284.30 (4) whether the current service setting is the most integrated setting available and
284.31 appropriate for the person; and

284.32 (5) how services must be coordinated across other providers licensed under this
284.33 chapter serving the same person to ensure continuity of care for the person.

284.34 (c) Within the scope of services, the license holder must, at a minimum, assess
284.35 the following areas:

285.1 (1) the person's ability to self-manage health and medical needs to maintain or
285.2 improve physical, mental, and emotional well-being, including, when applicable, allergies,
285.3 seizures, choking, special dietary needs, chronic medical conditions, self-administration
285.4 of medication or treatment orders, preventative screening, and medical and dental
285.5 appointments;

285.6 (2) the person's ability to self-manage personal safety to avoid injury or accident in
285.7 the service setting, including, when applicable, risk of falling, mobility, regulating water
285.8 temperature, community survival skills, water safety skills, and sensory disabilities; and

285.9 (3) the person's ability to self-manage symptoms or behavior that may otherwise
285.10 result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to
285.11 (7), suspension or termination of services by the license holder, or other symptoms
285.12 or behaviors that may jeopardize the health and safety of the person or others. The
285.13 assessments must produce information about the person that is descriptive of the person's
285.14 overall strengths, functional skills and abilities, and behaviors or symptoms.

285.15 Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the
285.16 45-day meeting, the license holder must develop and document the service outcomes and
285.17 supports based on the assessments completed under subdivision 3 and the requirements
285.18 in section 245D.07, subdivision 1a. The outcomes and supports must be included in the
285.19 coordinated service and support plan addendum.

285.20 (b) The license holder must document the supports and methods developed under
285.21 paragraph (a). The documentation must include:

285.22 (1) the methods or actions that will be used to support the person and to accomplish
285.23 the service outcomes, including information about:

285.24 (i) any changes or modifications to the physical and social environments necessary
285.25 when the service supports are provided;

285.26 (ii) any equipment and materials required; and

285.27 (iii) techniques that are consistent with the person's communication mode and
285.28 learning style;

285.29 (2) the measurable and observable criteria for identifying when the desired outcome
285.30 has been achieved and how data will be collected;

285.31 (3) the projected starting date for implementing the supports and methods and
285.32 the date by which progress towards accomplishing the outcomes will be reviewed and
285.33 evaluated; and

285.34 (4) the names of the staff or position responsible for implementing the supports
285.35 and methods.

286.1 (c) Within 20 working days of the 45-day meeting, the license holder must obtain
286.2 dated signatures from the person or the person's legal representative and case manager
286.3 to document completion and approval of the assessment and coordinated service and
286.4 support plan addendum.

286.5 Subd. 5. **Progress reviews.** (a) The license holder must give the person or the
286.6 person's legal representative and case manager an opportunity to participate in the ongoing
286.7 review and development of the methods used to support the person and accomplish
286.8 outcomes identified in subdivisions 3 and 4. The license holder, in coordination with the
286.9 person's support team or expanded support team, must meet with the person, the person's
286.10 legal representative, and the case manager, and participate in progress review meetings
286.11 following stated timelines established in the person's coordinated service and support plan
286.12 or within 30 days of a written request by the person, the person's legal representative, or
286.13 the case manager, at a minimum of once per year.

286.14 (b) The license holder must summarize the person's progress toward achieving the
286.15 identified outcomes and make recommendations and identify the rationale for changing,
286.16 continuing, or discontinuing implementation of supports and methods identified in
286.17 subdivision 4 in a written report sent to the person or the person's legal representative
286.18 and case manager five working days prior to the review meeting, unless the person, the
286.19 person's legal representative, or the case manager request to receive the report at the
286.20 time of the meeting.

286.21 (c) Within ten working days of the progress review meeting, the license holder
286.22 must obtain dated signatures from the person or the person's legal representative and
286.23 the case manager to document approval of any changes to the coordinated service and
286.24 support plan addendum.

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

286.26 Sec. 26. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND**
286.27 **OVERSIGHT.**

286.28 Subdivision 1. **Program coordination and evaluation.** (a) The license holder
286.29 is responsible for:

286.30 (1) coordination of service delivery and evaluation for each person served by the
286.31 program as identified in subdivision 2; and

286.32 (2) program management and oversight that includes evaluation of the program
286.33 quality and program improvement for services provided by the license holder as identified
286.34 in subdivision 3.

287.1 (b) The same person may perform the functions in paragraph (a) if the work and
287.2 education qualifications are met in subdivisions 2 and 3.

287.3 Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery
287.4 and evaluation of services provided by the license holder must be coordinated by a
287.5 designated staff person. The designated coordinator must provide supervision, support,
287.6 and evaluation of activities that include:

287.7 (1) oversight of the license holder's responsibilities assigned in the person's
287.8 coordinated service and support plan and the coordinated service and support plan
287.9 addendum;

287.10 (2) taking the action necessary to facilitate the accomplishment of the outcomes
287.11 according to the requirements in section 245D.07;

287.12 (3) instruction and assistance to direct support staff implementing the coordinated
287.13 service and support plan and the service outcomes, including direct observation of service
287.14 delivery sufficient to assess staff competency; and

287.15 (4) evaluation of the effectiveness of service delivery, methodologies, and progress on
287.16 the person's outcomes based on the measurable and observable criteria for identifying when
287.17 the desired outcome has been achieved according to the requirements in section 245D.07.

287.18 (b) The license holder must ensure that the designated coordinator is competent to
287.19 perform the required duties identified in paragraph (a) through education and training in
287.20 human services and disability-related fields, and work experience in providing direct care
287.21 services and supports to persons with disabilities. The designated coordinator must have
287.22 the skills and ability necessary to develop effective plans and to design and use data
287.23 systems to measure effectiveness of services and supports. The license holder must verify
287.24 and document competence according to the requirements in section 245D.09, subdivision
287.25 3. The designated coordinator must minimally have:

287.26 (1) a baccalaureate degree in a field related to human services, and one year of
287.27 full-time work experience providing direct care services to persons with disabilities or
287.28 persons age 65 and older;

287.29 (2) an associate degree in a field related to human services, and two years of
287.30 full-time work experience providing direct care services to persons with disabilities or
287.31 persons age 65 and older;

287.32 (3) a diploma in a field related to human services from an accredited postsecondary
287.33 institution and three years of full-time work experience providing direct care services to
287.34 persons with disabilities or persons age 65 and older; or

287.35 (4) a combination of education and training related to human services that is
287.36 equivalent to a diploma program from an accredited postsecondary institution, and

288.1 four years of full-time work experience providing direct care services to persons with
288.2 disabilities or persons age 65 and older.

288.3 Subd. 3. **Program management and oversight.** (a) The license holder must
288.4 designate a managerial staff person or persons to provide program management and
288.5 oversight of the services provided by the license holder. The designated manager is
288.6 responsible for the following:

288.7 (1) maintaining a current understanding of the licensing requirements sufficient to
288.8 ensure compliance throughout the program as identified in section 245A.04, subdivision
288.9 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21,
288.10 paragraph (b);

288.11 (2) ensuring the duties of the designated coordinator are fulfilled according to the
288.12 requirements in subdivision 2;

288.13 (3) ensuring the program implements corrective action identified as necessary
288.14 by the program following review of incident and emergency reports according to the
288.15 requirements in section 245D.11, subdivision 2, clause (7). An internal review of
288.16 incident reports of alleged or suspected maltreatment must be conducted according to the
288.17 requirements in section 245A.65, subdivision 1, paragraph (b);

288.18 (4) evaluation of satisfaction of persons served by the program, the person's legal
288.19 representative, if any, and the case manager, with the service delivery and progress
288.20 towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and
288.21 ensuring and protecting each person's rights as identified in section 245D.04;

288.22 (5) ensuring staff competency requirements are met according to the requirements in
288.23 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
288.24 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

288.25 (6) ensuring corrective action is taken when ordered by the commissioner and that
288.26 the terms and condition of the license and any variances are met; and

288.27 (7) evaluating the information identified in clauses (1) to (6) to develop, document,
288.28 and implement ongoing program improvements.

288.29 (b) The designated manager must be competent to perform the duties as required and
288.30 must minimally meet the education and training requirements identified in subdivision
288.31 2, paragraph (b), and have a minimum of three years of supervisory level experience in
288.32 a program providing direct support services to persons with disabilities or persons age
288.33 65 and older.

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

289.1 Sec. 27. Minnesota Statutes 2012, section 245D.09, is amended to read:

289.2 **245D.09 STAFFING STANDARDS.**

289.3 Subdivision 1. **Staffing requirements.** The license holder must provide the level of
289.4 direct service support staff sufficient supervision, assistance, and training necessary:
289.5 (1) to ensure the health, safety, and protection of rights of each person; and
289.6 (2) to be able to implement the responsibilities assigned to the license holder in each
289.7 person's coordinated service and support plan or identified in the coordinated service and
289.8 support plan addendum, according to the requirements of this chapter.

289.9 Subd. 2. **Supervision of staff having direct contact.** Except for a license holder
289.10 who is the sole direct service support staff, the license holder must provide adequate
289.11 supervision of staff providing direct service support to ensure the health, safety, and
289.12 protection of rights of each person and implementation of the responsibilities assigned to
289.13 the license holder in each person's service plan coordinated service and support plan.

289.14 Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing
289.15 direct support, or staff who have responsibilities related to supervising or managing the
289.16 provision of direct support service, is competent as demonstrated through skills and
289.17 knowledge training, experience, and education to meet the person's needs and additional
289.18 requirements as written in the coordinated service and support plan, or when otherwise
289.19 required by the case manager or the federal waiver plan. The license holder must verify
289.20 and maintain evidence of staff competency, including documentation of:
289.21 (1) education and experience qualifications relevant to the job responsibilities
289.22 assigned to the staff and the needs of the general population of persons served by the
289.23 program, including a valid degree and transcript, or a current license, registration, or
289.24 certification, when a degree or licensure, registration, or certification is required by this
289.25 chapter or in the coordinated service and support plan;
289.26 (2) completion of required demonstrated competency in the orientation and training
289.27 areas required under this chapter, including and when applicable, completion of continuing
289.28 education required to maintain professional licensure, registration, or certification
289.29 requirements. Competency in these areas is determined by the license holder through
289.30 knowledge testing and observed skill assessment conducted by the trainer or instructor; and
289.31 (3) except for a license holder who is the sole direct service support staff, periodic
289.32 performance evaluations completed by the license holder of the direct service support staff
289.33 person's ability to perform the job functions based on direct observation.
289.34 (b) Staff under 18 years of age may not perform overnight duties or administer
289.35 medication.

Subd. 4. **Orientation to program requirements.** ~~(a)~~ Except for a license holder who does not supervise any direct ~~service~~ support staff, within ~~90 days of hiring direct service staff~~ 60 days of hire, unless stated otherwise, the license holder must provide and ensure completion of orientation for direct support staff that combines supervised on-the-job training with review of and instruction ~~on~~ in the following areas:

(1) the job description and how to complete specific job functions, including:

(i) responding to and reporting incidents as required under section 245D.06, subdivision 1; and

(ii) following safety practices established by the license holder and as required in section 245D.06, subdivision 2;

(2) the license holder's current policies and procedures required under this chapter, including their location and access, and staff responsibilities related to implementation of those policies and procedures;

(3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices;

(4) the service recipient rights ~~under section 245D.04~~, and staff responsibilities related to ensuring the exercise and protection of those rights according to the requirements in section 245D.04;

(5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment. This orientation must be provided within 72 hours of first providing direct contact services and annually thereafter according to section 245A.65, subdivision 3;

(6) ~~what constitutes use of restraints, seclusion, and psychotropic medications, and staff responsibilities related to the prohibitions of their use~~ the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person; and

(7) other topics as determined necessary in the person's coordinated service and support plan by the case manager or other areas identified by the license holder.

~~(b) License holders who provide direct service themselves must complete the orientation required in paragraph (a), clauses (3) to (7).~~

Subd. 4a. **Orientation to individual service recipient needs.** ~~(c)~~ (a) Before ~~providing~~ having unsupervised direct ~~service to~~ contact with a person served by the program, or for whom the staff person has not previously provided direct ~~service~~ support, or any time the plans or procedures identified in ~~clauses (1) and (2)~~ paragraphs (b) to

291.1 (e) are revised, the staff person must review and receive instruction on the following
291.2 as it relates requirements in paragraphs (b) to (e) as they relate to the staff person's job
291.3 functions for that person:.

291.4 (1) (b) The staff person must review and receive instruction on the person's
291.5 coordinated service and support plan as it relates to the responsibilities assigned to the
291.6 license holder, and when applicable, the person's individual abuse prevention plan
291.7 according to section 245A.65, to achieve and demonstrate an understanding of the person
291.8 as a unique individual, and how to implement those plans; and.

291.9 (2) (c) The staff person must review and receive instruction on medication
291.10 administration procedures established for the person when medication administration is
291.11 assigned to the license holder according to section 245D.05, subdivision 1, paragraph
291.12 (b). Unlicensed staff may administer medications only after successful completion of a
291.13 medication administration training, from a training curriculum developed by a registered
291.14 nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse
291.15 practitioner, physician's assistant, or physician incorporating. The training curriculum
291.16 must incorporate an observed skill assessment conducted by the trainer to ensure staff
291.17 demonstrate the ability to safely and correctly follow medication procedures.

291.18 Medication administration must be taught by a registered nurse, clinical nurse
291.19 specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of
291.20 service initiation or any time thereafter, the person has or develops a health care condition
291.21 that affects the service options available to the person because the condition requires:

291.22 (i) (1) specialized or intensive medical or nursing supervision; and

291.23 (ii) (2) nonmedical service providers to adapt their services to accommodate the
291.24 health and safety needs of the person; and.

291.25 (iii) necessary training in order to meet the health service needs of the person as
291.26 determined by the person's physician.

291.27 (d) The staff person must review and receive instruction on the safe and correct
291.28 operation of medical equipment used by the person to sustain life, including but not
291.29 limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided
291.30 by a licensed health care professional or a manufacturer's representative and incorporate
291.31 an observed skill assessment to ensure staff demonstrate the ability to safely and correctly
291.32 operate the equipment according to the treatment orders and the manufacturer's instructions.

291.33 (e) The staff person must review and receive instruction on what constitutes use of
291.34 restraints, time out, and seclusion, including chemical restraint, and staff responsibilities
291.35 related to the prohibitions of their use according to the requirements in section 245D.06,
291.36 subdivision 5, why such procedures are not effective for reducing or eliminating symptoms

292.1 or undesired behavior and why they are not safe, and the safe and correct use of manual
292.2 restraint on an emergency basis according to the requirements in section 245D.061.
292.3 (f) In the event of an emergency service initiation, the license holder must ensure
292.4 the training required in this subdivision occurs within 72 hours of the direct support staff
292.5 person first having unsupervised contact with the person receiving services. The license
292.6 holder must document the reason for the unplanned or emergency service initiation and
292.7 maintain the documentation in the person's service recipient record.
292.8 (g) License holders who provide direct support services themselves must complete
292.9 the orientation required in subdivision 4, clauses (3) to (7).
292.10 Subd. 5. **Annual training.** (a) A license holder must provide annual training to
292.11 direct service support staff on the topics identified in subdivision 4, paragraph (a), clauses
292.12 (3) to (6) (7). Training on relevant topics received from sources other than the license
292.13 holder may count toward training requirements.
292.14 (b) A license holder providing behavioral programming, specialist services, personal
292.15 support, 24-hour emergency assistance, night supervision, independent living skills,
292.16 structured day, prevocational, or supported employment services must provide a minimum
292.17 of eight hours of annual training to direct service staff that addresses:
292.18 (1) topics related to the general health, safety, and service needs of the population
292.19 served by the license holder; and
292.20 (2) other areas identified by the license holder or in the person's current service plan.
292.21 Training on relevant topics received from sources other than the license holder
292.22 may count toward training requirements.
292.23 (c) When the license holder is the owner, lessor, or tenant of the service site and
292.24 whenever a person receiving services is present at the site, the license holder must have
292.25 a staff person available on site who is trained in basic first aid and, when required in a
292.26 person's service plan, cardiopulmonary resuscitation.
292.27 Subd. 5a. **Alternative sources of training.** Orientation or training received by the
292.28 staff person from sources other than the license holder in the same subjects as identified
292.29 in subdivision 4 may count toward the orientation and annual training requirements if
292.30 received in the 12-month period before the staff person's date of hire. The license holder
292.31 must maintain documentation of the training received from other sources and of each staff
292.32 person's competency in the required area according to the requirements in subdivision 3.
292.33 Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a
292.34 subcontractor or temporary staff to perform services licensed under this chapter on the
292.35 license holder's behalf, the license holder must ensure that the subcontractor or temporary
292.36 staff meets and maintains compliance with all requirements under this chapter that apply

293.1 to the services to be provided, including training, orientation, and supervision necessary
293.2 to fulfill their responsibilities. The license holder must ensure that a background study
293.3 has been completed according to the requirements in sections 245C.03, subdivision 1,
293.4 and 245C.04. Subcontractors and temporary staff hired by the license holder must meet
293.5 the Minnesota licensing requirements applicable to the disciplines in which they are
293.6 providing services. The license holder must maintain documentation that the applicable
293.7 requirements have been met.

293.8 Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide
293.9 direct support services to persons served by the program receive the training, orientation,
293.10 and supervision necessary to fulfill their responsibilities. The license holder must ensure
293.11 that a background study has been completed according to the requirements in sections
293.12 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation
293.13 that the applicable requirements have been met.

293.14 Subd. 8. **Staff orientation and training plan.** The license holder must develop
293.15 a staff orientation and training plan documenting when and how compliance with
293.16 subdivisions 4, 4a, and 5 will be met.

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

293.18 Sec. 28. **[245D.091] INTERVENTION SERVICES.**

293.19 Subdivision 1. **Licensure requirements.** An individual meeting the staff
293.20 qualification requirements of this section who is an employee of a program licensed
293.21 according to this chapter and providing behavioral support services, specialist services,
293.22 or crisis respite services is not required to hold a separate license under this chapter.
293.23 An individual meeting the staff qualifications of this section who is not providing these
293.24 services as an employee of a program licensed according to this chapter must obtain a
293.25 license according to this chapter.

293.26 Subd. 2. **Behavior professional qualifications.** A behavior professional, as defined
293.27 in the brain injury and community alternatives for disabled individuals waiver plans or
293.28 successor plans, must have competencies in areas related to:

293.29 (1) ethical considerations;

293.30 (2) functional assessment;

293.31 (3) functional analysis;

293.32 (4) measurement of behavior and interpretation of data;

293.33 (5) selecting intervention outcomes and strategies;

293.34 (6) behavior reduction and elimination strategies that promote least restrictive
293.35 approved alternatives;

294.1 (7) data collection;

294.2 (8) staff and caregiver training;

294.3 (9) support plan monitoring;

294.4 (10) co-occurring mental disorders or neuro-cognitive disorder;

294.5 (11) demonstrated expertise with populations being served; and

294.6 (12) must be a:

294.7 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the
294.8 Board of Psychology competencies in the above identified areas;

294.9 (ii) clinical social worker licensed as an independent clinical social worker under
294.10 chapter 148D, or a person with a master's degree in social work from an accredited college
294.11 or university, with at least 4,000 hours of post-master's supervised experience in the
294.12 delivery of clinical services in the areas identified in clauses (1) to (11);

294.13 (iii) physician licensed under chapter 147 and certified by the American Board
294.14 of Psychiatry and Neurology or eligible for board certification in psychiatry with
294.15 competencies in the areas identified in clauses (1) to (11);

294.16 (iv) licensed professional clinical counselor licensed under sections 148B.29 to
294.17 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery
294.18 of clinical services who has demonstrated competencies in the areas identified in clauses
294.19 (1) to (11);

294.20 (v) person with a master's degree from an accredited college or university in one
294.21 of the behavioral sciences or related fields, with at least 4,000 hours of post-master's
294.22 supervised experience in the delivery of clinical services with demonstrated competencies
294.23 in the areas identified in clauses (1) to (11); or

294.24 (vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is
294.25 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
294.26 mental health nursing by a national nurse certification organization, or who has a master's
294.27 degree in nursing or one of the behavioral sciences or related fields from an accredited
294.28 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
294.29 experience in the delivery of clinical services.

294.30 Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in
294.31 the brain injury and community alternatives for disabled individuals waiver plans or
294.32 successor plans, must:

294.33 (1) have obtained a baccalaureate degree, master's degree, or a PhD in a social
294.34 services discipline; or

294.35 (2) meet the qualifications of a mental health practitioner as defined in section
294.36 245.462, subdivision 17.

295.1 (b) In addition, a behavior analyst must:
295.2 (1) have four years of supervised experience working with individuals who exhibit
295.3 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;
295.4 (2) have received ten hours of instruction in functional assessment and functional
295.5 analysis;
295.6 (3) have received 20 hours of instruction in the understanding of the function of
295.7 behavior;
295.8 (4) have received ten hours of instruction on design of positive practices behavior
295.9 support strategies;
295.10 (5) have received 20 hours of instruction on the use of behavior reduction approved
295.11 strategies used only in combination with behavior positive practices strategies;
295.12 (6) be determined by a behavior professional to have the training and prerequisite
295.13 skills required to provide positive practice strategies as well as behavior reduction
295.14 approved and permitted intervention to the person who receives behavioral support; and
295.15 (7) be under the direct supervision of a behavior professional.
295.16 Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined
295.17 in the brain injury and community alternatives for disabled individuals waiver plans or
295.18 successor plans, must meet the following qualifications:
295.19 (1) have an associate's degree in a social services discipline; or
295.20 (2) have two years of supervised experience working with individuals who exhibit
295.21 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.
295.22 (b) In addition, a behavior specialist must:
295.23 (1) have received a minimum of four hours of training in functional assessment;
295.24 (2) have received 20 hours of instruction in the understanding of the function of
295.25 behavior;
295.26 (3) have received ten hours of instruction on design of positive practices behavioral
295.27 support strategies;
295.28 (4) be determined by a behavior professional to have the training and prerequisite
295.29 skills required to provide positive practices strategies as well as behavior reduction
295.30 approved intervention to the person who receives behavioral support; and
295.31 (5) be under the direct supervision of a behavior professional.
295.32 Subd. 5. **Specialist services qualifications.** An individual providing specialist
295.33 services, as defined in the developmental disabilities waiver plan or successor plan, must
295.34 have:
295.35 (1) the specific experience and skills required of the specialist to meet the needs of
295.36 the person identified by the person's service planning team; and

296.1 (2) the qualifications of the specialist identified in the person's coordinated service
296.2 and support plan.

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

296.4 Sec. 29. **[245D.095] RECORD REQUIREMENTS.**

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

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

296.12 Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of
296.13 current services provided to each person on the premises where the services are provided
296.14 or coordinated. When the services are provided in a licensed facility, the records must
296.15 be maintained at the facility, otherwise the records must be maintained at the license
296.16 holder's program office. The license holder must protect service recipient records against
296.17 loss, tampering, or unauthorized disclosure according to the requirements in sections
296.18 13.01 to 13.10 and 13.46.

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

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

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

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

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

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

297.1 (i) current orders for medication, treatments, or medical equipment and a signed
297.2 authorization from the person or the person's legal representative to administer or assist in
297.3 administering the medication or treatments, if applicable;
297.4 (ii) a signed statement authorizing the license holder to act in a medical emergency
297.5 when the person's legal representative, if any, cannot be reached or is delayed in arriving;
297.6 (iii) medication administration procedures;
297.7 (iv) a medication administration record documenting the implementation of the
297.8 medication administration procedures, the medication administration record reviews, and
297.9 including any agreements for administration of injectable medications by the license
297.10 holder according to the requirements in section 245D.05; and
297.11 (v) a medical appointment schedule when the license holder is assigned
297.12 responsibility for assisting with medical appointments;
297.13 (4) the person's current coordinated service and support plan or that portion of the
297.14 plan assigned to the license holder;
297.15 (5) copies of the individual abuse prevention plan and assessments as required under
297.16 section 245D.071, subdivisions 2 and 3;
297.17 (6) a record of other service providers serving the person when the person's
297.18 coordinated service and support plan identifies the need for coordination between the
297.19 service providers, that includes a contact person and telephone numbers, services being
297.20 provided, and names of staff responsible for coordination;
297.21 (7) documentation of orientation to service recipient rights according to section
297.22 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to
297.23 section 245A.65, subdivision 1, paragraph (c);
297.24 (8) copies of authorizations to handle a person's funds, according to section 245D.06,
297.25 subdivision 4, paragraph (a);
297.26 (9) documentation of complaints received and grievance resolution;
297.27 (10) incident reports involving the person, required under section 245D.06,
297.28 subdivision 1;
297.29 (11) copies of written reports regarding the person's status when requested according
297.30 to section 245D.07, subdivision 3, progress review reports as required under section
297.31 245D.071, subdivision 5, progress or daily log notes that are recorded by the program,
297.32 and reports received from other agencies involved in providing services or care to the
297.33 person; and
297.34 (12) discharge summary, including service termination notice and related
297.35 documentation, when applicable.

298.1 Subd. 4. **Access to service recipient records.** The license holder must ensure that
298.2 the following people have access to the information in subdivision 1 in accordance with
298.3 applicable state and federal law, regulation, or rule:
298.4 (1) the person, the person's legal representative, and anyone properly authorized
298.5 by the person;
298.6 (2) the person's case manager;
298.7 (3) staff providing services to the person unless the information is not relevant to
298.8 carrying out the coordinated service and support plan; and
298.9 (4) the county child or adult foster care licensor, when services are also licensed as
298.10 child or adult foster care.
298.11 Subd. 5. **Personnel records.** (a) The license holder must maintain a personnel
298.12 record of each employee to document and verify staff qualifications, orientation, and
298.13 training. The personnel record must include:
298.14 (1) the employee's date of hire, completed application, an acknowledgement signed
298.15 by the employee that job duties were reviewed with the employee and the employee
298.16 understands those duties, and documentation that the employee meets the position
298.17 requirements as determined by the license holder;
298.18 (2) documentation of staff qualifications, orientation, training, and performance
298.19 evaluations as required under section 245D.09, subdivisions 3 to 5, including the date
298.20 the training was completed, the number of hours per subject area, and the name of the
298.21 trainer or instructor; and
298.22 (3) a completed background study as required under chapter 245C.
298.23 (b) For employees hired after January 1, 2014, the license holder must maintain
298.24 documentation in the personnel record or elsewhere, sufficient to determine the date of the
298.25 employee's first supervised direct contact with a person served by the program, and the
298.26 date of first unsupervised direct contact with a person served by the program.

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

298.28 Sec. 30. Minnesota Statutes 2012, section 245D.10, is amended to read:

298.29 **245D.10 POLICIES AND PROCEDURES.**

298.30 Subdivision 1. **Policy and procedure requirements.** ~~The~~ A license holder
298.31 providing either basic or intensive supports and services must establish, enforce, and
298.32 maintain policies and procedures as required in this chapter, chapter 245A, and other
298.33 applicable state and federal laws and regulations governing the provision of home and
298.34 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:

301.1 (i) policies and procedures in clause (2);
301.2 (ii) emergency use of manual restraints policy and procedure required under
301.3 subdivision 3a; and
301.4 (iii) data privacy requirements under section 245D.11, subdivision 3.
301.5 (c) The license holder must provide a written notice at least 30 days before
301.6 implementing any revised policies and procedures affecting a person's rights under section
301.7 245D.04. The notice must explain the revision that was made and include a copy of
301.8 the revised policy and procedure. The license holder must document the reason for not
301.9 providing the notice at least 30 days before implementing the revisions.
301.10 (d) Before implementing revisions to required policies and procedures, the license
301.11 holder must inform all employees of the revisions and provide training on implementation
301.12 of the revised policies and procedures.

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

301.14 Sec. 31. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT**
301.15 **SERVICES.**
301.16 Subdivision 1. **Policy and procedure requirements.** A license holder providing
301.17 intensive support services as identified in section 245D.03, subdivision 1, paragraph (c),
301.18 must establish, enforce, and maintain policies and procedures as required in this section.
301.19 Subd. 2. **Health and safety.** The license holder must establish policies and
301.20 procedures that promote health and safety by ensuring:
301.21 (1) use of universal precautions and sanitary practices in compliance with section
301.22 245D.06, subdivision 2, clause (5);
301.23 (2) if the license holder operates a residential program, health service coordination
301.24 and care according to the requirements in section 245D.05, subdivision 1;
301.25 (3) safe medication assistance and administration according to the requirements
301.26 in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
301.27 consultation with a registered nurse, nurse practitioner, physician's assistant, or medical
301.28 doctor and require completion of medication administration training according to the
301.29 requirements in section 245D.09, subdivision 4a, paragraph (c). Medication assistance
301.30 and administration includes, but is not limited to:
301.31 (i) providing medication-related services for a person;
301.32 (ii) medication setup;
301.33 (iii) medication administration;
301.34 (iv) medication storage and security;
301.35 (v) medication documentation and charting;

302.1 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
302.2 handling and administration;
302.3 (vii) coordination of medication refills;
302.4 (viii) handling changes to prescriptions and implementation of those changes;
302.5 (ix) communicating with the pharmacy; and
302.6 (x) coordination and communication with prescriber;
302.7 (4) safe transportation, when the license holder is responsible for transportation of
302.8 persons, with provisions for handling emergency situations according to the requirements
302.9 in section 245D.06, subdivision 2, clauses (2) to (4);
302.10 (5) a plan for ensuring the safety of persons served by the program in emergencies as
302.11 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
302.12 to the license holder. A license holder with a community residential setting or a day service
302.13 facility license must ensure the policy and procedures comply with the requirements in
302.14 section 245D.22, subdivision 4;
302.15 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision
302.16 11; and reporting all incidents required to be reported according to section 245D.06,
302.17 subdivision 1. The plan must:
302.18 (i) provide the contact information of a source of emergency medical care and
302.19 transportation; and
302.20 (ii) require staff to first call 911 when the staff believes a medical emergency may be
302.21 life threatening, or to call the mental health crisis intervention team when the person is
302.22 experiencing a mental health crisis; and
302.23 (7) a procedure for the review of incidents and emergencies to identify trends or
302.24 patterns, and corrective action if needed. The license holder must establish and maintain
302.25 a record-keeping system for the incident and emergency reports. Each incident and
302.26 emergency report file must contain a written summary of the incident. The license holder
302.27 must conduct a review of incident reports for identification of incident patterns, and
302.28 implementation of corrective action as necessary to reduce occurrences. Each incident
302.29 report must include:
302.30 (i) the name of the person or persons involved in the incident. It is not necessary
302.31 to identify all persons affected by or involved in an emergency unless the emergency
302.32 resulted in an incident;
302.33 (ii) the date, time, and location of the incident or emergency;
302.34 (iii) a description of the incident or emergency;

303.1 (iv) a description of the response to the incident or emergency and whether a person's
303.2 individual service and support plan or risk management plan, or program policies and
303.3 procedures were implemented as applicable;
303.4 (v) the name of the staff person or persons who responded to the incident or
303.5 emergency; and
303.6 (vi) the determination of whether corrective action is necessary based on the results
303.7 of the review.
303.8 Subd. 3. **Data privacy.** The license holder must establish policies and procedures that
303.9 promote service recipient rights by ensuring data privacy according to the requirements in:
303.10 (1) the Minnesota Government Data Practices Act, section 13.46, and all other
303.11 applicable Minnesota laws and rules in handling all data related to the services provided;
303.12 and
303.13 (2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the
303.14 extent that the license holder performs a function or activity involving the use of protected
303.15 health information as defined under Code of Federal Regulations, title 45, section 164.501,
303.16 including, but not limited to, providing health care services; health care claims processing
303.17 or administration; data analysis, processing, or administration; utilization review; quality
303.18 assurance; billing; benefit management; practice management; repricing; or as otherwise
303.19 provided by Code of Federal Regulations, title 45, section 160.103. The license holder
303.20 must comply with the Health Insurance Portability and Accountability Act of 1996 and
303.21 its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164,
303.22 and all applicable requirements.
303.23 Subd. 4. **Admission criteria.** The license holder must establish policies and
303.24 procedures that promote continuity of care by ensuring that admission or service initiation
303.25 criteria:
303.26 (1) is consistent with the license holder's registration information identified in the
303.27 requirements in section 245D.031, subdivision 2, and with the service-related rights
303.28 identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);
303.29 (2) identifies the criteria to be applied in determining whether the license holder
303.30 can develop services to meet the needs specified in the person's coordinated service and
303.31 support plan;
303.32 (3) requires a license holder providing services in a health care facility to comply
303.33 with the requirements in section 243.166, subdivision 4b, to provide notification to
303.34 residents when a registered predatory offender is admitted into the program or to a
303.35 potential admission when the facility was already serving a registered predatory offender.
303.36 For purposes of this clause, "health care facility" means a facility licensed by the

304.1 commissioner as a residential facility under chapter 245A to provide adult foster care or
304.2 residential services to persons with disabilities;
304.3 (4) requires that the license holder must not refuse to admit a person based solely on
304.4 the basis of the type of residential services a person is receiving or solely on the basis of
304.5 the person's severity of disability, orthopedic or neurological handicaps, sight or hearing
304.6 impairments, lack of communication skills, physical disabilities, toilet habits, behavioral
304.7 disorders, or past failure to make progress; and
304.8 (5) requires that when a person or the person's legal representative requests services
304.9 from the license holder, a refusal to admit the person must be based on an evaluation of
304.10 the person's assessed needs and the license holder's lack of capacity to meet the needs of
304.11 the person. Documentation of the basis for refusal must be provided to the person or the
304.12 person's legal representative and case manager upon request.

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

304.14 Sec. 32. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND**
304.15 **APPLICATION PROCESS.**

304.16 Subdivision 1. **Community residential settings and day service facilities.** For
304.17 purposes of this section, "facility" means both a community residential setting and day
304.18 service facility and the physical plant.
304.19 Subd. 2. **Inspections and code compliance.** (a) Physical plants must comply with
304.20 applicable state and local fire, health, building, and zoning codes.
304.21 (b)(1) The facility must be inspected by a fire marshal or their delegate within
304.22 12 months before initial licensure to verify that it meets the applicable occupancy
304.23 requirements as defined in the State Fire Code and that the facility complies with the fire
304.24 safety standards for that occupancy code contained in the State Fire Code.
304.25 (2) The fire marshal inspection of a community residential setting must verify the
304.26 residence is a dwelling unit within a residential occupancy as defined in section 9.117 of
304.27 the State Fire Code. A home safety checklist, approved by the commissioner, must be
304.28 completed for a community residential setting by the license holder and the commissioner
304.29 before the satellite license is reissued.
304.30 (3) The facility shall be inspected according to the facility capacity specified on the
304.31 initial application form.
304.32 (4) If the commissioner has reasonable cause to believe that a potentially hazardous
304.33 condition may be present or the licensed capacity is increased, the commissioner shall
304.34 request a subsequent inspection and written report by a fire marshal to verify the absence
304.35 of hazard.

305.1 (5) Any condition cited by a fire marshal, building official, or health authority as
305.2 hazardous or creating an immediate danger of fire or threat to health and safety must be
305.3 corrected before a license is issued by the department, and for community residential
305.4 settings, before a license is reissued.
305.5 (c) The facility must maintain in a permanent file the reports of health, fire, and
305.6 other safety inspections.
305.7 (d) The facility's plumbing, ventilation, heating, cooling, lighting, and other
305.8 fixtures and equipment, including elevators or food service, if provided, must conform to
305.9 applicable health, sanitation, and safety codes and regulations.

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

305.11 Sec. 33. **[245D.22] FACILITY SANITATION AND HEALTH.**
305.12 Subdivision 1. **General maintenance.** The license holder must maintain the interior
305.13 and exterior of buildings, structures, or enclosures used by the facility, including walls,
305.14 floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a
305.15 sanitary and safe condition. The facility must be clean and free from accumulations of
305.16 dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must
305.17 correct building and equipment deterioration, safety hazards, and unsanitary conditions.
305.18 Subd. 2. **Hazards and toxic substances.** The license holder must ensure that
305.19 service sites owned or leased by the license holder are free from hazards that would
305.20 threaten the health or safety of a person receiving services by ensuring the requirements
305.21 in paragraphs (a) to (g) are met.
305.22 (a) Chemicals, detergents, and other hazardous or toxic substances must not be
305.23 stored with food products or in any way that poses a hazard to persons receiving services.
305.24 (b) The license holder must install handrails and nonslip surfaces on interior and
305.25 exterior runways, stairways, and ramps according to the applicable building code.
305.26 (c) If there are elevators in the facility, the license holder must have elevators
305.27 inspected each year. The date of the inspection, any repairs needed, and the date the
305.28 necessary repairs were made must be documented.
305.29 (d) The license holder must keep stairways, ramps, and corridors free of obstructions.
305.30 (e) Outside property must be free from debris and safety hazards. Exterior stairs and
305.31 walkways must be kept free of ice and snow.
305.32 (f) Heating, ventilation, air conditioning units, and other hot surfaces and moving
305.33 parts of machinery must be shielded or enclosed.
305.34 (g) Use of dangerous items or equipment by persons served by the program must be
305.35 allowed in accordance with the person's coordinated service and support plan addendum

306.1 or the program abuse prevention plan, if not addressed in the coordinated service and
306.2 support plan addendum.

306.3 Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in
306.4 the facility that are named in section 152.02, subdivision 3, must be stored in a locked
306.5 storage area permitting access only by persons and staff authorized to administer the
306.6 medication. This must be incorporated into the license holder's medication administration
306.7 policy and procedures required under section 245D.11, subdivision 2, clause (3).
306.8 Medications must be disposed of according to the Environmental Protection Agency
306.9 recommendations.

306.10 Subd. 4. **First aid.** (a) A staff person must be trained in first aid and, when required
306.11 in a person's coordinated service and support plan, cardiopulmonary resuscitation, in
306.12 compliance with section 245D.06, subdivision 2, clause (1), item (iv).

306.13 (b) A facility must have first aid kits readily available for use by, and that meets
306.14 the needs of, persons receiving services and staff. At a minimum, the first aid kit must
306.15 be equipped with accessible first aid supplies including bandages, sterile compresses,
306.16 scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap,
306.17 adhesive tape, and first aid manual.

306.18 Subd. 5. **Emergencies.** (a) The license holder must have a written plan for
306.19 responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the
306.20 safety of persons served in the facility. The plan must include:

306.21 (1) procedures for emergency evacuation and emergency sheltering, including:

306.22 (i) how to report a fire or other emergency;

306.23 (ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive
306.24 procedures or equipment to assist with the safe evacuation of persons with physical or
306.25 sensory disabilities; and

306.26 (iii) instructions on closing off the fire area, using fire extinguishers, and activating
306.27 and responding to alarm systems;

306.28 (2) a floor plan that identifies:

306.29 (i) the location of fire extinguishers;

306.30 (ii) the location of audible or visual alarm systems, including but not limited to
306.31 manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and
306.32 sprinkler systems;

306.33 (iii) the location of exits, primary and secondary evacuation routes, and accessible
306.34 egress routes, if any; and

306.35 (iv) the location of emergency shelter within the facility;

306.36 (3) a site plan that identifies:

307.1 (i) designated assembly points outside the facility;
307.2 (ii) the locations of fire hydrants; and
307.3 (iii) the routes of fire department access;
307.4 (4) the responsibilities each staff person must assume in case of emergency;
307.5 (5) procedures for conducting quarterly drills each year and recording the date of
307.6 each drill in the file of emergency plans;
307.7 (6) procedures for relocation or service suspension when services are interrupted
307.8 for more than 24 hours;
307.9 (7) for a community residential setting with three or more dwelling units, a floor
307.10 plan that identifies the location of enclosed exit stairs; and
307.11 (8) an emergency escape plan for each resident.
307.12 (b) The license holder must:
307.13 (1) maintain a log of quarterly fire drills on file in the facility;
307.14 (2) provide an emergency response plan that is readily available to staff and persons
307.15 receiving services;
307.16 (3) inform each person of a designated area within the facility where the person
307.17 should go to for emergency shelter during severe weather and the designated assembly
307.18 points outside the facility; and
307.19 (4) maintain emergency contact information for persons served at the facility that
307.20 can be readily accessed in an emergency.
307.21 Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable
307.22 radio or television set that do not require electricity and can be used if a power failure
307.23 occurs.
307.24 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated
307.25 telephone that is readily accessible. A list of emergency numbers must be posted in a
307.26 prominent location. When an area has a 911 number or a mental health crisis intervention
307.27 team number, both numbers must be posted and the emergency number listed must be
307.28 911. In areas of the state without a 911 number, the numbers listed must be those of the
307.29 local fire department, police department, emergency transportation, and poison control
307.30 center. The names and telephone numbers of each person's representative, physician, and
307.31 dentist must be readily available.

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

307.33 Sec. 34. **[245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE**
307.34 **LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

308.1 Subdivision 1. **Separate satellite license required for separate sites.** (a) A license
308.2 holder providing residential support services must obtain a separate satellite license for
308.3 each community residential setting located at separate addresses when the community
308.4 residential settings are to be operated by the same license holder. For purposes of this
308.5 chapter, a community residential setting is a satellite of the home and community-based
308.6 services license.

308.7 (b) Community residential settings are permitted single-family use homes. After a
308.8 license has been issued, the commissioner shall notify the local municipality where the
308.9 residence is located of the approved license.

308.10 Subd. 2. **Notification to local agency.** The license holder must notify the local
308.11 agency within 24 hours of the onset of changes in a residence resulting from construction,
308.12 remodeling, or damages requiring repairs that require a building permit or may affect a
308.13 licensing requirement in this chapter.

308.14 Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate
308.15 overnight supervision technology adult foster care license according to section 245A.11,
308.16 subdivision 7a, that converts to a community residential setting satellite license according
308.17 to this chapter must retain that designation.

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

308.19 Sec. 35. **[245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL**
308.20 **PLANT AND ENVIRONMENT.**

308.21 Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling
308.22 unit in a residential occupancy.

308.23 Subd. 2. **Common area requirements.** The living area must be provided with an
308.24 adequate number of furnishings for the usual functions of daily living and social activities.
308.25 The dining area must be furnished to accommodate meals shared by all persons living in
308.26 the residence. These furnishings must be in good repair and functional to meet the daily
308.27 needs of the persons living in the residence.

308.28 Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in
308.29 writing, to sharing a bedroom with one another. No more than two people receiving
308.30 services may share one bedroom.

308.31 (b) A single occupancy bedroom must have at least 80 square feet of floor space with
308.32 a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
308.33 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and
308.34 other habitable rooms by floor to ceiling walls containing no openings except doorways
308.35 and must not serve as a corridor to another room used in daily living.

309.1 (c) A person's personal possessions and items for the person's own use are the only
309.2 items permitted to be stored in a person's bedroom.
309.3 (d) Unless otherwise documented through assessment as a safety concern for the
309.4 person, each person must be provided with the following furnishings:
309.5 (1) a separate bed of proper size and height for the convenience and comfort of the
309.6 person, with a clean mattress in good repair;
309.7 (2) clean bedding appropriate for the season for each person;
309.8 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
309.9 possessions and clothing; and
309.10 (4) a mirror for grooming.
309.11 (e) When possible, a person must be allowed to have items of furniture that the
309.12 person personally owns in the bedroom, unless doing so would interfere with safety
309.13 precautions, violate a building or fire code, or interfere with another person's use of the
309.14 bedroom. A person may choose to not have a cabinet, dresser, shelves, or a mirror in the
309.15 bedroom, as otherwise required under paragraph (d), clause (3) or (4). If a person chooses
309.16 not to have a piece of required furniture, the license holder must document this choice and
309.17 is not required to provide the item.
309.18 (f) A person must be allowed to bring personal possessions into the bedroom
309.19 and other designated storage space, if such space is available, in the residence. The
309.20 person must be allowed to accumulate possessions to the extent the residence is able to
309.21 accommodate them, unless doing so is contraindicated for the person's physical or mental
309.22 health, would interfere with safety precautions or another person's use of the bedroom, or
309.23 would violate a building or fire code. The license holder must allow for locked storage
309.24 of personal items. Any restriction on the possession or locked storage of personal items,
309.25 including requiring a person to use a lock provided by the license holder, must comply
309.26 with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if
309.27 and when the license holder opens the lock.

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

309.29 Sec. 36. **[245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND**
309.30 **WATER.**

309.31 Subdivision 1. **Water.** Potable water from privately owned wells must be tested
309.32 annually by a Department of Health-certified laboratory for coliform bacteria and nitrate
309.33 nitrogens to verify safety. The health authority may require retesting and corrective
309.34 measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in

310.1 the event of a flooding or incident which may put the well at risk of contamination. To
310.2 prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

310.3 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as
310.4 prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day
310.5 must be served or made available to persons, and nutritious snacks must be available
310.6 between meals.

310.7 Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to
310.8 prevent contamination, spoilage, or a threat to the health of a person.

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

310.10 Sec. 37. **[245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION**
310.11 **AND HEALTH.**

310.12 Subdivision 1. **Goods provided by the license holder.** Individual clean bed linens
310.13 appropriate for the season and the person's comfort, including towels and wash cloths,
310.14 must be available for each person. Usual or customary goods for the operation of a
310.15 residence which are communally used by all persons receiving services living in the
310.16 residence must be provided by the license holder, including household items for meal
310.17 preparation, cleaning supplies to maintain the cleanliness of the residence, window
310.18 coverings on windows for privacy, toilet paper, and hand soap.

310.19 Subd. 2. **Personal items.** Personal health and hygiene items must be stored in a
310.20 safe and sanitary manner.

310.21 Subd. 3. **Pets and service animals.** Pets and service animals housed within
310.22 the residence must be immunized and maintained in good health as required by local
310.23 ordinances and state law. The license holder must ensure that the person and the person's
310.24 representative is notified before admission of the presence of pets in the residence.

310.25 Subd. 4. **Smoking in the residence.** License holders must comply with the
310.26 requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when
310.27 smoking is permitted in the residence.

310.28 Subd. 5. **Weapons.** Weapons and ammunition must be stored separately in locked
310.29 areas that are inaccessible to a person receiving services. For purposes of this subdivision,
310.30 "weapons" means firearms and other instruments or devices designed for and capable of
310.31 producing bodily harm.

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

311.1 Sec. 38. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE**
311.2 **REQUIREMENTS AND APPLICATION PROCESS.**

311.3 Except for day service facilities on the same or adjoining lot, the license holder
311.4 providing day services must apply for a separate license for each facility-based service
311.5 site when the license holder is the owner, lessor, or tenant of the service site at which
311.6 persons receive day services and the license holder's employees who provide day services
311.7 are present for a cumulative total of more than 30 days within any 12-month period. For
311.8 purposes of this chapter, a day services facility license is a satellite license of the day
311.9 services program. A day services program may operate multiple licensed day service
311.10 facilities in one or more counties in the state. For the purposes of this section, "adjoining
311.11 lot" means day services facilities that are next door to or across the street from one another.

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

311.13 Sec. 39. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND**
311.14 **SPACE REQUIREMENTS.**

311.15 Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility
311.16 capacity of each day service facility must be determined by the amount of primary space
311.17 available, the scheduling of activities at other service sites, and the space requirements of
311.18 all persons receiving services at the facility, not just the licensed services. The facility
311.19 capacity must specify the maximum number of persons that may receive services on
311.20 site at any one time.

311.21 (b) When a facility is located in a multifunctional organization, the facility may
311.22 share common space with the multifunctional organization if the required available
311.23 primary space for use by persons receiving day services is maintained while the facility is
311.24 operating. The license holder must comply at all times with all applicable fire and safety
311.25 codes under section 245A.04, subdivision 2a, and adequate supervision requirements
311.26 under section 245D.31 for all persons receiving day services.

311.27 (c) A day services facility must have a minimum of 40 square feet of primary space
311.28 available for each person and each staff person or employee who is present at the site at
311.29 any one time. Primary space does not include:

311.30 (1) common areas, such as hallways, stairways, closets, utility areas, bathrooms,
311.31 and kitchens;

311.32 (2) floor areas beneath stationary equipment; or

311.33 (3) any space occupied by persons associated with the multifunctional organization
311.34 while persons receiving day services are using common space.

312.1 Subd. 2. **Individual personal articles.** Each person must be provided space in a
312.2 closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own
312.3 use while receiving services at the facility, unless doing so would interfere with safety
312.4 precautions, another person's work space, or violate a building or fire code.

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

312.6 Sec. 40. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY**
312.7 **REQUIREMENTS.**

312.8 Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service
312.9 sites owned or leased by the license holder for storing perishable foods and perishable
312.10 portions of bag lunches, whether the foods are supplied by the license holder or the
312.11 persons receiving services, the refrigeration must have a temperature of 40 degrees
312.12 Fahrenheit or less.

312.13 Subd. 2. **Drinking water.** Drinking water must be available to all persons
312.14 receiving services. If a person is unable to request or obtain drinking water, it must be
312.15 provided according to that person's individual needs. Drinking water must be provided in
312.16 single-service containers or from drinking fountains accessible to all persons.

312.17 Subd. 3. **Individuals who become ill during the day.** There must be an area in
312.18 which a person receiving services can rest if:

312.19 (1) the person becomes ill during the day;

312.20 (2) the person does not live in a licensed residential site;

312.21 (3) the person requires supervision; and

312.22 (4) there is not a caretaker immediately available. Supervision must be provided
312.23 until the caretaker arrives to bring the person home.

312.24 Subd. 4. **Safety procedures.** The license holder must establish general written
312.25 safety procedures that include criteria for selecting, training, and supervising persons who
312.26 work with hazardous machinery, tools, or substances. Safety procedures specific to each
312.27 person's activities must be explained and be available in writing to all staff members
312.28 and persons receiving services.

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

312.30 Sec. 41. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND**
312.31 **FACILITY COVERAGE.**

312.32 Subdivision 1. **Scope.** This section applies only to facility-based day services.

313.1 Subd. 2. **Factors.** (a) The number of direct support service staff members that a
313.2 license holder must have on duty at the facility at a given time to meet the minimum
313.3 staffing requirements established in this section varies according to:
313.4 (1) the number of persons who are enrolled and receiving direct support services
313.5 at that given time;
313.6 (2) the staff ratio requirement established under subdivision 3 for each person who
313.7 is present; and
313.8 (3) whether the conditions described in subdivision 8 exist and warrant additional
313.9 staffing beyond the number determined to be needed under subdivision 7.
313.10 (b) The commissioner must consider the factors in paragraph (a) in determining a
313.11 license holder's compliance with the staffing requirements and must further consider
313.12 whether the staff ratio requirement established under subdivision 3 for each person
313.13 receiving services accurately reflects the person's need for staff time.
313.14 Subd. 3. **Staff ratio requirement for each person receiving services.** The case
313.15 manager, in consultation with the interdisciplinary team, must determine at least once each
313.16 year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving
313.17 services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio
313.18 assigned each person and the documentation of how the ratio was arrived at must be kept
313.19 in each person's individual service plan. Documentation must include an assessment of the
313.20 person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard
313.21 assessment form required by the commissioner.
313.22 Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a
313.23 staff ratio requirement of one to four if:
313.24 (1) on a daily basis the person requires total care and monitoring or constant
313.25 hand-over-hand physical guidance to successfully complete at least three of the following
313.26 activities: toileting, communicating basic needs, eating, ambulating; or is not capable of
313.27 taking appropriate action for self-preservation under emergency conditions; or
313.28 (2) the person engages in conduct that poses an imminent risk of physical harm to
313.29 self or others at a documented level of frequency, intensity, or duration requiring frequent
313.30 daily ongoing intervention and monitoring as established in the person's coordinated
313.31 service and support plan or coordinated service and support plan addendum.
313.32 Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a
313.33 staff ratio requirement of one to eight if:
313.34 (1) the person does not meet the requirements in subdivision 4; and
313.35 (2) on a daily basis the person requires verbal prompts or spot checks and minimal
313.36 or no physical assistance to successfully complete at least four of the following activities:

314.1 toileting, communicating basic needs, eating, ambulating, or taking appropriate action for
314.2 self-preservation under emergency conditions.
314.3 Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have
314.4 any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio
314.5 requirement of one to six.
314.6 Subd. 7. **Determining number of direct support service staff required.** The
314.7 minimum number of direct support service staff members required at any one time to
314.8 meet the combined staff ratio requirements of the persons present at that time can be
314.9 determined by the following steps:
314.10 (1) assign each person in attendance the three-digit decimal below that corresponds
314.11 to the staff ratio requirement assigned to that person. A staff ratio requirement of one to
314.12 four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio
314.13 requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;
314.14 (2) add all of the three-digit decimals (one three-digit decimal for every person in
314.15 attendance) assigned in clause (1);
314.16 (3) when the sum in clause (2) falls between two whole numbers, round off the sum
314.17 to the larger of the two whole numbers; and
314.18 (4) the larger of the two whole numbers in clause (3) equals the number of direct
314.19 support service staff members needed to meet the staff ratio requirements of the persons
314.20 in attendance.
314.21 Subd. 8. **Staff to be included in calculating minimum staffing requirement.** Only
314.22 direct support staff must be counted as staff members in calculating the staff to participant
314.23 ratio. A volunteer may be counted as a direct support staff in calculating the staff to
314.24 participant ratio if the volunteer meets the same standards and requirements as paid staff.
314.25 No person receiving services must be counted as or be substituted for a staff member in
314.26 calculating the staff to participant ratio.
314.27 Subd. 9. **Conditions requiring additional direct support staff.** The license holder
314.28 must increase the number of direct support staff members present at any one time beyond
314.29 the number arrived at in subdivision 4 if necessary when any one or combination of the
314.30 following circumstances can be documented by the commissioner as existing:
314.31 (1) the health and safety needs of the persons receiving services cannot be met by
314.32 the number of staff members available under the staffing pattern in effect even though the
314.33 number has been accurately calculated under subdivision 7; or
314.34 (2) the person's conduct frequently presents an imminent risk of physical harm to
314.35 self or others.

315.1 Subd. 10. **Supervision requirements.** (a) At no time must one direct support
315.2 staff member be assigned responsibility for supervision and training of more than ten
315.3 persons receiving supervision and training, except as otherwise stated in each person's risk
315.4 management plan.
315.5 (b) In the temporary absence of the director or a supervisor, a direct support staff
315.6 member must be designated to supervise the center.
315.7 Subd. 11. **Multifunctional programs.** A multifunctional program may count other
315.8 employees of the organization besides direct support staff of the day service facility in
315.9 calculating the staff to participant ratio if the employee is assigned to the day services
315.10 facility for a specified amount of time, during which the employee is not assigned to
315.11 another organization or program.

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

315.13 Sec. 42. **[245D.32] ALTERNATIVE LICENSING INSPECTIONS.**
315.14 Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license
315.15 holder providing services licensed under this chapter, with a qualifying accreditation and
315.16 meeting the eligibility criteria in paragraphs (b) and (c) may request approval for an
315.17 alternative licensing inspection when all services provided under the license holder's
315.18 license are accredited. A license holder with a qualifying accreditation and meeting
315.19 the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative
315.20 licensing inspection for individual community residential settings or day services facilities
315.21 licensed under this chapter.
315.22 (b) In order to be eligible for an alternative licensing inspection, the program must
315.23 have had at least one inspection by the commissioner following issuance of the initial
315.24 license. For programs operating a day services facility, each facility must have had at least
315.25 one on-site inspection by the commissioner following issuance of the initial license.
315.26 (c) In order to be eligible for an alternative licensing inspection, the program must
315.27 have been in "substantial and consistent compliance" at the time of the last licensing
315.28 inspection and during the current licensing period. For purposes of this section, substantial
315.29 and consistent compliance means:
315.30 (1) the license holder's license was not made conditional, suspended, or revoked;
315.31 (2) there have been no substantiated allegations of maltreatment against the license
315.32 holder;
315.33 (3) there were no program deficiencies identified that would jeopardize the health,
315.34 safety, or rights of persons being served; and

316.1 (4) the license holder maintained substantial compliance with the other requirements
316.2 of chapters 245A and 245C and other applicable laws and rules.
316.3 (d) For the purposes of this section, the license holder's license includes services
316.4 licensed under this chapter that were previously licensed under chapter 245B until
316.5 December 31, 2013.
316.6 Subd. 2. **Qualifying accreditation.** The commissioner must accept a three-year
316.7 accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)
316.8 as a qualifying accreditation.
316.9 Subd. 3. **Request for approval of an alternative inspection status.** (a) A request
316.10 for an alternative inspection must be made on the forms and in the manner prescribed
316.11 by the commissioner. When submitting the request, the license holder must submit all
316.12 documentation issued by the accrediting body verifying that the license holder has obtained
316.13 and maintained the qualifying accreditation and has complied with recommendations
316.14 or requirements from the accrediting body during the period of accreditation. Based
316.15 on the request and the additional required materials, the commissioner may approve
316.16 an alternative inspection status.
316.17 (b) The commissioner must notify the license holder in writing that the request for
316.18 an alternative inspection status has been approved. Approval must be granted until the
316.19 end of the qualifying accreditation period.
316.20 (c) The license holder must submit a written request for approval to be renewed
316.21 one month before the end of the current approval period according to the requirements
316.22 in paragraph (a). If the license holder does not submit a request to renew approval as
316.23 required, the commissioner must conduct a licensing inspection.
316.24 Subd. 4. **Programs approved for alternative licensing inspection; deemed**
316.25 **compliance licensing requirements.** (a) A license holder approved for alternative
316.26 licensing inspection under this section is required to maintain compliance with all
316.27 licensing standards according to this chapter.
316.28 (b) A license holder approved for alternative licensing inspection under this section
316.29 must be deemed to be in compliance with all the requirements of this chapter, and the
316.30 commissioner must not perform routine licensing inspections.
316.31 (c) Upon receipt of a complaint regarding the services of a license holder approved
316.32 for alternative licensing inspection under this section, the commissioner must investigate
316.33 the complaint and may take any action as provided under section 245A.06 or 245A.07.
316.34 Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this
316.35 section changes the commissioner's responsibilities to investigate alleged or suspected
316.36 maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

317.1 Subd. 6. **Termination or denial of subsequent approval.** Following approval of
317.2 an alternative licensing inspection, the commissioner may terminate or deny subsequent
317.3 approval of an alternative licensing inspection if the commissioner determines that:
317.4 (1) the license holder has not maintained the qualifying accreditation;
317.5 (2) the commissioner has substantiated maltreatment for which the license holder or
317.6 facility is determined to be responsible during the qualifying accreditation period; or
317.7 (3) during the qualifying accreditation period, the license holder has been issued
317.8 an order for conditional license, fine, suspension, or license revocation that has not been
317.9 reversed upon appeal.
317.10 Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for
317.11 an alternative licensing inspection have not been met is final and not subject to appeal
317.12 under the provisions of chapter 14.
317.13 Subd. 8. **Commissioner's programs.** Home and community-based services licensed
317.14 under this chapter for which the commissioner is the license holder with a qualifying
317.15 accreditation are excluded from being approved for an alternative licensing inspection.

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

317.17 Sec. 43. **[245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.**
317.18 (a) The commissioner of human services shall issue a mental health certification
317.19 for services licensed under this chapter, when a license holder is determined to have met
317.20 the requirements under paragraph (b). This certification is voluntary for license holders.
317.21 The certification shall be printed on the license and identified on the commissioner's
317.22 public Web site.
317.23 (b) The requirements for certification are:
317.24 (1) all staff have received at least seven hours of annual training covering all of
317.25 the following topics:
317.26 (i) mental health diagnoses;
317.27 (ii) mental health crisis response and de-escalation techniques;
317.28 (iii) recovery from mental illness;
317.29 (iv) treatment options, including evidence-based practices;
317.30 (v) medications and their side effects;
317.31 (vi) co-occurring substance abuse and health conditions; and
317.32 (vii) community resources;
317.33 (2) a mental health professional, as defined in section 245.462, subdivision 18, or a
317.34 mental health practitioner as defined in section 245.462, subdivision 17, is available
317.35 for consultation and assistance;

318.1 (3) there is a plan and protocol in place to address a mental health crisis; and

318.2 (4) each person's individual service and support plan identifies who is providing
318.3 clinical services and their contact information, and includes an individual crisis prevention
318.4 and management plan developed with the person.

318.5 (c) License holders seeking certification under this section must request this
318.6 certification on forms and in the manner prescribed by the commissioner.

318.7 (d) If the commissioner finds that the license holder has failed to comply with the
318.8 certification requirements under paragraph (b), the commissioner may issue a correction
318.9 order and an order of conditional license in accordance with section 245A.06 or may
318.10 issue a sanction in accordance with section 245A.07, including and up to removal of
318.11 the certification.

318.12 (e) A denial of the certification or the removal of the certification based on a
318.13 determination that the requirements under paragraph (b) have not been met is not subject to
318.14 appeal. A license holder that has been denied a certification or that has had a certification
318.15 removed may again request certification when the license holder is in compliance with the
318.16 requirements of paragraph (b).

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

318.18 Sec. 44. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

318.19 Subdivision 1. **Provider qualifications.** (a) For the home and community-based
318.20 waivers providing services to seniors and individuals with disabilities under sections
318.21 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

318.22 (1) agreements with enrolled waiver service providers to ensure providers meet
318.23 Minnesota health care program requirements;

318.24 (2) regular reviews of provider qualifications, and including requests of proof of
318.25 documentation; and

318.26 (3) processes to gather the necessary information to determine provider qualifications.

318.27 (b) Beginning July 1, 2012, staff that provide direct contact, as defined in section
318.28 245C.02, subdivision 11, for services specified in the federally approved waiver plans
318.29 must meet the requirements of chapter 245C prior to providing waiver services and as
318.30 part of ongoing enrollment. Upon federal approval, this requirement must also apply to
318.31 consumer-directed community supports.

318.32 (c) Beginning January 1, 2014, service owners and managerial officials overseeing
318.33 the management or policies of services that provide direct contact as specified in the
318.34 federally approved waiver plans must meet the requirements of chapter 245C prior to

319.1 reenrollment or, for new providers, prior to initial enrollment if they have not already done
319.2 so as a part of service licensure requirements.

319.3 Sec. 45. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:
319.4 Subd. 7. **Applicant and license holder training.** An applicant or license holder
319.5 for the home and community-based waivers providing services to seniors and individuals
319.6 with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is
319.7 not enrolled as a Minnesota health care program home and community-based services
319.8 waiver provider at the time of application must ensure that at least one controlling
319.9 individual completes a onetime training on the requirements for providing home and
319.10 community-based services ~~from a qualified source~~ as determined by the commissioner,
319.11 before a provider is enrolled or license is issued. Within six months of enrollment, a newly
319.12 enrolled home and community-based waiver service provider must ensure that at least one
319.13 controlling individual has completed training on waiver and related program billing.

319.14 Sec. 46. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
319.15 subdivision to read:
319.16 Subd. 8. **Definitions.** (a) For the purposes of this section the following terms have
319.17 the meanings given them.
319.18 (b) "Controlling individual" means a public body, governmental agency, business
319.19 entity, officer, owner, or managerial official whose responsibilities include the direction of
319.20 the management or policies of a program.
319.21 (c) "Managerial official" means an individual who has decision-making authority
319.22 related to the operation of the program and responsibility for the ongoing management of
319.23 or direction of the policies, services, or employees of the program.
319.24 (d) "Owner" means an individual who has direct or indirect ownership interest in
319.25 a corporation or partnership, or business association enrolling with the Department of
319.26 Human Services as a provider of waiver services.

319.27 Sec. 47. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
319.28 subdivision to read:
319.29 Subd. 9. **Enrollment requirements.** All home and community-based waiver
319.30 providers must provide, at the time of enrollment and within 30 days of a request, in a
319.31 format determined by the commissioner, information and documentation that includes, but
319.32 is not limited to, the following:

320.1 (1) proof of surety bond coverage in the amount of $50,000 or ten percent of the
320.2 provider's payments from Medicaid in the previous calendar year, whichever is greater;
320.3 (2) proof of fidelity bond coverage in the amount of $20,000; and
320.4 (3) proof of liability insurance.

320.5 Sec. 48. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:
320.6 Subd. 9a. **Evaluation and referral of reports made to common entry point unit.**
320.7 The common entry point must screen the reports of alleged or suspected maltreatment for
320.8 immediate risk and make all necessary referrals as follows:
320.9 (1) if the common entry point determines that there is an immediate need for
320.10 adult protective services, the common entry point agency shall immediately notify the
320.11 appropriate county agency;
320.12 (2) if the report contains suspected criminal activity against a vulnerable adult, the
320.13 common entry point shall immediately notify the appropriate law enforcement agency;
320.14 (3) the common entry point shall refer all reports of alleged or suspected
320.15 maltreatment to the appropriate lead investigative agency as soon as possible, but in any
320.16 event no longer than two working days; and
320.17 ~~(4) if the report involves services licensed by the Department of Human Services~~
320.18 ~~and subject to chapter 245D, the common entry point shall refer the report to the county as~~
320.19 ~~the lead agency according to clause (3), but shall also notify the Department of Human~~
320.20 ~~Services of the report; and~~
320.21 ~~(5)~~ (4) if the report contains information about a suspicious death, the common
320.22 entry point shall immediately notify the appropriate law enforcement agencies, the local
320.23 medical examiner, and the ombudsman for mental health and developmental disabilities
320.24 established under section 245.92. Law enforcement agencies shall coordinate with the
320.25 local medical examiner and the ombudsman as provided by law.

320.26 Sec. 49. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:
320.27 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
320.28 administrative agency responsible for investigating reports made under section 626.557.
320.29 (a) The Department of Health is the lead investigative agency for facilities or
320.30 services licensed or required to be licensed as hospitals, home care providers, nursing
320.31 homes, boarding care homes, hospice providers, residential facilities that are also federally
320.32 certified as intermediate care facilities that serve people with developmental disabilities,
320.33 or any other facility or service not listed in this subdivision that is licensed or required to
320.34 be licensed by the Department of Health for the care of vulnerable adults. "Home care

321.1 provider" has the meaning provided in section 144A.43, subdivision 4, and applies when
321.2 care or services are delivered in the vulnerable adult's home, whether a private home or a
321.3 housing with services establishment registered under chapter 144D, including those that
321.4 offer assisted living services under chapter 144G.

321.5 (b) ~~Except as provided under paragraph (c), for services licensed according to~~
321.6 ~~chapter 245D,~~ The Department of Human Services is the lead investigative agency for
321.7 facilities or services licensed or required to be licensed as adult day care, adult foster care,
321.8 programs for people with developmental disabilities, family adult day services, mental
321.9 health programs, mental health clinics, chemical dependency programs, the Minnesota
321.10 sex offender program, or any other facility or service not listed in this subdivision that is
321.11 licensed or required to be licensed by the Department of Human Services.

321.12 (c) The county social service agency or its designee is the lead investigative agency
321.13 for all other reports, including, but not limited to, reports involving vulnerable adults
321.14 receiving services from a personal care provider organization under section 256B.0659~~,~~
321.15 ~~or receiving home and community-based services licensed by the Department of Human~~
321.16 ~~Services and subject to chapter 245D~~.

321.17 Sec. 50. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
321.18 **AND COMMUNITY-BASED SERVICES.**

321.19 (a) The Department of Health Compliance Monitoring Division and the Department
321.20 of Human Services Licensing Division shall jointly develop an integrated licensing system
321.21 for providers of both home care services subject to licensure under Minnesota Statutes,
321.22 chapter 144A, and for home and community-based services subject to licensure under
321.23 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

321.24 (1) require only one license of any provider of services under Minnesota Statutes,
321.25 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

321.26 (2) promote quality services that recognize a person's individual needs and protect
321.27 the person's health, safety, rights, and well-being;

321.28 (3) promote provider accountability through application requirements, compliance
321.29 inspections, investigations, and enforcement actions;

321.30 (4) reference other applicable requirements in existing state and federal laws,
321.31 including the federal Affordable Care Act;

321.32 (5) establish internal procedures to facilitate ongoing communications between the
321.33 agencies, and with providers and services recipients about the regulatory activities;

321.34 (6) create a link between the agency Web sites so that providers and the public can
321.35 access the same information regardless of which Web site is accessed initially; and

322.1 (7) collect data on identified outcome measures as necessary for the agencies to
322.2 report to the Centers for Medicare and Medicaid Services.
322.3 (b) The joint recommendations for legislative changes to implement the integrated
322.4 licensing system are due to the legislature by February 15, 2014.
322.5 (c) Before implementation of the integrated licensing system, providers licensed as
322.6 home care providers under Minnesota Statutes, chapter 144A, may also provide home
322.7 and community-based services subject to licensure under Minnesota Statutes, chapter
322.8 245D, without obtaining a home and community-based services license under Minnesota
322.9 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
322.10 apply to these providers:
322.11 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
322.12 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;
322.13 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
322.14 enforced by the Department of Health under the enforcement authority set forth in
322.15 Minnesota Statutes, section 144A.475; and
322.16 (3) the Department of Health will provide information to the Department of Human
322.17 Services about each provider licensed under this section, including the provider's license
322.18 application, licensing documents, inspections, information about complaints received, and
322.19 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

322.20 Sec. 51. **REPEALER.**
322.21 (a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031;
322.22 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and
322.23 245B.08, are repealed effective January 1, 2014.
322.24 (b) Minnesota Statutes 2012, sections 256B.092, subdivision 11; and 256B.49,
322.25 subdivision 22, are repealed.
322.26 (c) Minnesota Statutes 2012, section 245D.08, is repealed.

322.27 **ARTICLE 10**
322.28 **WAIVER PROVIDER STANDARDS TECHNICAL CHANGES**

322.29 Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:
322.30 Subd. 5. **Specific purchases.** The solicitation process described in this chapter is
322.31 not required for acquisition of the following:
322.32 (1) merchandise for resale purchased under policies determined by the commissioner;
322.33 (2) farm and garden products which, as determined by the commissioner, may be
322.34 purchased at the prevailing market price on the date of sale;

323.1 (3) goods and services from the Minnesota correctional facilities;
323.2 (4) goods and services from rehabilitation facilities and extended employment
323.3 providers that are certified by the commissioner of employment and economic
323.4 development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01~~
323.5 ~~to 245B.08~~ chapter 245D;
323.6 (5) goods and services for use by a community-based facility operated by the
323.7 commissioner of human services;
323.8 (6) goods purchased at auction or when submitting a sealed bid at auction provided
323.9 that before authorizing such an action, the commissioner consult with the requesting
323.10 agency to determine a fair and reasonable value for the goods considering factors
323.11 including, but not limited to, costs associated with submitting a bid, travel, transportation,
323.12 and storage. This fair and reasonable value must represent the limit of the state's bid;
323.13 (7) utility services where no competition exists or where rates are fixed by law or
323.14 ordinance; and
323.15 (8) goods and services from Minnesota sex offender program facilities.

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

323.17 Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:
323.18 Subdivision 1. **Service contracts.** The commissioner of administration shall
323.19 ensure that a portion of all contracts for janitorial services; document imaging;
323.20 document shredding; and mailing, collating, and sorting services be awarded by the
323.21 state to rehabilitation programs and extended employment providers that are certified
323.22 by the commissioner of employment and economic development, and day ~~training and~~
323.23 ~~habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D. The
323.24 amount of each contract awarded under this section may exceed the estimated fair market
323.25 price as determined by the commissioner for the same goods and services by up to six
323.26 percent. The aggregate value of the contracts awarded to eligible providers under this
323.27 section in any given year must exceed 19 percent of the total value of all contracts for
323.28 janitorial services; document imaging; document shredding; and mailing, collating, and
323.29 sorting services entered into in the same year. For the 19 percent requirement to be
323.30 applicable in any given year, the contract amounts proposed by eligible providers must be
323.31 within six percent of the estimated fair market price for at least 19 percent of the contracts
323.32 awarded for the corresponding service area.

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

Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660, or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable successor rules or laws;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units; or

(10) services for persons with developmental disabilities that are provided under a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until January 1, 1998, or under chapter ~~245B~~ 245D.

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

Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The operating standards for special transportation service adopted under this section do not apply to special transportation provided by:

(1) a common carrier operating on fixed routes and schedules;

(2) a volunteer driver using a private automobile;

(3) a school bus as defined in section 169.011, subdivision 71; or

(4) an emergency ambulance regulated under chapter 144.

(b) The operating standards adopted under this section only apply to providers of special transportation service who receive grants or other financial assistance from either the state or the federal government, or both, to provide or assist in providing that service; except that the operating standards adopted under this section do not apply to any nursing home licensed under section 144A.02, to any board and care facility licensed under section 144.50, or to any day training and habilitation services, day care, or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or program provides transportation to nonresidents on a regular basis and the facility receives reimbursement, other than per diem payments, for that service under rules promulgated by the commissioner of human services.

(c) Notwithstanding paragraph (b), the operating standards adopted under this section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that provides transportation services to consumers or residents of other vendors licensed under chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents and the driver.

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

Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:

Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the meanings given them in this section.

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

Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:

Subd. 9. **License holder.** "License holder" means an individual, corporation, partnership, voluntary association, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

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

326.1 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:
326.2 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
326.3 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
326.4 person receiving supported living services may provide licensed services to that person if:
326.5 (1) the person who receives supported living services received these services in a
326.6 residential site on July 1, 2005;
326.7 (2) the services under clause (1) were provided in a corporate foster care setting for
326.8 adults and were funded by the developmental disabilities home and community-based
326.9 services waiver defined in section 256B.092;
326.10 (3) the individual who is related obtains and maintains both a license under chapter
326.11 ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105
326.12 to 9555.6265; and
326.13 (4) the individual who is related is not the guardian of the person receiving supported
326.14 living services.

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

326.16 Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:
326.17 Subd. 13. **Funds and property; other requirements.** (a) A license holder must
326.18 ensure that persons served by the program retain the use and availability of personal funds
326.19 or property unless restrictions are justified in the person's individual plan. ~~This subdivision~~
326.20 ~~does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~
326.21 (b) The license holder must ensure separation of funds of persons served by the
326.22 program from funds of the license holder, the program, or program staff.
326.23 (c) Whenever the license holder assists a person served by the program with the
326.24 safekeeping of funds or other property, the license holder must:
326.25 (1) immediately document receipt and disbursement of the person's funds or other
326.26 property at the time of receipt or disbursement, including the person's signature, or the
326.27 signature of the conservator or payee; and
326.28 (2) return to the person upon the person's request, funds and property in the license
326.29 holder's possession subject to restrictions in the person's treatment plan, as soon as
326.30 possible, but no later than three working days after the date of request.
326.31 (d) License holders and program staff must not:
326.32 (1) borrow money from a person served by the program;
326.33 (2) purchase personal items from a person served by the program;
326.34 (3) sell merchandise or personal services to a person served by the program;

327.1 (4) require a person served by the program to purchase items for which the license
327.2 holder is eligible for reimbursement; or
327.3 (5) use funds of persons served by the program to purchase items for which the
327.4 facility is already receiving public or private payments.

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

327.6 Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:
327.7 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may
327.8 suspend or revoke a license, or impose a fine if:
327.9 (1) a license holder fails to comply fully with applicable laws or rules;
327.10 (2) a license holder, a controlling individual, or an individual living in the household
327.11 where the licensed services are provided or is otherwise subject to a background study has
327.12 a disqualification which has not been set aside under section 245C.22;
327.13 (3) a license holder knowingly withholds relevant information from or gives false
327.14 or misleading information to the commissioner in connection with an application for
327.15 a license, in connection with the background study status of an individual, during an
327.16 investigation, or regarding compliance with applicable laws or rules; or
327.17 (4) after July 1, 2012, and upon request by the commissioner, a license holder fails
327.18 to submit the information required of an applicant under section 245A.04, subdivision 1,
327.19 paragraph (f) or (g).
327.20 A license holder who has had a license suspended, revoked, or has been ordered
327.21 to pay a fine must be given notice of the action by certified mail or personal service. If
327.22 mailed, the notice must be mailed to the address shown on the application or the last
327.23 known address of the license holder. The notice must state the reasons the license was
327.24 suspended, revoked, or a fine was ordered.
327.25 (b) If the license was suspended or revoked, the notice must inform the license
327.26 holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
327.27 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
327.28 a license. The appeal of an order suspending or revoking a license must be made in writing
327.29 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
327.30 the commissioner within ten calendar days after the license holder receives notice that the
327.31 license has been suspended or revoked. If a request is made by personal service, it must be
327.32 received by the commissioner within ten calendar days after the license holder received
327.33 the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits
327.34 a timely appeal of an order suspending or revoking a license, the license holder may

328.1 continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs
328.2 (g) and (h), until the commissioner issues a final order on the suspension or revocation.
328.3 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the
328.4 license holder of the responsibility for payment of fines and the right to a contested case
328.5 hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal
328.6 of an order to pay a fine must be made in writing by certified mail or personal service. If
328.7 mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
328.8 days after the license holder receives notice that the fine has been ordered. If a request is
328.9 made by personal service, it must be received by the commissioner within ten calendar
328.10 days after the license holder received the order.
328.11 (2) The license holder shall pay the fines assessed on or before the payment date
328.12 specified. If the license holder fails to fully comply with the order, the commissioner
328.13 may issue a second fine or suspend the license until the license holder complies. If the
328.14 license holder receives state funds, the state, county, or municipal agencies or departments
328.15 responsible for administering the funds shall withhold payments and recover any payments
328.16 made while the license is suspended for failure to pay a fine. A timely appeal shall stay
328.17 payment of the fine until the commissioner issues a final order.
328.18 (3) A license holder shall promptly notify the commissioner of human services,
328.19 in writing, when a violation specified in the order to forfeit a fine is corrected. If upon
328.20 reinspection the commissioner determines that a violation has not been corrected as
328.21 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
328.22 commissioner shall notify the license holder by certified mail or personal service that a
328.23 second fine has been assessed. The license holder may appeal the second fine as provided
328.24 under this subdivision.
328.25 (4) Fines shall be assessed as follows: the license holder shall forfeit $1,000 for
328.26 each determination of maltreatment of a child under section 626.556 or the maltreatment
328.27 of a vulnerable adult under section 626.557 for which the license holder is determined
328.28 responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i),
328.29 or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit $200 for each
328.30 occurrence of a violation of law or rule governing matters of health, safety, or supervision,
328.31 including but not limited to the provision of adequate staff-to-child or adult ratios, and
328.32 failure to comply with background study requirements under chapter 245C; and the license
328.33 holder shall forfeit $100 for each occurrence of a violation of law or rule other than
328.34 those subject to a $1,000 or $200 fine above. For purposes of this section, "occurrence"
328.35 means each violation identified in the commissioner's fine order. Fines assessed against a
328.36 license holder that holds a license to provide ~~the residential-based habilitation~~ <u>home and</u>

community-based services, as ~~defined under~~ identified in section ~~245B.02, subdivision 20~~ 245D.03, subdivision 1, and a community residential setting or day services facility license ~~to provide foster care~~ under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

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

Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); ~~or~~ a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified ~~developmental disabilities specialist under section 245B.07, subdivision 4~~ designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

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

Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

Subd. 2. **Contract provisions.** (a) The service contract with each intermediate care facility must include provisions for:

(1) modifying payments when significant changes occur in the needs of the consumers;

(2) appropriate and necessary statistical information required by the commissioner;

(3) annual aggregate facility financial information; and

(4) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

(b) The commissioner of human services and the commissioner of health, in consultation with representatives from counties, advocacy organizations, and the provider community, shall review ~~the consolidated standards under chapter 245B and~~ the home and community-based services standards under chapter 245D and the supervised living facility rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for intermediate care facilities in order to enable facilities to implement the performance measures in their contract and provide quality services to residents without a duplication of or increase in regulatory requirements.

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

Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:

Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered into through action of their governing bodies, may jointly or cooperatively exercise any power common to the contracting parties or any similar powers, including those which are the same except for the territorial limits within which they may be exercised. The agreement may provide for the exercise of such powers by one or more of the participating governmental units on behalf of the other participating units. The term "governmental unit" as used in this section includes every city, county, town, school district, independent nonprofit firefighting corporation, other political subdivision of this or another state, another state, federally recognized Indian tribe, the University of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under sections 144.50 to 144.56, rehabilitation facilities and extended employment providers that are certified by the commissioner of employment and economic development, ~~day training and habilitation services licensed under sections 245B.01 to 245B.08,~~ day and supported employment services licensed under chapter 245D, and any agency of the state of Minnesota or the United States, and includes any instrumentality of a governmental

331.1 unit. For the purpose of this section, an instrumentality of a governmental unit means an
331.2 instrumentality having independent policy-making and appropriating authority.

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

331.4 Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:
331.5 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
331.6 given them unless the specific content indicates otherwise:
331.7 (a) "Family assessment" means a comprehensive assessment of child safety, risk
331.8 of subsequent child maltreatment, and family strengths and needs that is applied to a
331.9 child maltreatment report that does not allege substantial child endangerment. Family
331.10 assessment does not include a determination as to whether child maltreatment occurred
331.11 but does determine the need for services to address the safety of family members and the
331.12 risk of subsequent maltreatment.
331.13 (b) "Investigation" means fact gathering related to the current safety of a child
331.14 and the risk of subsequent maltreatment that determines whether child maltreatment
331.15 occurred and whether child protective services are needed. An investigation must be used
331.16 when reports involve substantial child endangerment, and for reports of maltreatment in
331.17 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
331.18 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
331.19 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
331.20 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.
331.21 (c) "Substantial child endangerment" means a person responsible for a child's care,
331.22 and in the case of sexual abuse includes a person who has a significant relationship to the
331.23 child as defined in section 609.341, or a person in a position of authority as defined in
331.24 section 609.341, who by act or omission commits or attempts to commit an act against a
331.25 child under their care that constitutes any of the following:
331.26 (1) egregious harm as defined in section 260C.007, subdivision 14;
331.27 (2) sexual abuse as defined in paragraph (d);
331.28 (3) abandonment under section 260C.301, subdivision 2;
331.29 (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the
331.30 child's physical or mental health, including a growth delay, which may be referred to as
331.31 failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
331.32 (5) murder in the first, second, or third degree under section 609.185, 609.19, or
331.33 609.195;
331.34 (6) manslaughter in the first or second degree under section 609.20 or 609.205;

332.1 (7) assault in the first, second, or third degree under section 609.221, 609.222, or
332.2 609.223;
332.3 (8) solicitation, inducement, and promotion of prostitution under section 609.322;
332.4 (9) criminal sexual conduct under sections 609.342 to 609.3451;
332.5 (10) solicitation of children to engage in sexual conduct under section 609.352;
332.6 (11) malicious punishment or neglect or endangerment of a child under section
332.7 609.377 or 609.378;
332.8 (12) use of a minor in sexual performance under section 617.246; or
332.9 (13) parental behavior, status, or condition which mandates that the county attorney
332.10 file a termination of parental rights petition under section 260C.301, subdivision 3,
332.11 paragraph (a).
332.12 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
332.13 child's care, by a person who has a significant relationship to the child, as defined in
332.14 section 609.341, or by a person in a position of authority, as defined in section 609.341,
332.15 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
332.16 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),
332.17 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
332.18 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
332.19 abuse also includes any act which involves a minor which constitutes a violation of
332.20 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
332.21 threatened sexual abuse which includes the status of a parent or household member
332.22 who has committed a violation which requires registration as an offender under section
332.23 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section
332.24 243.166, subdivision 1b, paragraph (a) or (b).
332.25 (e) "Person responsible for the child's care" means (1) an individual functioning
332.26 within the family unit and having responsibilities for the care of the child such as a
332.27 parent, guardian, or other person having similar care responsibilities, or (2) an individual
332.28 functioning outside the family unit and having responsibilities for the care of the child
332.29 such as a teacher, school administrator, other school employees or agents, or other lawful
332.30 custodian of a child having either full-time or short-term care responsibilities including,
332.31 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
332.32 and coaching.
332.33 (f) "Neglect" means the commission or omission of any of the acts specified under
332.34 clauses (1) to (9), other than by accidental means:

333.1 (1) failure by a person responsible for a child's care to supply a child with necessary
333.2 food, clothing, shelter, health, medical, or other care required for the child's physical or
333.3 mental health when reasonably able to do so;
333.4 (2) failure to protect a child from conditions or actions that seriously endanger the
333.5 child's physical or mental health when reasonably able to do so, including a growth delay,
333.6 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
333.7 is due to parental neglect;
333.8 (3) failure to provide for necessary supervision or child care arrangements
333.9 appropriate for a child after considering factors as the child's age, mental ability, physical
333.10 condition, length of absence, or environment, when the child is unable to care for the
333.11 child's own basic needs or safety, or the basic needs or safety of another child in their care;
333.12 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
333.13 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
333.14 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;
333.15 (5) nothing in this section shall be construed to mean that a child is neglected solely
333.16 because the child's parent, guardian, or other person responsible for the child's care in
333.17 good faith selects and depends upon spiritual means or prayer for treatment or care of
333.18 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,
333.19 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
333.20 if a lack of medical care may cause serious danger to the child's health. This section does
333.21 not impose upon persons, not otherwise legally responsible for providing a child with
333.22 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;
333.23 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
333.24 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
333.25 symptoms in the child at birth, results of a toxicology test performed on the mother at
333.26 delivery or the child at birth, medical effects or developmental delays during the child's
333.27 first year of life that medically indicate prenatal exposure to a controlled substance, or the
333.28 presence of a fetal alcohol spectrum disorder;
333.29 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);
333.30 (8) chronic and severe use of alcohol or a controlled substance by a parent or
333.31 person responsible for the care of the child that adversely affects the child's basic needs
333.32 and safety; or
333.33 (9) emotional harm from a pattern of behavior which contributes to impaired
333.34 emotional functioning of the child which may be demonstrated by a substantial and
333.35 observable effect in the child's behavior, emotional response, or cognition that is not

334.1 within the normal range for the child's age and stage of development, with due regard to
334.2 the child's culture.
334.3 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,
334.4 inflicted by a person responsible for the child's care on a child other than by accidental
334.5 means, or any physical or mental injury that cannot reasonably be explained by the child's
334.6 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
334.7 that have not been authorized under section 121A.67 or 245.825.
334.8 Abuse does not include reasonable and moderate physical discipline of a child
334.9 administered by a parent or legal guardian which does not result in an injury. Abuse does
334.10 not include the use of reasonable force by a teacher, principal, or school employee as
334.11 allowed by section 121A.582. Actions which are not reasonable and moderate include,
334.12 but are not limited to, any of the following that are done in anger or without regard to the
334.13 safety of the child:
334.14 (1) throwing, kicking, burning, biting, or cutting a child;
334.15 (2) striking a child with a closed fist;
334.16 (3) shaking a child under age three;
334.17 (4) striking or other actions which result in any nonaccidental injury to a child
334.18 under 18 months of age;
334.19 (5) unreasonable interference with a child's breathing;
334.20 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
334.21 (7) striking a child under age one on the face or head;
334.22 (8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
334.23 substances which were not prescribed for the child by a practitioner, in order to control or
334.24 punish the child; or other substances that substantially affect the child's behavior, motor
334.25 coordination, or judgment or that results in sickness or internal injury, or subjects the
334.26 child to medical procedures that would be unnecessary if the child were not exposed
334.27 to the substances;
334.28 (9) unreasonable physical confinement or restraint not permitted under section
334.29 609.379, including but not limited to tying, caging, or chaining; or
334.30 (10) in a school facility or school zone, an act by a person responsible for the child's
334.31 care that is a violation under section 121A.58.
334.32 (h) "Report" means any report received by the local welfare agency, police
334.33 department, county sheriff, or agency responsible for assessing or investigating
334.34 maltreatment pursuant to this section.
334.35 (i) "Facility" means:

335.1 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
335.2 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
335.3 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;
335.4 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
335.5 124D.10; or
335.6 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
335.7 subdivision 16, and 256B.0625, subdivision 19a.
335.8 (j) "Operator" means an operator or agency as defined in section 245A.02.
335.9 (k) "Commissioner" means the commissioner of human services.
335.10 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
335.11 not limited to employee assistance counseling and the provision of guardian ad litem and
335.12 parenting time expeditor services.
335.13 (m) "Mental injury" means an injury to the psychological capacity or emotional
335.14 stability of a child as evidenced by an observable or substantial impairment in the child's
335.15 ability to function within a normal range of performance and behavior with due regard to
335.16 the child's culture.
335.17 (n) "Threatened injury" means a statement, overt act, condition, or status that
335.18 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
335.19 injury includes, but is not limited to, exposing a child to a person responsible for the
335.20 child's care, as defined in paragraph (e), clause (1), who has:
335.21 (1) subjected a child to, or failed to protect a child from, an overt act or condition
335.22 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
335.23 similar law of another jurisdiction;
335.24 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
335.25 (4), or a similar law of another jurisdiction;
335.26 (3) committed an act that has resulted in an involuntary termination of parental rights
335.27 under section 260C.301, or a similar law of another jurisdiction; or
335.28 (4) committed an act that has resulted in the involuntary transfer of permanent
335.29 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section
335.30 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a
335.31 similar law of another jurisdiction.
335.32 A child is the subject of a report of threatened injury when the responsible social
335.33 services agency receives birth match data under paragraph (o) from the Department of
335.34 Human Services.
335.35 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a
335.36 birth record or recognition of parentage identifying a child who is subject to threatened

336.1 injury under paragraph (n), the Department of Human Services shall send the data to the
336.2 responsible social services agency. The data is known as "birth match" data. Unless the
336.3 responsible social services agency has already begun an investigation or assessment of the
336.4 report due to the birth of the child or execution of the recognition of parentage and the
336.5 parent's previous history with child protection, the agency shall accept the birth match
336.6 data as a report under this section. The agency may use either a family assessment or
336.7 investigation to determine whether the child is safe. All of the provisions of this section
336.8 apply. If the child is determined to be safe, the agency shall consult with the county
336.9 attorney to determine the appropriateness of filing a petition alleging the child is in need
336.10 of protection or services under section 260C.007, subdivision 6, clause (16), in order to
336.11 deliver needed services. If the child is determined not to be safe, the agency and the county
336.12 attorney shall take appropriate action as required under section 260C.301, subdivision 3.

336.13 (p) Persons who conduct assessments or investigations under this section shall take
336.14 into account accepted child-rearing practices of the culture in which a child participates
336.15 and accepted teacher discipline practices, which are not injurious to the child's health,
336.16 welfare, and safety.

336.17 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected
336.18 occurrence or event which:

336.19 (1) is not likely to occur and could not have been prevented by exercise of due
336.20 care; and

336.21 (2) if occurring while a child is receiving services from a facility, happens when the
336.22 facility and the employee or person providing services in the facility are in compliance
336.23 with the laws and rules relevant to the occurrence or event.

336.24 (r) "Nonmaltreatment mistake" means:

336.25 (1) at the time of the incident, the individual was performing duties identified in the
336.26 center's child care program plan required under Minnesota Rules, part 9503.0045;

336.27 (2) the individual has not been determined responsible for a similar incident that
336.28 resulted in a finding of maltreatment for at least seven years;

336.29 (3) the individual has not been determined to have committed a similar
336.30 nonmaltreatment mistake under this paragraph for at least four years;

336.31 (4) any injury to a child resulting from the incident, if treated, is treated only with
336.32 remedies that are available over the counter, whether ordered by a medical professional or
336.33 not; and

336.34 (5) except for the period when the incident occurred, the facility and the individual
336.35 providing services were both in compliance with all licensing requirements relevant to the
336.36 incident.

337.1 This definition only applies to child care centers licensed under Minnesota
337.2 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of
337.3 substantiated maltreatment by the individual, the commissioner of human services shall
337.4 determine that a nonmaltreatment mistake was made by the individual.

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

337.6 Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:
337.7 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
337.8 to believe a child is being neglected or physically or sexually abused, as defined in
337.9 subdivision 2, or has been neglected or physically or sexually abused within the preceding
337.10 three years, shall immediately report the information to the local welfare agency, agency
337.11 responsible for assessing or investigating the report, police department, or the county
337.12 sheriff if the person is:
337.13 (1) a professional or professional's delegate who is engaged in the practice of
337.14 the healing arts, social services, hospital administration, psychological or psychiatric
337.15 treatment, child care, education, correctional supervision, probation and correctional
337.16 services, or law enforcement; or
337.17 (2) employed as a member of the clergy and received the information while
337.18 engaged in ministerial duties, provided that a member of the clergy is not required by
337.19 this subdivision to report information that is otherwise privileged under section 595.02,
337.20 subdivision 1, paragraph (c).
337.21 The police department or the county sheriff, upon receiving a report, shall
337.22 immediately notify the local welfare agency or agency responsible for assessing or
337.23 investigating the report, orally and in writing. The local welfare agency, or agency
337.24 responsible for assessing or investigating the report, upon receiving a report, shall
337.25 immediately notify the local police department or the county sheriff orally and in writing.
337.26 The county sheriff and the head of every local welfare agency, agency responsible
337.27 for assessing or investigating reports, and police department shall each designate a
337.28 person within their agency, department, or office who is responsible for ensuring that
337.29 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
337.30 this subdivision shall be construed to require more than one report from any institution,
337.31 facility, school, or agency.
337.32 (b) Any person may voluntarily report to the local welfare agency, agency responsible
337.33 for assessing or investigating the report, police department, or the county sheriff if the
337.34 person knows, has reason to believe, or suspects a child is being or has been neglected or
337.35 subjected to physical or sexual abuse. The police department or the county sheriff, upon

receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter ~~245B~~ <u>245D</u>; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Any person mandated to report shall receive a summary of the disposition of any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

<u>**EFFECTIVE DATE.** This section is effective January 1, 2014.</u>

Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ <u>245D</u>, or a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed personal care provider organization as defined in section 256B.04, subdivision 16, and 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide

339.1 the following information to the parent, guardian, or legal custodian of a child alleged to
339.2 have been neglected, physically abused, sexually abused, or the victim of maltreatment
339.3 of a child in the facility: the name of the facility; the fact that a report alleging neglect,
339.4 physical abuse, sexual abuse, or maltreatment of a child in the facility has been received;
339.5 the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child
339.6 in the facility; that the agency is conducting an assessment or investigation; any protective
339.7 or corrective measures being taken pending the outcome of the investigation; and that a
339.8 written memorandum will be provided when the investigation is completed.

339.9 (b) The commissioner of the agency responsible for assessing or investigating the
339.10 report or local welfare agency may also provide the information in paragraph (a) to the
339.11 parent, guardian, or legal custodian of any other child in the facility if the investigative
339.12 agency knows or has reason to believe the alleged neglect, physical abuse, sexual
339.13 abuse, or maltreatment of a child in the facility has occurred. In determining whether
339.14 to exercise this authority, the commissioner of the agency responsible for assessing
339.15 or investigating the report or local welfare agency shall consider the seriousness of the
339.16 alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the
339.17 number of children allegedly neglected, physically abused, sexually abused, or victims of
339.18 maltreatment of a child in the facility; the number of alleged perpetrators; and the length
339.19 of the investigation. The facility shall be notified whenever this discretion is exercised.

339.20 (c) When the commissioner of the agency responsible for assessing or investigating
339.21 the report or local welfare agency has completed its investigation, every parent, guardian,
339.22 or legal custodian previously notified of the investigation by the commissioner or
339.23 local welfare agency shall be provided with the following information in a written
339.24 memorandum: the name of the facility investigated; the nature of the alleged neglect,
339.25 physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's
339.26 name; a summary of the investigation findings; a statement whether maltreatment was
339.27 found; and the protective or corrective measures that are being or will be taken. The
339.28 memorandum shall be written in a manner that protects the identity of the reporter and
339.29 the child and shall not contain the name, or to the extent possible, reveal the identity of
339.30 the alleged perpetrator or of those interviewed during the investigation. If maltreatment
339.31 is determined to exist, the commissioner or local welfare agency shall also provide the
339.32 written memorandum to the parent, guardian, or legal custodian of each child in the facility
339.33 who had contact with the individual responsible for the maltreatment. When the facility is
339.34 the responsible party for maltreatment, the commissioner or local welfare agency shall also
339.35 provide the written memorandum to the parent, guardian, or legal custodian of each child
339.36 who received services in the population of the facility where the maltreatment occurred.

340.1 This notification must be provided to the parent, guardian, or legal custodian of each child
340.2 receiving services from the time the maltreatment occurred until either the individual
340.3 responsible for maltreatment is no longer in contact with a child or children in the facility
340.4 or the conclusion of the investigation. In the case of maltreatment within a school facility,
340.5 as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner
340.6 of education need not provide notification to parents, guardians, or legal custodians of
340.7 each child in the facility, but shall, within ten days after the investigation is completed,
340.8 provide written notification to the parent, guardian, or legal custodian of any student
340.9 alleged to have been maltreated. The commissioner of education may notify the parent,
340.10 guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

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

340.12 Sec. 16. **REPEALER.**

340.13 Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective
340.14 January 1, 2014.

340.15 **ARTICLE 11**

340.16 **MISCELLANEOUS**

340.17 Section 1. Minnesota Statutes 2012, section 246.54, is amended to read:

340.18 **246.54 LIABILITY OF COUNTY; REIMBURSEMENT.**

340.19 Subdivision 1. **County portion for cost of care.** (a) Except for chemical
340.20 dependency services provided under sections 254B.01 to 254B.09, the client's county
340.21 shall pay to the state of Minnesota a portion of the cost of care provided in a regional
340.22 treatment center or a state nursing facility to a client legally settled in that county. A
340.23 county's payment shall be made from the county's own sources of revenue and payments
340.24 shall equal a percentage of the cost of care, as determined by the commissioner, for each
340.25 day, or the portion thereof, that the client spends at a regional treatment center or a state
340.26 nursing facility according to the following schedule:

340.27 (1) zero percent for the first 30 days;

340.28 (2) 20 percent for days 31 to 60; and

340.29 (3) ~~50~~ 75 percent for any days over 60.

340.30 (b) The increase in the county portion for cost of care under paragraph (a), clause
340.31 (3), shall be imposed when the treatment facility has determined that it is clinically
340.32 appropriate for the client to be discharged.

341.1 (c) If payments received by the state under sections 246.50 to 246.53 exceed 80
341.2 percent of the cost of care for days 31 to 60, or ~~50~~ 25 percent for days over 60, the county
341.3 shall be responsible for paying the state only the remaining amount. The county shall
341.4 not be entitled to reimbursement from the client, the client's estate, or from the client's
341.5 relatives, except as provided in section 246.53.

341.6 Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the
341.7 Minnesota Security Hospital ~~or the Minnesota extended treatment options program~~. For
341.8 services at ~~these facilities~~ the Minnesota Security Hospital, a county's payment shall be
341.9 made from the county's own sources of revenue and payments ~~shall be paid as follows:~~.
341.10 Excluding the state-operated forensic transition service, payments to the state from the
341.11 county shall equal ten percent of the cost of care, as determined by the commissioner, for
341.12 each day, or the portion thereof, that the client spends at the facility. For the state-operated
341.13 forensic transition service, payments to the state from the county shall equal 50 percent of
341.14 the cost of care, as determined by the commissioner, for each day, or the portion thereof,
341.15 that the client spends in the program. If payments received by the state under sections
341.16 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the
341.17 state-operated forensic transition service, exceed 90 percent of the cost of care, the county
341.18 shall be responsible for paying the state only the remaining amount. If payments received
341.19 by the state under sections 246.50 to 246.53 for the state-operated forensic transition service
341.20 exceed 50 percent of the cost of care, the county shall be responsible for paying the state
341.21 only the remaining amount. The county shall not be entitled to reimbursement from the
341.22 client, the client's estate, or from the client's relatives, except as provided in section 246.53.

341.23 (b) Regardless of the facility to which the client is committed, subdivision 1 does
341.24 not apply to the following individuals:

341.25 ~~(1) clients who are committed as mentally ill and dangerous under section 253B.02,~~
341.26 ~~subdivision 17;~~

341.27 ~~(2)~~ (1) clients who are committed as sexual psychopathic personalities under section
341.28 253B.02, subdivision 18b; and

341.29 ~~(3)~~ (2) clients who are committed as sexually dangerous persons under section
341.30 253B.02, subdivision 18c.

341.31 ~~For each of the individuals in clauses (1) to (3), the payment by the county to the state~~
341.32 ~~shall equal ten percent of the cost of care for each day as determined by the commissioner.~~

341.33 Sec. 2. Minnesota Statutes 2012, section 402A.10, is amended to read:

341.34 **402A.10 DEFINITIONS.**

342.1 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined
342.2 in this section have the meanings given.

342.3 Subd. 1a. **Balanced set of program measures.** A "balanced set of program
342.4 measures" is a set of measures that, together, adequately quantify achievement toward a
342.5 particular program's outcome. As directed by section 402A.16, the Human Services
342.6 Performance Council must recommend to the commissioner when a particular program
342.7 has a balanced set of program measures.

342.8 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
342.9 services.

342.10 Subd. 3. **Council.** "Council" means the State-County Results, Accountability, and
342.11 Service Delivery Redesign Council established in section 402A.20.

342.12 Subd. 4. **Essential human services or essential services.** "Essential human
342.13 services" or "essential services" means assistance and services to recipients or potential
342.14 recipients of public welfare and other services delivered by counties or tribes that are
342.15 mandated in federal and state law that are to be available in all counties of the state.

342.16 Subd. 4a. **Essential human services program.** An "essential human services
342.17 program" for the purposes of remedies under section 402A.18 means the following
342.18 programs:

342.19 (1) child welfare, including protection, truancy, minor parent, guardianship, and
342.20 adoption;

342.21 (2) children's mental health;

342.22 (3) children's disability services;

342.23 (4) public assistance eligibility, including measures related to processing timelines
342.24 across information services programs;

342.25 (5) MFIP;

342.26 (6) child support;

342.27 (7) chemical dependency;

342.28 (8) adult disability;

342.29 (9) adult mental health;

342.30 (10) adult services such as long-term care; and

342.31 (11) adult protection.

342.32 Subd. 4b. **Measure.** A "measure" means a quantitative indicator of a performance
342.33 outcome.

342.34 Subd. 4c. **Performance improvement plan.** A "performance improvement plan"
342.35 means a plan developed by a county or service delivery authority that describes steps the
342.36 county or service delivery authority must take to improve performance on a specific

343.1 measure or set of measures. The performance improvement plan must be negotiated
343.2 with and approved by the commissioner. The performance improvement plan must
343.3 require a specific numerical improvement in the measure or measures on which the plan
343.4 is based and may include specific programmatic best practices or specific performance
343.5 management practices that the county must implement.

343.6 Subd. 4d. **Performance management system for human services.** A "performance
343.7 management system for human services" means a process by which performance data for
343.8 essential human services is collected from counties or service delivery authorities and used
343.9 to inform a variety of stakeholders and to improve performance over time.

343.10 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single
343.11 county, or consortium of counties operating by execution of a joint powers agreement
343.12 under section 471.59 or other contractual agreement, that has voluntarily chosen by
343.13 resolution of the county board of commissioners to participate in the redesign under this
343.14 chapter or has been assigned by the commissioner pursuant to section 402A.18. A service
343.15 delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen
343.16 by resolution of tribal government to participate in redesign under this chapter.

343.17 Subd. 6. **Steering committee.** "Steering committee" means the Steering Committee
343.18 on Performance and Outcome Reforms.

343.19 Sec. 3. **[402A.12] ESTABLISHMENT OF A PERFORMANCE MANAGEMENT**
343.20 **SYSTEM FOR HUMAN SERVICES.**

343.21 By January 1, 2014, the commissioner shall implement a performance management
343.22 system for essential human services as described in sections 402A.15 to 402A.18 that
343.23 includes initial performance measures and standards consistent with the recommendations
343.24 of the Steering Committee on Performance and Outcome Reforms in the December 2012
343.25 report to the legislature.

343.26 Sec. 4. **[402A.16] HUMAN SERVICES PERFORMANCE COUNCIL.**

343.27 Subdivision 1. **Establishment.** By October 1, 2013, the commissioner shall convene
343.28 a Human Services Performance Council to advise the commissioner on the implementation
343.29 and operation of the performance management system for human services.

343.30 Subd. 2. **Duties.** The Human Services Performance Council shall:

343.31 (1) hold meetings at least quarterly that are in compliance with Minnesota's Open
343.32 Meeting Law under chapter 13D;

343.33 (2) annually review the annual performance data submitted by counties or service
343.34 delivery authorities;

344.1 (3) review and advise the commissioner on department procedures related to the
344.2 implementation of the performance management system and system process requirements
344.3 and on barriers to process improvement in human services delivery;
344.4 (4) advise the commissioner on the training and technical assistance needs of county
344.5 or service delivery authority and department personnel;
344.6 (5) review instances in which a county or service delivery authority has not made
344.7 adequate progress on a performance improvement plan and make recommendations to
344.8 the commissioner under section 402A.18;
344.9 (6) consider appeals from counties or service delivery authorities that are in the
344.10 remedies process and make recommendations to the commissioner on resolving the issue;
344.11 (7) convene working groups to update and develop outcomes, measures, and
344.12 performance standards for the performance management system and, on an annual basis,
344.13 present these recommendations to the commissioner, including recommendations on when
344.14 a particular essential human service program has a balanced set of program measures
344.15 in place;
344.16 (8) make recommendations on human services administrative rules or statutes that
344.17 could be repealed in order to improve service delivery;
344.18 (9) provide information to stakeholders on the council's role and regularly collect
344.19 stakeholder input on performance management system performance; and
344.20 (10) submit an annual report to the legislature and the commissioner, which
344.21 includes a comprehensive report on the performance of individual counties or service
344.22 delivery authorities as it relates to system measures; a list of counties or service delivery
344.23 authorities that have been required to create performance improvement plans and the areas
344.24 identified for improvement as part of the remedies process; a summary of performance
344.25 improvement training and technical assistance activities offered to the county personnel
344.26 by the department; recommendations on administrative rules or state statutes that could be
344.27 repealed in order to improve service delivery; recommendations for system improvements,
344.28 including updates to system outcomes, measures and standards; and a response from
344.29 the commissioner.
344.30 Subd. 3. **Membership.** (a) Human Services Performance Council membership shall
344.31 be equally balanced among the following five stakeholder groups: the Association of
344.32 Minnesota Counties, the Minnesota Association of County Social Service Administrators,
344.33 the Department of Human Services, tribes and communities of color, and service providers
344.34 and advocates for persons receiving human services. The Association of Minnesota
344.35 Counties and the Minnesota Association of County Social Service Administrators shall
344.36 appoint their own respective representatives. The commissioner of human services shall

345.1 appoint representatives of the Department of Human Services, tribes and communities of
345.2 color, and social services providers and advocates. Minimum council membership shall
345.3 be 15 members, with at least three representatives from each stakeholder group, and
345.4 maximum council membership shall be 20 members, with four representatives from
345.5 each stakeholder group.

345.6 (b) Notwithstanding section 15.059, Human Services Performance Council members
345.7 shall be appointed for a minimum of two years, but may serve longer terms at the
345.8 discretion of their appointing authority.

345.9 (c) Notwithstanding section 15.059, members of the council shall receive no
345.10 compensation for their services.

345.11 (d) A commissioner's representative and a county representative from either the
345.12 Association of Minnesota Counties or the Minnesota Association of County Social Service
345.13 Administrators shall serve as Human Services Performance Council cochairs.

345.14 Subd. 4. **Commissioner duties.** The commissioner shall:

345.15 (1) implement and maintain the performance management system for human services;

345.16 (2) establish and regularly update the system's outcomes, measures, and standards,
345.17 including the minimum performance standard for each performance measure;

345.18 (3) determine when a particular program has a balanced set of measures;

345.19 (4) receive reports from counties or service delivery authorities at least annually on
345.20 their performance against system measures, provide counties with data needed to assess
345.21 performance and monitor progress, and provide timely feedback to counties or service
345.22 delivery authorities on their performance;

345.23 (5) implement and monitor the remedies process in section 402A.18;

345.24 (6) report to the Human Services Performance Council on county or service delivery
345.25 authority performance on a semiannual basis;

345.26 (7) provide general training and technical assistance to counties or service delivery
345.27 authorities on topics related to performance measurement and performance improvement;

345.28 (8) provide targeted training and technical assistance to counties or service delivery
345.29 authorities that supports their performance improvement plans; and

345.30 (9) provide staff support for the Human Services Performance Council.

345.31 Subd. 5. **County or service delivery authority duties.** The counties or service
345.32 delivery authorities shall:

345.33 (1) report performance data to meet performance management system requirements;
345.34 and

345.35 (2) provide training to personnel on basic principles of performance measurement
345.36 and improvement and participate in training provided by the department.

Sec. 5. Minnesota Statutes 2012, section 402A.18, is amended to read:

402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET PERFORMANCE OUTCOMES.

Subdivision 1. **Underperforming county; specific service.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance ~~outcomes~~ standards for a specific essential ~~service~~ human services program, the commissioner may impose the following remedies and adjust state and federal program allocations accordingly:

(1) voluntary incorporation of the administration and operation of the specific essential ~~service~~ human services program with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of the specific essential ~~service~~ human services program with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of the specific essential ~~service~~ human services program to the commissioner.

Subd. 2. **Underperforming county; more than one-half of services.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance ~~outcomes~~ standards for more than one-half of the defined essential human services programs, the commissioner may impose the following remedies:

(1) voluntary incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for ~~program~~ administration and operation of essential human services programs to the commissioner.

347.1 Subd. 2a. **Financial responsibility of underperforming county.** A county subject
347.2 to remedies under subdivision 1 or 2 shall provide to the entity assuming administration
347.3 of the ~~essential service or~~ essential human services program or programs the amount of
347.4 nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

347.5 Subd. 3. **Conditions prior to imposing remedies.** ~~Before the commissioner may~~
347.6 ~~impose the remedies authorized under this section, the following conditions must be met:~~

347.7 ~~(1) the county or service delivery authority determined by the commissioner~~
347.8 ~~to be deficient in achieving minimum performance outcomes has the opportunity, in~~
347.9 ~~coordination with the council, to develop a program outcome improvement plan. The~~
347.10 ~~program outcome improvement plan must be developed no later than six months from the~~
347.11 ~~date of the deficiency determination; and~~

347.12 ~~(2) the council has conducted an assessment of the program outcome improvement~~
347.13 ~~plan to determine if the county or service delivery authority has made satisfactory progress~~
347.14 ~~toward performance outcomes and has made a recommendation about remedies to the~~
347.15 ~~commissioner. The assessment and recommendation must be made to the commissioner~~
347.16 ~~within 12 months from the date of the deficiency determination.~~ (a) The commissioner
347.17 shall notify a county or service delivery authority that it must submit a performance
347.18 improvement plan if:

347.19 (1) the county or service delivery authority does not meet the minimum performance
347.20 standard for a measure; or

347.21 (2) the county or service delivery authority does not meet the minimum performance
347.22 standard for one or more racial or ethnic subgroup for which there is a statistically valid
347.23 population size for three or more measures, even if the county or service delivery authority
347.24 met the standard for the overall population.

347.25 The commissioner must approve the performance improvement plan. The county or
347.26 service delivery authority may negotiate the terms of the performance improvement plan
347.27 with the commissioner.

347.28 (b) When the department determines that a county or service delivery authority does
347.29 not meet the minimum performance standard for a given measure, the commissioner
347.30 must advise the county or service delivery authority that fiscal penalties may result if the
347.31 performance does not improve. The department must offer technical assistance to the
347.32 county or service delivery authority. Within 30 days of the initial advisement from the
347.33 department, the county or service delivery authority may claim and the department may
347.34 approve an extenuating circumstance that relieves the county or service delivery authority
347.35 of any further remedy. If a county or service delivery authority has a small number of
347.36 participants in an essential human services program such that reliable measurement is

348.1 not possible, the commissioner may approve extenuating circumstances or may average
348.2 performance over three years.
348.3 (c) If there are no extenuating circumstances, the county or service delivery authority
348.4 must submit a performance improvement plan to the commissioner within 60 days of the
348.5 initial advisement from the department. The term of the performance improvement plan
348.6 must be two years, starting with the date the plan is approved by the commissioner. This
348.7 plan must include a target level for improvement for each measure that did not meet
348.8 the minimum performance standard. The commissioner must approve the performance
348.9 improvement plan within 60 days of submittal.
348.10 (d) The department must monitor the performance improvement plan for two
348.11 years. After two years, if the county or service delivery authority meets the minimum
348.12 performance standard, there is no further remedy. If the county or service delivery
348.13 authority fails to meet the minimum performance standard, but meets the improvement
348.14 target in the performance improvement plan, the county or service delivery authority shall
348.15 modify the performance improvement plan for further improvement and the department
348.16 shall continue to monitor the plan.
348.17 (e) If, after two years of monitoring, the county or service delivery authority fails to
348.18 meet both the minimum performance standard and the improvement target identified in
348.19 the performance improvement plan, the next step of the remedies process shall be invoked
348.20 by the commissioner. This phase of the remedies process may include:
348.21 (1) fiscal penalties for the county or service delivery authority that do not exceed
348.22 one percent of the county's human services expenditures and that are negotiated in the
348.23 performance improvement plan, based on what is needed to improve outcomes. Counties
348.24 or service delivery authorities must reinvest the amount of the fiscal penalty into the
348.25 essential human services program that was underperforming. A county or service delivery
348.26 authority shall not be required to pay more than three fiscal penalties in a year; and
348.27 (2) the department's provision of technical assistance to the county or service
348.28 delivery authority that is targeted to address the specific performance issues.
348.29 The commissioner shall continue monitoring the performance improvement plan for a
348.30 third year.
348.31 (f) If, after the third year of monitoring, the county or service delivery authority
348.32 meets the minimum performance standard, there is no further remedy. If the county or
348.33 service delivery authority fails to meet the minimum performance standard, but meets the
348.34 improvement target for the performance improvement plan, the county or service delivery
348.35 authority shall modify the performance improvement plan for further improvement and
348.36 the department shall continue to monitor the plan.

349.1 (g) If, after the third year of monitoring, the county or service delivery authority fails
349.2 to meet the minimum performance standard and the improvement target identified in the
349.3 performance improvement plan, the Human Services Performance Council shall review
349.4 the situation and recommend a course of action to the commissioner.
349.5 (h) If the commissioner has determined that a program has a balanced set of program
349.6 measures and a county or service delivery authority is subject to fiscal penalties for more
349.7 than one-half of the measures for that program, the commissioner may apply further
349.8 remedies as described in subdivisions 1 and 2.

349.9 Sec. 6. Laws 1998, chapter 407, article 6, section 116, is amended to read:
349.10 Sec. 116. **EBT TRANSACTION COSTS~~; APPROVAL FROM LEGISLATURE~~.**
349.11 The commissioner of human services shall ~~request and receive approval from the~~
349.12 ~~legislature before adjusting the payment to~~ not subsidize retailers for electronic benefit
349.13 transfer ~~transaction costs~~ Supplemental Nutrition Assistance Program transactions.

349.14 **EFFECTIVE DATE.** This section is effective 30 days after the commissioner
349.15 notifies retailers of the termination of their agreement with the state. The commissioner of
349.16 human services must notify the revisor of statutes of that date.

349.17 **ARTICLE 12**
349.18 **HOME CARE PROVIDERS**

349.19 Section 1. Minnesota Statutes 2012, section 144.051, is amended by adding a
349.20 subdivision to read:
349.21 Subd. 3. **Data classification; private data.** The following data collected, created,
349.22 or maintained by the commissioner are classified as "private data" as defined in section
349.23 13.02, subdivision 12:
349.24 (1) data submitted by or on behalf of applicants for licenses prior to issuance of
349.25 the license;
349.26 (2) the identity of complainants who have made reports concerning licensees or
349.27 applicants unless the complainant consents to the disclosure;
349.28 (3) the identity of individuals who provide information as part of surveys and
349.29 investigations;
349.30 (4) Social Security numbers; and
349.31 (5) health record data.

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

350.3 Subd. 4. **Data classification; public data.** The following data collected, created,
350.4 or maintained by the commissioner are classified as "public data" as defined in section
350.5 13.02, subdivision 15:

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

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

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

350.10 (4) final enforcement actions pursuant to chapter 14;

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

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

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

350.16 Subd. 5. **Data classification; confidential data.** The following data collected,
350.17 created, or maintained by the Department of Health are classified as "confidential data"
350.18 as defined in section 13.02, subdivision 3: active investigative data relating to the
350.19 investigation of potential violations of law by licensee including data from the survey
350.20 process before the correction order is issued by the department.

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

350.23 Subd. 6. **Release of private or confidential data.** The department may release
350.24 private or confidential data, except Social Security numbers, to the appropriate state,
350.25 federal, or local agency and law enforcement office to enhance investigative or
350.26 enforcement efforts or further public health protective process. Types of offices include,
350.27 but are not limited to, Adult Protective Services, Office of the Ombudsmen for Long-Term
350.28 Care and Office of the Ombudsmen for Mental Health and Developmental Disabilities, the
350.29 health licensing boards, Department of Human Services, county or city attorney's offices,
350.30 police, and local or county public health offices.

350.31 Sec. 5. Minnesota Statutes 2012, section 144A.43, is amended to read:

350.32 **144A.43 DEFINITIONS.**

Subdivision 1. **Applicability.** The definitions in this section apply to sections 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.

Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall be served and who is authorized to accept service of notices and orders on behalf of the home care provider.

Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association, corporation, unit of government, or other entity that applies for a temporary license, license, or renewal of their home care provider license under section 144A.472.

Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

Subd. 1d. **Client record.** "Client record" means all records that document information about the home care services provided to the client by the home care provider.

Subd. 1e. **Client representative.** "Client representative" means a person who, because of the client's needs, makes decisions about the client's care on behalf of the client. A client representative may be a guardian, health care agent, family member, or other agent of the client. Nothing in this section expands or diminishes the rights of persons to act on behalf of clients under other law.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given in section 152.01, subdivision 4.

Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken by mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissue, glandulars, or metabolites.

Subd. 2d. **Dietician.** "Dietitian" is a person licensed under sections 148.621 to 148.633.

Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is performed by a licensed dietician or licensed nutritionist and includes the activities of assessment, setting priorities and objectives, providing nutrition counseling, developing and implementing nutrition care services, and evaluating and maintaining appropriate standards of quality of nutrition care under sections 148.621 to 148.633.

Subd. 3. **Home care service.** "Home care service" means any of the following services ~~when~~ delivered in ~~a place of residence to~~ the home of a person whose illness, disability, or physical condition creates a need for the service:

~~(1) nursing services, including the services of a home health aide;~~

~~(2) personal care services not included under sections 148.171 to 148.285;~~

~~(3) physical therapy;~~

~~(4) speech therapy;~~

~~(5) respiratory therapy;~~

~~(6) occupational therapy;~~

~~(7) nutritional services;~~

~~(8) home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home management services include at least two of the following services: housekeeping, meal preparation, and shopping;~~

~~(9) medical social services;~~

~~(10) the provision of medical supplies and equipment when accompanied by the provision of a home care service; and~~

~~(11) other similar medical services and health-related support services identified by the commissioner in rule.~~

~~"Home care service" does not include the following activities conducted by the commissioner of health or a board of health as defined in section 145A.02, subdivision 2: communicable disease investigations or testing; administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease; or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.~~

(1) assistive tasks provided by unlicensed personnel;

(2) services provided by a registered nurse or licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;

(3) medication and treatment management services; or

(4) the provision of durable medical equipment services when provided with any of the home care services listed in clauses (1) to (3).

Subd. 3a. **Hands-on-assistance.** "Hands-on-assistance" means physical help by another person without which the client is not able to perform the activity.

Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of residence.

Subd. 4. **Home care provider.** "Home care provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery of at least one home care service, directly ~~or by contractual arrangement, of home care services~~ in a client's home for a fee and who has a valid current temporary license or license issued under sections 144A.43 to 144A.482. ~~At least one~~

~~home care service must be provided directly, although additional home care services may be provided by contractual arrangements. "Home care provider" does not include:~~

~~(1) any home care or nursing services conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing;~~

~~(2) an individual who only provides services to a relative;~~

~~(3) an individual not connected with a home care provider who provides assistance with home management services or personal care needs if the assistance is provided primarily as a contribution and not as a business;~~

~~(4) an individual not connected with a home care provider who shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;~~

~~(5) an individual or agency providing home-delivered meal services;~~

~~(6) an agency providing senior companion services and other older American volunteer programs established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

~~(7) an employee of a nursing home licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 who responds to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home or boarding care home;~~

~~(8) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in subdivision 3;~~

~~(9) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;~~

~~(10) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service;~~

~~(11) an individual licensed under chapter 147; or~~

~~(12) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver.~~

~~Subd. 5.~~ **Medication reminder.** ~~"Medication reminder" means providing a verbal or visual reminder to a client to take medication. This includes bringing the medication~~

354.1 ~~to the client and providing liquids or nutrition to accompany medication that a client is~~
354.2 ~~self-administering.~~
354.3 Subd. 6. **License.** "License" means a basic or comprehensive home care license
354.4 issued by the commissioner to a home care provider.
354.5 Subd. 7. **Licensed health professional.** "Licensed health professional" means a
354.6 person, other than a registered nurse or licensed practical nurse, who provides home care
354.7 services within the scope of practice of the person's health occupation license, registration,
354.8 or certification as regulated and who is licensed by the appropriate Minnesota state board
354.9 or agency.
354.10 Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under
354.11 this chapter.
354.12 Subd. 9. **Managerial official.** "Managerial official" means an administrator,
354.13 director, officer, trustee, or employee of a home care provider, however designated, who
354.14 has the authority to establish or control business policy.
354.15 Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug.
354.16 For purposes of this chapter only, medication includes dietary supplements.
354.17 Subd. 11. **Medication administration.** "Medication administration" means
354.18 performing a set of tasks to ensure a client takes medications, and includes the following:
354.19 (1) checking the client's medication record;
354.20 (2) preparing the medication as necessary;
354.21 (3) administering the medication to the client;
354.22 (4) documenting the administration or reason for not administering the medication;
354.23 and
354.24 (5) reporting to a nurse any concerns about the medication, the client, or the client's
354.25 refusal to take the medication.
354.26 Subd. 12. **Medication management.** "Medication management" means the
354.27 provision of any of the following medication-related services to a client:
354.28 (1) performing medication setup;
354.29 (2) administering medication;
354.30 (3) storing and securing medications;
354.31 (4) documenting medication activities;
354.32 (5) verifying and monitoring effectiveness of systems to ensure safe handling and
354.33 administration;
354.34 (6) coordinating refills;
354.35 (7) handling and implementing changes to prescriptions;
354.36 (8) communicating with the pharmacy about the client's medications; and

355.1 (9) coordinating and communicating with the prescriber.

355.2 Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a
355.3 nurse, pharmacy, or authorized prescriber for later administration by the client or by
355.4 comprehensive home care staff.

355.5 Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to
355.6 148.285.

355.7 Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is
355.8 licensed under sections 148.6401 to 148.6450.

355.9 Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is
355.10 not required by federal law to bear the symbol "Rx only."

355.11 Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who
355.12 has five percent or more of equity interest in a limited partnership, a person who owns or
355.13 controls voting stock in a corporation in an amount equal to or greater than five percent of
355.14 the shares issued and outstanding, or a corporation that owns equity interest in a licensee
355.15 or applicant for a license.

355.16 Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01,
355.17 subdivision 3.

355.18 Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed
355.19 under sections 148.65 to 148.78.

355.20 Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.

355.21 Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections
355.22 148.235; 151.01, subdivision 23; and 151.37, to prescribe prescription drugs.

355.23 Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01,
355.24 subdivision 16.

355.25 Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned
355.26 to be completed at predetermined times or according to a predetermined routine.

355.27 Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder
355.28 to a client.

355.29 Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who
355.30 is licensed under chapter 147C.

355.31 Subd. 26. **Revenues.** "Revenues" means all money or the value of property or
355.32 services received by a registrant and derived from the provision of home care services,
355.33 including fees for services, grants, bequests, gifts, donations, appropriations of public
355.34 money, and earned interest or dividends.

356.1 Subd. 27. **Service plan.** "Service plan" means the written plan between the client or
356.2 client's representative and the temporary licensee or licensee about the services that will
356.3 be provided to the client.

356.4 Subd. 28. **Social worker.** "Social worker" means a person who is licensed under
356.5 chapter 148D or 148E.

356.6 Subd. 29. **Speech language pathologist.** "Speech language pathologist" has the
356.7 meaning given in section 148.512.

356.8 Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another
356.9 person within arm's reach to minimize the risk of injury while performing daily activities
356.10 through physical intervention or cuing.

356.11 Subd. 31. **Substantial compliance.** "Substantial compliance" means complying
356.12 with the requirements in this chapter sufficiently to prevent unacceptable health or safety
356.13 risks to the home care client.

356.14 Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for
356.15 licensure for compliance with this chapter.

356.16 Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized
356.17 to conduct surveys of home care providers and applicants.

356.18 Subd. 34. **Temporary license.** "Temporary license" means the initial basic or
356.19 comprehensive home care license the department issues after approval of a complete
356.20 written application and before the department completes the temporary license survey and
356.21 determines that the temporary licensee is in substantial compliance.

356.22 Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision
356.23 of care, other than medications, ordered or prescribed by a licensed health professional
356.24 provided to a client to cure, rehabilitate, or ease symptoms.

356.25 Subd. 36. **Unit of government.** "Unit of government" means every city, county,
356.26 town, school district, other political subdivisions of the state, and any agency of the state
356.27 or federal government, which includes any instrumentality of a unit of government.

356.28 Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not
356.29 otherwise licensed or certified by a governmental health board or agency who provide
356.30 home care services in the client's home.

356.31 Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

356.32 Sec. 6. Minnesota Statutes 2012, section 144A.44, is amended to read:

356.33 **144A.44 HOME CARE BILL OF RIGHTS.**

356.34 Subdivision 1. **Statement of rights.** A person who receives home care services
356.35 has these rights:

357.1 (1) the right to receive written information about rights ~~in advance of~~ before
357.2 receiving ~~care or during the initial evaluation visit before the initiation of treatment~~
357.3 services, including what to do if rights are violated;
357.4 (2) the right to receive care and services according to a suitable and up-to-date plan,
357.5 and subject to accepted health care, medical or nursing standards, to take an active part
357.6 in ~~creating and changing the plan~~ developing, modifying, and evaluating ~~care~~ the plan
357.7 and services;
357.8 (3) the right to be told ~~in advance of~~ before receiving ~~care about the~~ services ~~that will~~
357.9 ~~be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will
357.10 be providing the services, the frequency of visits proposed to be furnished, other choices
357.11 that are available for addressing home care needs, and ~~the consequences of these choices~~
357.12 ~~including~~ the potential consequences of refusing these services;
357.13 (4) the right to be told in advance of any ~~change~~ recommended changes by the
357.14 provider in the service plan ~~of care~~ and to take an active part in any ~~change~~ decisions
357.15 about changes to the service plan;
357.16 (5) the right to refuse services or treatment;
357.17 (6) the right to know, ~~in advance~~ before receiving services or during the initial
357.18 visit, any limits to the services available from a home care provider~~, and the provider's~~
357.19 ~~grounds for a termination of services~~;
357.20 ~~(7) the right to know in advance of receiving care whether the services are covered~~
357.21 ~~by health insurance, medical assistance, or other health programs, the charges for services~~
357.22 ~~that will not be covered by Medicare, and the charges that the individual may have to pay;~~
357.23 ~~(8)~~ (7) the right to ~~know~~ be told before services are initiated what the provider
357.24 charges are for the services, ~~no matter who will be paying the bill~~ and if known to what
357.25 extent payment may be expected from health insurance, public programs or other sources,
357.26 and what charges the client may be responsible for paying;
357.27 ~~(9)~~ (8) the right to know that there may be other services available in the community,
357.28 including other home care services and providers, and to know where to ~~go for~~ find
357.29 information about these services;
357.30 ~~(10)~~ (9) the right to choose freely among available providers and to change providers
357.31 after services have begun, within the limits of health insurance, long-term care insurance,
357.32 medical assistance, or other health programs;
357.33 ~~(11)~~ (10) the right to have personal, financial, and medical information kept private,
357.34 and to be advised of the provider's policies and procedures regarding disclosure of such
357.35 information;

358.1 ~~(12)~~ (11) the right to ~~be allowed~~ access ~~to~~ the client's own records and written
358.2 information from those records in accordance with sections 144.291 to 144.298;
358.3 ~~(13)~~ (12) the right to be served by people who are properly trained and competent
358.4 to perform their duties;
358.5 ~~(14)~~ (13) the right to be treated with courtesy and respect, and to have the ~~patient's~~
358.6 client's property treated with respect;
358.7 ~~(15)~~ (14) the right to be free from physical and verbal abuse, neglect, financial
358.8 exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and
358.9 the Maltreatment of Minors Act;
358.10 ~~(16)~~ (15) the right to reasonable, advance notice of changes in services or charges~~,~~
358.11 ~~including~~;
358.12 (16) the right to know the provider's reason for termination of services;
358.13 (17) the right to at least ten days' advance notice of the termination of a service by a
358.14 provider, except in cases where:
358.15 (i) the ~~recipient of services~~ client engages in conduct that significantly alters the
358.16 ~~conditions of employment as specified in the employment contract between~~ terms of
358.17 the service plan with the home care provider ~~and the individual providing home care~~
358.18 ~~services, or creates~~;
358.19 (ii) the client, person who lives with the client, or others create an abusive or unsafe
358.20 work environment for the ~~individual~~ person providing home care services; or
358.21 ~~(ii)~~ (iii) an emergency ~~for the informal caregiver~~ or a significant change in the
358.22 ~~recipient's~~ client's condition has resulted in service needs that exceed the current service
358.23 ~~provider agreement~~ plan and that cannot be safely met by the home care provider;
358.24 ~~(17)~~ (18) the right to a coordinated transfer when there will be a change in the
358.25 provider of services;
358.26 ~~(18)~~ (19) the right to ~~voice grievances regarding treatment or care that is~~ complain
358.27 about services that are provided, or ~~fails to be, furnished, or regarding~~ fail to be provided,
358.28 and the lack of courtesy or respect to the ~~patient~~ client or the ~~patient's~~ client's property;
358.29 ~~(19)~~ (20) the right to know how to contact an individual associated with the home
358.30 care provider who is responsible for handling problems and to have the home care provider
358.31 investigate and attempt to resolve the grievance or complaint;
358.32 ~~(20)~~ (21) the right to know the name and address of the state or county agency to
358.33 contact for additional information or assistance; and
358.34 ~~(21)~~ (22) the right to assert these rights personally, or have them asserted by
358.35 the ~~patient's family or guardian when the patient has been judged incompetent,~~ client's
358.36 representative or by anyone on behalf of the client, without retaliation.

Subd. 2. **Interpretation and enforcement of rights.** These rights are established for the benefit of ~~persons~~ clients who receive home care services. ~~"Home care services" means home care services as defined in section 144A.43, subdivision 3, and unlicensed personal care assistance services, including services covered by medical assistance under section 256B.0625, subdivision 19a.~~ All home care providers, including those exempted under section 144A.471, must comply with this section. The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a ~~person~~ client to surrender any of these rights as a condition of receiving services. ~~A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights.~~ This statement of rights does not replace or diminish other rights and liberties that may exist relative to ~~persons~~ clients receiving home care services, persons providing home care services, or providers licensed under ~~Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services, including personal care assistance services, are initiated. The copy shall also contain the address and phone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long-Term Care shall be included in notices of change in client fees and in notices where home care providers initiate transfer or discontinuation of services~~ sections 144A.43 to 144A.482.

Sec. 7. Minnesota Statutes 2012, section 144A.45, is amended to read:

144A.45 REGULATION OF HOME CARE SERVICES.

Subdivision 1. **~~Rules~~ Regulations.** The commissioner shall ~~adopt rules for the regulation of~~ regulate home care providers pursuant to sections 144A.43 to ~~144A.47~~ 144A.482. The ~~rules~~ regulations shall include the following:

(1) provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services while respecting clients' autonomy and choice;

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

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

(4) standards for provision of home care services;

360.1 ~~(4)~~ (5) standards for medication management ~~which may vary according to the~~
360.2 ~~nature of the services provided, the setting in which the services are provided, or the~~
360.3 ~~status of the consumer. Medication management includes the central storage, handling,~~
360.4 ~~distribution, and administration of medications~~;
360.5 ~~(5)~~ (6) standards for supervision of home care services ~~requiring supervision by a~~
360.6 ~~registered nurse or other appropriate health care professional which must occur on site~~
360.7 ~~at least every 62 days, or more frequently if indicated by a clinical assessment, and in~~
360.8 ~~accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a~~
360.9 ~~person performing home care aide tasks for a class B licensee providing paraprofessional~~
360.10 ~~services does not require nursing supervision~~;
360.11 ~~(6)~~ (7) standards for client evaluation or assessment ~~which may vary according to~~
360.12 ~~the nature of the services provided or the status of the consumer~~;
360.13 ~~(7)~~ (8) requirements for the involvement of a ~~consumer's physician~~ client's health
360.14 care provider, the documentation of ~~physicians'~~ health care providers' orders, if required,
360.15 and the ~~consumer's treatment~~ client's service plan~~, and~~;
360.16 (9) the maintenance of accurate, current ~~clinical~~ client records;
360.17 ~~(8)~~ (10) the establishment of ~~different classes~~ basic and comprehensive levels of
360.18 licenses ~~for different types of providers and different standards and requirements for~~
360.19 ~~different kinds of home care~~ based on services provided; and
360.20 ~~(9) operating procedures required to implement~~ (11) provisions to enforce these
360.21 regulations and the home care bill of rights.
360.22 ~~Subd. 1a.~~ ~~**Home care aide tasks.**~~ ~~Notwithstanding the provisions of Minnesota~~
360.23 ~~Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting~~
360.24 ~~toileting, transfers, and ambulation if the client is ambulatory and if the client has no~~
360.25 ~~serious acute illness or infectious disease.~~
360.26 ~~Subd. 1b.~~ ~~**Home health aide qualifications.**~~ ~~Notwithstanding the provisions of~~
360.27 ~~Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks~~
360.28 ~~if the person maintains current registration as a nursing assistant on the Minnesota nursing~~
360.29 ~~assistant registry. Maintaining current registration on the Minnesota nursing assistant~~
360.30 ~~registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110,~~
360.31 ~~subpart 3.~~
360.32 Subd. 2. **Regulatory functions.** ~~(a)~~ The commissioner shall:
360.33 (1) ~~evaluate, monitor, and~~ license, survey, and monitor without advance notice, home
360.34 care providers in accordance with sections ~~144A.45 to 144A.47~~ 144A.43 to 144A.482;
360.35 ~~(2) inspect the office and records of a provider during regular business hours without~~
360.36 ~~advance notice to the home care provider;~~

361.1 (2) survey every temporary licensee within one year of the temporary license issuance
361.2 date subject to the temporary licensee providing home care services to a client or clients;
361.3 (3) survey all licensed home care providers on an interval that will promote the
361.4 health and safety of clients;
361.5 ~~(3)~~ (4) with the consent of the ~~consumer~~ client, visit the home where services are
361.6 being provided;
361.7 ~~(4)~~ (5) issue correction orders and assess civil penalties in accordance with section
361.8 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to ~~144A.47 or the rules~~
361.9 ~~adopted under those sections~~ 144A.482;
361.10 ~~(5)~~ (6) take action as authorized in section ~~144A.46, subdivision 3~~ 144A.475; and
361.11 ~~(6)~~ (7) take other action reasonably required to accomplish the purposes of sections
361.12 144A.43 to ~~144A.47~~ 144A.482.
361.13 ~~(b) In the exercise of the authority granted in sections 144A.43 to 144A.47, the~~
361.14 ~~commissioner shall comply with the applicable requirements of section 144.122, the~~
361.15 ~~Government Data Practices Act, and the Administrative Procedure Act.~~
361.16 ~~Subd. 4.~~ ~~**Medicaid reimbursement.**~~ ~~Notwithstanding the provisions of section~~
361.17 ~~256B.37 or state plan requirements to the contrary, certification by the federal Medicare~~
361.18 ~~program must not be a requirement of Medicaid payment for services delivered under~~
361.19 ~~section 144A.4605.~~
361.20 ~~Subd. 5.~~ ~~**Home care providers; services for Alzheimer's disease or related**~~
361.21 ~~**disorder.**~~ ~~(a) If a home care provider licensed under section 144A.46 or 144A.4605 markets~~
361.22 ~~or otherwise promotes services for persons with Alzheimer's disease or related disorders,~~
361.23 ~~the facility's direct care staff and their supervisors must be trained in dementia care.~~
361.24 ~~(b) Areas of required training include:~~
361.25 ~~(1) an explanation of Alzheimer's disease and related disorders;~~
361.26 ~~(2) assistance with activities of daily living;~~
361.27 ~~(3) problem solving with challenging behaviors; and~~
361.28 ~~(4) communication skills.~~
361.29 ~~(c) The licensee shall provide to consumers in written or electronic form a~~
361.30 ~~description of the training program, the categories of employees trained, the frequency~~
361.31 ~~of training, and the basic topics covered.~~

361.32 Sec. 8. **[144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.**
361.33 Subdivision 1. **License required.** A home care provider may not open, operate,
361.34 manage, conduct, maintain, or advertise itself as a home care provider or provide home

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

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

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

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

362.10 (3) establishes the charges;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

363.9 (2) providing standby assistance;

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

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

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

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

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

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

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

363.27 (3) medication management services;

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

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

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

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

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

364.5 (1) an individual or organization that offers, provides, or arranges for personal care
364.6 assistance services under the medical assistance program as authorized under sections
364.7 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;

364.8 (2) a provider that is licensed by the commissioner of human services to provide
364.9 semi-independent living services for persons with developmental disabilities under section
364.10 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

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

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

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

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

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

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

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

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

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

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

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

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

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

365.1 (3) a business that provides staff to home care providers, such as a temporary
365.2 employment agency, if the business:
365.3 (i) only provides staff under contract to licensed or exempt providers;
365.4 (ii) provides no services under direct agreements with clients; and
365.5 (iii) is contractually bound to perform services under the contracting home care
365.6 provider's direction and supervision;
365.7 (4) any home care services conducted by and for the adherents of any recognized
365.8 church or religious denomination for its members through spiritual means, or by prayer
365.9 for healing;
365.10 (5) an individual who only provides home care services to a relative;
365.11 (6) an individual not connected with a home care provider that provides assistance
365.12 with basic home care needs if the assistance is provided primarily as a contribution and
365.13 not as a business;
365.14 (7) an individual not connected with a home care provider that shares housing with
365.15 and provides primarily housekeeping or homemaking services to an elderly or disabled
365.16 person in return for free or reduced-cost housing;
365.17 (8) an individual or provider providing home-delivered meal services;
365.18 (9) an individual providing senior companion services and other Older American
365.19 Volunteer Programs (OAVP) established under the Domestic Volunteer Service Act of
365.20 1973, United States Code, title 42, chapter 66;
365.21 (10) an employee of a nursing home licensed under this chapter or an employee of a
365.22 boarding care home licensed under sections 144.50 to 144.56 who responds to occasional
365.23 emergency calls from individuals residing in a residential setting that is attached to or
365.24 located on property contiguous to the nursing home or boarding care home;
365.25 (11) a member of a professional corporation organized under chapter 319B that
365.26 does not regularly offer or provide home care services as defined in section 144A.43,
365.27 subdivision 3;
365.28 (12) the following organizations established to provide medical or surgical services
365.29 that do not regularly offer or provide home care services as defined in section 144A.43,
365.30 subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit
365.31 corporation organized under chapter 317A, a partnership organized under chapter 323, or
365.32 any other entity determined by the commissioner;
365.33 (13) an individual or agency that provides medical supplies or durable medical
365.34 equipment, except when the provision of supplies or equipment is accompanied by a
365.35 home care service;
365.36 (14) a physician licensed under chapter 147;

366.1 (15) an individual who provides home care services to a person with a developmental
366.2 disability who lives in a place of residence with a family, foster family, or primary caregiver;
366.3 (16) a business that only provides services that are primarily instructional and not
366.4 medical services or health-related support services;
366.5 (17) an individual who performs basic home care services for no more than 14 hours
366.6 each calendar week to no more than one client;
366.7 (18) an individual or business licensed as hospice as defined in sections 144A.75 to
366.8 144A.755 who is not providing home care services independent of hospice service;
366.9 (19) activities conducted by the commissioner of health or a board of health as
366.10 defined in section 145A.02, subdivision 2, including communicable disease investigations
366.11 or testing; or
366.12 (20) administering or monitoring a prescribed therapy necessary to control or
366.13 prevent a communicable disease, or the monitoring of an individual's compliance with a
366.14 health directive as defined in section 144.4172, subdivision 6.

366.15 Sec. 9. **[144A.472] HOME CARE PROVIDER LICENSE; APPLICATION AND**
366.16 **RENEWAL.**
366.17 Subdivision 1. **License applications.** Each application for a home care provider
366.18 license must include information sufficient to show that the applicant meets the
366.19 requirements of licensure, including:
366.20 (1) the applicant's name, e-mail address, physical address, and mailing address,
366.21 including the name of the county in which the applicant resides and has a principal
366.22 place of business;
366.23 (2) the initial license fee in the amount specified in subdivision 7;
366.24 (3) e-mail address, physical address, mailing address, and telephone number of the
366.25 principal administrative office;
366.26 (4) e-mail address, physical address, mailing address, and telephone number of
366.27 each branch office, if any;
366.28 (5) names, e-mail and mailing addresses, and telephone numbers of all owners
366.29 and managerial officials;
366.30 (6) documentation of compliance with the background study requirements of section
366.31 144A.476 for all persons involved in the management, operation, or control of the home
366.32 care provider;
366.33 (7) documentation of a background study as required by section 144.057 for any
366.34 individual seeking employment, paid or volunteer, with the home care provider;

367.1 (8) evidence of workers' compensation coverage as required by sections 176.181
367.2 and 176.182;
367.3 (9) documentation of liability coverage, if the provider has it;
367.4 (10) identification of the license level the provider is seeking;
367.5 (11) documentation that identifies the managerial official who is in charge of
367.6 day-to-day operations and attestation that the person has reviewed and understands the
367.7 home care provider regulations;
367.8 (12) documentation that the applicant has designated one or more owners,
367.9 managerial officials, or employees as an agent or agents, which shall not affect the legal
367.10 responsibility of any other owner or managerial official under this chapter;
367.11 (13) the signature of the officer or managing agent on behalf of an entity, corporation,
367.12 association, or unit of government;
367.13 (14) verification that the applicant has the following policies and procedures in place
367.14 so that if a license is issued, the applicant will implement the policies and procedures
367.15 and keep them current:
367.16 (i) requirements in sections 626.556, reporting of maltreatment of minors, and
367.17 626.557, reporting of maltreatment of vulnerable adults;
367.18 (ii) conducting and handling background studies on employees;
367.19 (iii) orientation, training, and competency evaluations of home care staff, and a
367.20 process for evaluating staff performance;
367.21 (iv) handling complaints from clients, family members, or client representatives
367.22 regarding staff or services provided by staff;
367.23 (v) conducting initial evaluation of clients' needs and the providers' ability to provide
367.24 those services;
367.25 (vi) conducting initial and ongoing client evaluations and assessments and how
367.26 changes in a client's condition are identified, managed, and communicated to staff and
367.27 other health care providers as appropriate;
367.28 (vii) orientation to and implementation of the home care client bill of rights;
367.29 (viii) infection control practices;
367.30 (ix) reminders for medications, treatments, or exercises, if provided; and
367.31 (x) conducting appropriate screenings, or documentation of prior screenings, to
367.32 show that staff are free of tuberculosis, consistent with current United States Centers for
367.33 Disease Control standards; and
367.34 (15) other information required by the department.
367.35 Subd. 2. **Comprehensive home care license applications.** In addition to the
367.36 information and fee required in subdivision 1, applicants applying for a comprehensive

368.1 home care license must also provide verification that the applicant has the following
368.2 policies and procedures in place so that if a license is issued, the applicant will implement
368.3 the policies and procedures in this subdivision and keep them current:
368.4 (1) conducting initial and ongoing assessments of the client's needs by a registered
368.5 nurse or appropriate licensed health professional, including how changes in the client's
368.6 conditions are identified, managed, and communicated to staff and other health care
368.7 providers, as appropriate;
368.8 (2) ensuring that nurses and licensed health professionals have current and valid
368.9 licenses to practice;
368.10 (3) medication and treatment management;
368.11 (4) delegation of home care tasks by registered nurses or licensed health professionals;
368.12 (5) supervision of registered nurses and licensed health professionals; and
368.13 (6) supervision of unlicensed personnel performing delegated home care tasks.
368.14 Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license
368.15 may be renewed for a period of one year if the licensee satisfies the following:
368.16 (1) submits an application for renewal in the format provided by the commissioner
368.17 at least 30 days before expiration of the license;
368.18 (2) submits the renewal fee in the amount specified in subdivision 7;
368.19 (3) has provided home care services within the past 12 months;
368.20 (4) complies with sections 144A.43 to 144A.4799;
368.21 (5) provides information sufficient to show that the applicant meets the requirements
368.22 of licensure, including items required under subdivision 1;
368.23 (6) provides verification that all policies under subdivision 1, are current; and
368.24 (7) provides any other information deemed necessary by the commissioner.
368.25 (b) A renewal applicant who holds a comprehensive home care license must also
368.26 provide verification that policies listed under subdivision 2 are current.
368.27 Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately
368.28 licensed if the commissioner determines that the units cannot adequately share supervision
368.29 and administration of services from the main office.
368.30 Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license
368.31 issued by the commissioner may not be transferred to another party. Before acquiring
368.32 ownership of a home care provider business, a prospective applicant must apply for a
368.33 new temporary license. A change of ownership is a transfer of operational control to
368.34 a different business entity, and includes:
368.35 (1) transfer of the business to a different or new corporation;

369.1 (2) in the case of a partnership, the dissolution or termination of the partnership under
369.2 chapter 323A, with the business continuing by a successor partnership or other entity;
369.3 (3) relinquishment of control of the provider to another party, including to a contract
369.4 management firm that is not under the control of the owner of the business' assets;
369.5 (4) transfer of the business by a sole proprietor to another party or entity; or
369.6 (5) in the case of a privately held corporation, the change in ownership or control of
369.7 50 percent or more of the outstanding voting stock.
369.8 Subd. 6. **Notification of changes of information.** The temporary licensee or
369.9 licensee shall notify the commissioner in writing within ten working days after any
369.10 change in the information required in subdivision 1, except the information required in
369.11 subdivision 1, clause (5), is required at the time of license renewal.
369.12 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial
369.13 applicant seeking initial temporary home care licensure must submit the following
369.14 application fee to the commissioner along with a completed application:
369.15 (1) basic home care provider, $2,100; or
369.16 (2) comprehensive home care provider, $4,200.
369.17 (b) A home care provider who is filing a change of ownership as required under
369.18 subdivision 5 must submit the following application fee to the commissioner, along with
369.19 the documentation required for the change of ownership:
369.20 (1) basic home care provider, $2,100; or
369.21 (2) comprehensive home care provider, $4,200.
369.22 (c) A home care provider who is seeking to renew the provider's license shall pay a
369.23 fee to the commissioner based on revenues derived from the provision of home care
369.24 services during the calendar year prior to the year in which the application is submitted,
369.25 according to the following schedule:
369.26 **License Renewal Fee**

	Provider Annual Revenue	Fee
369.27	**Provider Annual Revenue**	**Fee**
369.28	greater than $1,500,000	$6,625
369.29 369.30	greater than $1,275,000 and no more than $1,500,000	$5,797
369.31 369.32	greater than $1,100,000 and no more than $1,275,000	$4,969
369.33 369.34	greater than $950,000 and no more than $1,100,000	$4,141
369.35 369.36	greater than $850,000 and no more than $950,000	$3,727
369.37 369.38	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. 10. **[144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.**

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

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

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

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

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

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

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

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

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

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

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

372.1 request process will be conducted internally by the commissioner or commissioner's
372.2 designee, and chapter 14 does not apply.
372.3 (c) The temporary licensee requesting reconsideration must make the request in
372.4 writing and must list and describe the reasons why the licensee disagrees with the decision
372.5 to deny the basic or comprehensive home care license.
372.6 (d) A temporary licensee whose license is denied must comply with the requirements
372.7 for notification and transfer of clients in section 144A.475, subdivision 5.

372.8 Sec. 11. **[144A.474] SURVEYS AND INVESTIGATIONS.**

372.9 Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home care
372.10 provider. Survey frequency may be based on the license level, the provider's compliance
372.11 history, number of clients served, or other factors as determined by the department deemed
372.12 necessary to ensure the health, safety, and welfare of clients and compliance with the law.
372.13 Subd. 2. **Scheduling surveys.** Surveys and investigations shall be conducted
372.14 without advance notice to home care providers. Surveyors may contact the home care
372.15 provider on the day of a survey to arrange for someone to be available at the survey site.
372.16 The contact does not constitute advance notice.
372.17 Subd. 3. **Information provided by home care provider.** The home care provider
372.18 shall provide accurate and truthful information to the department during a survey,
372.19 investigation, or other licensing activities.
372.20 Subd. 4. **Providing client records.** Upon request of a surveyor, home care providers
372.21 shall provide a list of current and past clients or client representatives that includes
372.22 addresses and telephone numbers and any other information requested about the services
372.23 to clients within a reasonable period of time.
372.24 Subd. 5. **Contacting and visiting clients.** Surveyors may contact or visit a home
372.25 care provider's clients to gather information without notice to the home care provider.
372.26 Before visiting a client, a surveyor shall obtain the client's or client's representative's
372.27 permission by telephone, mail, or in person. Surveyors shall inform all clients or client's
372.28 representatives of their right to decline permission for a visit.
372.29 Subd. 6. **Complaint investigations.** Upon receiving information alleging that
372.30 a home care provider has violated or is currently violating a requirement of sections
372.31 144A.43 to 144A.482, 626.556, and 626.557, the commissioner shall investigate the
372.32 complaint according to sections 144A.51 to 144A.54.
372.33 Subd. 7. **Correction orders.** (a) A correction order may be issued whenever the
372.34 commissioner finds upon survey or during a complaint investigation that a home care
372.35 provider, a controlling person, or an employee of the provider is not in compliance with

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

373.4 (b) The commissioner shall mail copies of any correction order to the last known
373.5 address of the home care provider. A copy of each correction order and copies of any
373.6 documentation supplied to the commissioner shall be kept on file by the home care
373.7 provider, and public documents shall be made available for viewing by any person upon
373.8 request. Copies may be kept electronically.

373.9 (c) By the correction order date, the home care provider must document in the
373.10 provider's records any action taken to comply with the correction order. The commissioner
373.11 may request a copy of this documentation and the home care provider's action to respond
373.12 to the correction order in future surveys, upon a complaint investigation, and as otherwise
373.13 needed.

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

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

373.21 (2) explain why they are in error; and

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

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

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

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

373.30 (1) determination of maltreatment of a child under section 626.556 or the
373.31 maltreatment of a vulnerable adult under section 626.557 for which the license holder is
373.32 determined responsible for the maltreatment under section 626.556, subdivision 10e,
373.33 paragraph (i), or 626.557, subdivision 9c, paragraph (c);

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

374.1 (3) failure to obtain background check clearance or exemption for direct care staff
374.2 prior to provision of services;
374.3 (4) willful violation of state licensing laws and regulations; and
374.4 (5) violation of employee health status guidance relating to control of infectious
374.5 diseases such as tuberculosis.
374.6 (c) If the commissioner finds that the applicant or a home care provider required to
374.7 be licensed under sections 144A.43 to 144A.482 has not corrected violations identified
374.8 in a survey or complaint investigation that were specified in the correction order or
374.9 conditional license, the commissioner may impose a fine. A notice of noncompliance with
374.10 a correction order must be mailed to the applicant's or provider's last known address. The
374.11 noncompliance notice must list the violations not corrected.
374.12 (d) Fines under this subdivision may be assessed according to paragraph (b), or
374.13 the commissioner may assess a fine other than those identified in paragraph (b) from
374.14 $500 to $2,000 per violation when the provider has failed to correct an order relating to
374.15 violation of state licensing laws.
374.16 (e) The license holder must pay the fines assessed on or before the payment date
374.17 specified. If the license holder fails to fully comply with the order, the commissioner may
374.18 issue a second fine or suspend the license until the license holder complies by paying the
374.19 fine. If the license holder receives state funds, the state, county, or municipal agencies or
374.20 departments responsible for administering the funds shall withhold payments and recover
374.21 any payments made while the license is suspended for failure to pay a fine. A timely
374.22 appeal shall stay payment of the fine until the commissioner issues a final order.
374.23 (f) A license holder shall promptly notify the commissioner in writing, including
374.24 by e-mail, when a violation specified in the order to forfeit a fine is corrected. If upon
374.25 reinspection the commissioner determines that a violation has not been corrected as
374.26 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
374.27 commissioner shall notify the license holder by mail to the last known address in the
374.28 licensing record that a second fine has been assessed. The license holder may appeal the
374.29 second fine as provided under this subdivision.
374.30 (g) A home care provider that has been assessed a fine under this subdivision has a
374.31 right to a hearing under this section and chapter 14.
374.32 (h) When a fine has been assessed, the license holder may not avoid payment by
374.33 closing, selling, or otherwise transferring the licensed program to a third party. In such an
374.34 event, the license holder shall be personally liable for payment of the fine. In the case
374.35 of a corporation, each controlling individual is personally and jointly liable for payment
374.36 of the fine.

375.1 (i) In addition to any fine imposed under this section, the commissioner may assess
375.2 costs related to an investigation that results in a final order assessing a fine or other
375.3 enforcement action authorized by this chapter.
375.4 (j) Fines collected under this subdivision shall be deposited in the state government
375.5 special revenue fund and credited to an account separate from the revenue collected under
375.6 section 144A.472. Subject to an appropriation by the legislature, the revenue from the
375.7 fines collected may be used by the commissioner for special projects to improve home care
375.8 regulations as recommended by the advisory council established in section 144A.4799.

375.9 Sec. 12. **[144A.475] ENFORCEMENT.**
375.10 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary
375.11 license, renew a license, suspend or revoke a license, or impose a conditional license if the
375.12 home care provider or owner or managerial official of the home care provider:
375.13 (1) is in violation of, or during the term of the license has violated, any of the
375.14 requirements in sections 144A.471 to 144A.482;
375.15 (2) permits, aids, or abets the commission of any illegal act in the provision of
375.16 home care;
375.17 (3) performs any act detrimental to the health, safety, and welfare of a client;
375.18 (4) obtains the license by fraud or misrepresentation;
375.19 (5) knowingly made or makes a false statement of a material fact in the application
375.20 for a license or in any other record or report required by this chapter;
375.21 (6) denies representatives of the department access to any part of the home care
375.22 provider's books, records, files, or employees;
375.23 (7) interferes with or impedes a representative of the department in contacting the
375.24 home care provider's clients;
375.25 (8) interferes with or impedes a representative of the department in the enforcement
375.26 of this chapter or has failed to fully cooperate with an inspection, survey, or investigation
375.27 by the department;
375.28 (9) destroys or makes unavailable any records or other evidence relating to the home
375.29 care provider's compliance with this chapter;
375.30 (10) refuses to initiate a background study under section 144.057 or 245A.04;
375.31 (11) fails to timely pay any fines assessed by the department;
375.32 (12) violates any local, city, or township ordinance relating to home care services;
375.33 (13) has repeated incidents of personnel performing services beyond their
375.34 competency level; or
375.35 (14) has operated beyond the scope of the home care provider's license level.

376.1 (b) A violation by a contractor providing the home care services of the home care
376.2 provider is a violation by the home care provider.
376.3 Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional
376.4 license designation may include terms that must be completed or met before a suspension
376.5 or conditional license designation is lifted. A conditional license designation may include
376.6 restrictions or conditions that are imposed on the provider. Terms for a suspension or
376.7 conditional license may include one or more of the following and the scope of each will be
376.8 determined by the commissioner:
376.9 (1) requiring a consultant to review, evaluate, and make recommended changes to
376.10 the home care provider's practices and submit reports to the commissioner at the cost of
376.11 the home care provider;
376.12 (2) requiring supervision of the home care provider or staff practices at the cost
376.13 of the home care provider by an unrelated person who has sufficient knowledge and
376.14 qualifications to oversee the practices and who will submit reports to the commissioner;
376.15 (3) requiring the home care provider or employees to obtain training at the cost of
376.16 the home care provider;
376.17 (4) requiring the home care provider to submit reports to the commissioner;
376.18 (5) prohibiting the home care provider from taking any new clients for a period
376.19 of time; or
376.20 (6) any other action reasonably required to accomplish the purpose of this
376.21 subdivision and section 144A.45, subdivision 2.
376.22 Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license,
376.23 the home care provider shall be entitled to notice and a hearing as provided by sections
376.24 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may,
376.25 without a prior contested case hearing, temporarily suspend a license or prohibit delivery
376.26 of services by a provider for not more than 90 days if the commissioner determines that
376.27 the health or safety of a consumer is in imminent danger, provided:
376.28 (1) advance notice is given to the home care provider;
376.29 (2) after notice, the home care provider fails to correct the problem;
376.30 (3) the commissioner has reason to believe that other administrative remedies are not
376.31 likely to be effective; and
376.32 (4) there is an opportunity for a contested case hearing within the 90 days.
376.33 Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties
376.34 under section 144A.45, subdivision 2, clause (5), and an action against a license under
376.35 this section, a provider must request a hearing no later than 15 days after the provider
376.36 receives notice of the action.

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

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

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

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

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

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

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

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

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

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

378.6 (d) The commissioner shall notify the home care provider 30 days in advance of
378.7 the date of nonrenewal, suspension, or revocation of the license. Within ten days after
378.8 the receipt of the notification, the home care provider may request, in writing, that the
378.9 commissioner stay the nonrenewal, revocation, or suspension of the license. The home
378.10 care provider shall specify the reasons for requesting the stay; the steps that will be taken
378.11 to attain or maintain compliance with the licensure laws and regulations; any limits on the
378.12 authority or responsibility of the owners or managerial officials whose actions resulted in
378.13 the notice of nonrenewal, revocation, or suspension; and any other information to establish
378.14 that the continuing affiliation with these individuals will not jeopardize client health, safety,
378.15 or well-being. The commissioner shall determine whether the stay will be granted within
378.16 30 days of receiving the provider's request. The commissioner may propose additional
378.17 restrictions or limitations on the provider's license and require that the granting of the stay
378.18 be contingent upon compliance with those provisions. The commissioner shall take into
378.19 consideration the following factors when determining whether the stay should be granted:

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

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

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

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

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

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

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

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

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

379.1 Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the
379.2 commissioner may bring an action in district court to enjoin a person who is involved in
379.3 the management, operation, or control of a home care provider or an employee of the
379.4 home care provider from illegally engaging in activities regulated by sections 144A.43 to
379.5 144A.482. The commissioner may bring an action under this subdivision in the district
379.6 court in Ramsey County or in the district in which a home care provider is providing
379.7 services. The court may grant a temporary restraining order in the proceeding if continued
379.8 activity by the person who is involved in the management, operation, or control of a home
379.9 care provider, or by an employee of the home care provider, would create an imminent
379.10 risk of harm to a recipient of home care services.

379.11 Subd. 10. **Subpoena.** In matters pending before the commissioner under sections
379.12 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance
379.13 of witnesses and the production of all necessary papers, books, records, documents, and
379.14 other evidentiary material. If a person fails or refuses to comply with a subpoena or
379.15 order of the commissioner to appear or testify regarding any matter about which the
379.16 person may be lawfully questioned or to produce any papers, books, records, documents,
379.17 or evidentiary materials in the matter to be heard, the commissioner may apply to the
379.18 district court in any district, and the court shall order the person to comply with the
379.19 commissioner's order or subpoena. The commissioner of health may administer oaths to
379.20 witnesses or take their affirmation. Depositions may be taken in or outside the state in the
379.21 manner provided by law for the taking of depositions in civil actions. A subpoena or other
379.22 process or paper may be served on a named person anywhere in the state by an officer
379.23 authorized to serve subpoenas in civil actions, with the same fees and mileage and in the
379.24 same manner as prescribed by law for a process issued out of a district court. A person
379.25 subpoenaed under this subdivision shall receive the same fees, mileage, and other costs
379.26 that are paid in proceedings in district court.

379.27 Sec. 13. **[144A.476] BACKGROUND STUDIES.**

379.28 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a)
379.29 Before the commissioner issues a temporary license or renews a license, an owner or
379.30 managerial official is required to complete a background study under section 144.057. No
379.31 person may be involved in the management, operation, or control of a home care provider
379.32 if the person has been disqualified under chapter 245C. If an individual is disqualified
379.33 under section 144.056 or chapter 245C, the individual may request reconsideration of
379.34 the disqualification. If the individual requests reconsideration and the commissioner
379.35 sets aside or rescinds the disqualification, the individual is eligible to be involved in the

380.1 management, operation, or control of the provider. If an individual has a disqualification
380.2 under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's
380.3 disqualification is barred from a set aside, and the individual must not be involved in the
380.4 management, operation, or control of the provider.

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

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

380.16 (d) The department shall not issue any license if the applicant or owner or managerial
380.17 official has been unsuccessful in having a background study disqualification set aside
380.18 under section 144.057 and chapter 245C; if the owner or managerial official, as an owner
380.19 or managerial official of another home care provider, was substantially responsible for
380.20 the other home care provider's failure to substantially comply with sections 144A.43 to
380.21 144A.482; or if an owner that has ceased doing business, either individually or as an
380.22 owner of a home care provider, was issued a correction order for failing to assist clients in
380.23 violation of this chapter.

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

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

380.32 Sec. 14. **[144A.477] COMPLIANCE.**

380.33 Subdivision 1. **Medicare-certified providers; coordination of surveys.** If feasible,
380.34 the commissioner shall survey licensees to determine compliance with this chapter at the
380.35 same time as surveys for certification for Medicare if Medicare certification is based on

381.1 compliance with the federal conditions of participation and on survey and enforcement
381.2 by the Department of Health as agent for the United States Department of Health and
381.3 Human Services.

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

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

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

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

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

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

381.15 (6) individualized monitoring and reassessment, sections 144A.4791, subdivision
381.16 8, and 144A.4792, subdivisions 2 and 3;

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

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

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

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

381.22 (11) qualifications for unlicensed personnel performing delegated tasks, section
381.23 144A.4795;

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

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

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

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

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

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

381.32 Sec. 15. **[144A.478] INNOVATION VARIANCE.**

381.33 Subdivision 1. **Definition.** For purposes of this section, "innovation variance"
381.34 means a specified alternative to a requirement of this chapter. An innovation variance
381.35 may be granted to allow a home care provider to offer home care services of a type or

382.1 in a manner that is innovative, will not impair the services provided, will not adversely
382.2 affect the health, safety, or welfare of the clients, and is likely to improve the services
382.3 provided. The innovative variance cannot change any of the client's rights under section
382.4 144A.44, home care bill of rights.

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

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

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

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

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

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

382.15 (4) the reasons for the request; and

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

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

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

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

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

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

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

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

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

383.1 Sec. 16. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES;**
383.2 **BUSINESS OPERATION.**

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

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

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

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

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

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

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

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

383.34 (c) Nothing in this section precludes a home care provider or staff from accepting
383.35 gifts of minimal value, or precludes the acceptance of donations or bequests made to a

384.1 home care provider that are exempt from income tax under section 501(c) of the Internal
384.2 Revenue Code of 1986.

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

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

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

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

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

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

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

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

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

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

385.1 Sec. 17. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH**
385.2 **RESPECT TO CLIENTS.**

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

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

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

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

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

385.29 Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related**
385.30 **disorders.** The home care provider that provides services to clients with dementia shall
385.31 provide in written or electronic form, to clients and families or other persons who request
385.32 it, a description of the training program and related training it provides, including the
385.33 categories of employees trained, the frequency of training, and the basic topics covered.
385.34 This information satisfies the disclosure requirements in section 325F.72, subdivision
385.35 2, clause (4).

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

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

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

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

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

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

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

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

386.32 Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When
386.33 the services being provided are comprehensive home care services, an individualized
386.34 initial assessment must be conducted in-person by a registered nurse. When the services
386.35 are provided by other licensed health professionals, the assessment must be conducted by

387.1 the appropriate health professional. This initial assessment must be completed within five
387.2 days after initiation of home care services.

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

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

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

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

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

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

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

387.25 (f) The service plan must include:

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

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

387.30 (3) the schedule and methods of monitoring reviews or assessments of the client;

387.31 (4) the frequency of sessions of supervision of staff and type of personnel who
387.32 will supervise staff; and

387.33 (5) a contingency plan that includes:

387.34 (i) the action to be taken by the home care provider and by the client or client's
387.35 representative if the scheduled service cannot be provided;

388.1 (ii) information and method for a client or client's representative to contact the
388.2 home care provider;
388.3 (iii) names and contact information of persons the client wishes to have notified
388.4 in an emergency or if there is a significant adverse change in the client's condition,
388.5 including identification of and information as to who has authority to sign for the client in
388.6 an emergency; and
388.7 (iv) the circumstances in which emergency medical services are not to be summoned
388.8 consistent with chapters 145B and 145C, and declarations made by the client under those
388.9 chapters.
388.10 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a
388.11 service plan with a client, and the client continues to need home care services, the home
388.12 care provider shall provide the client and the client's representative, if any, with a written
388.13 notice of termination which includes the following information:
388.14 (1) the effective date of termination;
388.15 (2) the reason for termination;
388.16 (3) a list of known licensed home care providers in the client's immediate geographic
388.17 area;
388.18 (4) a statement that the home care provider will participate in a coordinated transfer
388.19 of care of the client to another home care provider, health care provider, or caregiver, as
388.20 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);
388.21 (5) the name and contact information of a person employed by the home care
388.22 provider with whom the client may discuss the notice of termination; and
388.23 (6) if applicable, a statement that the notice of termination of home care services
388.24 does not constitute notice of termination of the housing with services contract with a
388.25 housing with services establishment.
388.26 (b) When the home care provider voluntarily discontinues services to all clients, the
388.27 home care provider must notify the commissioner, lead agencies, and the ombudsman for
388.28 long-term care about its clients and comply with the requirements in this subdivision.
388.29 Subd. 11. **Client complaint and investigative process.** (a) The home care
388.30 provider must have a written policy and system for receiving, investigating, reporting,
388.31 and attempting to resolve complaints from its clients or clients' representatives. The
388.32 policy should clearly identify the process by which clients may file a complaint or concern
388.33 about home care services and an explicit statement that the home care provider will not
388.34 discriminate or retaliate against a client for expressing concerns or complaints. A home
388.35 care provider must have a process in place to conduct investigations of complaints made
388.36 by the client or the client's representative about the services in the client's plan that are or

389.1 are not being provided or other items covered in the client's home care bill of rights. This
389.2 complaint system must provide reasonable accommodations for any special needs of the
389.3 client or client's representative if requested.

389.4 (b) The home care provider must document the complaint, name of the client,
389.5 investigation, and resolution of each complaint filed. The home care provider must
389.6 maintain a record of all activities regarding complaints received, including the date the
389.7 complaint was received, and the home care provider's investigation and resolution of the
389.8 complaint. This complaint record must be kept for each event for at least two years after
389.9 the date of entry and must be available to the commissioner for review.

389.10 (c) The required complaint system must provide for written notice to each client or
389.11 client's representative that includes:

389.12 (1) the client's right to complain to the home care provider about the services received;

389.13 (2) the name or title of the person or persons with the home care provider to contact
389.14 with complaints;

389.15 (3) the method of submitting a complaint to the home care provider; and

389.16 (4) a statement that the provider is prohibited against retaliation according to
389.17 paragraph (d).

389.18 (d) A home care provider must not take any action that negatively affects a client
389.19 in retaliation for a complaint made or a concern expressed by the client or the client's
389.20 representative.

389.21 Subd. 12. **Disaster planning and emergency preparedness plan.** The home care
389.22 provider must have a written plan of action to facilitate the management of the client's care
389.23 and services in response to a natural disaster, such as flood and storms, or other emergencies
389.24 that may disrupt the home care provider's ability to provide care or services. The licensee
389.25 must provide adequate orientation and training of staff on emergency preparedness.

389.26 Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a
389.27 client, family member, or other caregiver of the client requests that an employee or other
389.28 agent of the home care provider discontinue a life-sustaining treatment, the employee or
389.29 agent receiving the request:

389.30 (1) shall take no action to discontinue the treatment; and

389.31 (2) shall promptly inform their supervisor or other agent of the home care provider
389.32 of the client's request.

389.33 (b) Upon being informed of a request for termination of treatment, the home care
389.34 provider shall promptly:

389.35 (1) inform the client that the request will be made known to the physician who
389.36 ordered the client's treatment;

390.1 (2) inform the physician of the client's request; and
390.2 (3) work with the client and the client's physician to comply with the provisions of
390.3 the Health Care Directive Act in chapter 145C.
390.4 (c) This section does not require the home care provider to discontinue treatment,
390.5 except as may be required by law or court order.
390.6 (d) This section does not diminish the rights of clients to control their treatments,
390.7 refuse services, or terminate their relationships with the home care provider.
390.8 (e) This section shall be construed in a manner consistent with chapter 145B or
390.9 145C, whichever applies, and declarations made by clients under those chapters.

390.10 Sec. 18. **[144A.4792] MEDICATION MANAGEMENT.**
390.11 Subdivision 1. **Medication management services; comprehensive home care**
390.12 **license.** (a) This subdivision applies only to home care providers with a comprehensive
390.13 home care license that provides medication management services to clients. Medication
390.14 management services may not be provided by a home care provider that has a basic
390.15 home care license.
390.16 (b) A comprehensive home care provider who provides medication management
390.17 services must develop, implement, and maintain current written medication management
390.18 policies and procedures. The policies and procedures must be developed under the
390.19 supervision and direction of a registered nurse, licensed health professional, or pharmacist
390.20 consistent with current practice standards and guidelines.
390.21 (c) The written policies and procedures must address requesting and receiving
390.22 prescriptions for medications; preparing and giving medications; verifying that
390.23 prescription drugs are administered as prescribed; documenting medication management
390.24 activities; controlling and storing medications; monitoring and evaluating medication use;
390.25 resolving medication errors; communicating with the prescriber, pharmacist, and client
390.26 and client representative, if any; disposing of unused medications; and educating clients
390.27 and client representatives about medications. When controlled substances are being
390.28 managed, the policies and procedures must also identify how the provider will ensure
390.29 security and accountability for the overall management, control, and disposition of those
390.30 substances in compliance with state and federal regulations and with subdivision 22.
390.31 Subd. 2. **Provision of medication management services.** (a) For each client who
390.32 requests medication management services, the comprehensive home care provider shall,
390.33 prior to providing medication management services, have a registered nurse, licensed
390.34 health professional, or authorized prescriber under section 151.37 conduct an assessment
390.35 to determine what mediation management services will be provided and how the services

391.1 will be provided. This assessment must be conducted face-to-face with the client. The
391.2 assessment must include an identification and review of all medications the client is known
391.3 to be taking. The review and identification must include indications for medications, side
391.4 effects, contraindications, allergic or adverse reactions, and actions to address these issues.
391.5 (b) The assessment must identify interventions needed in management of
391.6 medications to prevent diversion of medication by the client or others who may have
391.7 access to the medications. Diversion of medications means the misuse, theft, or illegal
391.8 or improper disposition of medications.
391.9 Subd. 3. **Individualized medication monitoring and reassessment.** The
391.10 comprehensive home care provider must monitor and reassess the client's medication
391.11 management services as needed under subdivision 14 when the client presents with
391.12 symptoms or other issues that may be medication-related and, at a minimum, annually.
391.13 Subd. 4. **Client refusal.** The home care provider must document in the client's
391.14 record any refusal for an assessment for medication management by the client. The
391.15 provider must discuss with the client the possible consequences of the client's refusal and
391.16 document the discussion in the client's record.
391.17 Subd. 5. **Individualized medication management plan.** For each client receiving
391.18 medication management services, the comprehensive home care provider must prepare
391.19 and include in the service plan a written medication management plan. The written plan
391.20 must be updated when changes are made to the plan. The plan must contain at least the
391.21 following provisions:
391.22 (1) a statement describing the medication management services that will be provided;
391.23 (2) a description of storage of medications based on the client's needs and
391.24 preferences, risk of diversion, and consistent with the manufacturer's directions;
391.25 (3) procedures for documenting medications that clients are taking;
391.26 (4) procedures for verifying all prescription drugs are administered as prescribed;
391.27 (5) procedures for monitoring medication use to prevent possible complications or
391.28 adverse reactions;
391.29 (6) identification of persons responsible for monitoring medication supplies and
391.30 ensuring that medication refills are ordered on a timely basis;
391.31 (7) identification of medication management tasks that may be delegated to
391.32 unlicensed personnel; and
391.33 (8) procedures for staff notifying a registered nurse or appropriate licensed health
391.34 professional when a problem arises with medication management services.
391.35 Subd. 6. **Administration of medication.** Medications may be administered by a
391.36 nurse, physician, or other licensed health practitioner authorized to administer medications

392.1 or by unlicensed personnel who have been delegated medication administration tasks by
392.2 a registered nurse.

392.3 Subd. 7. **Delegation of medication administration.** When administration of
392.4 medications is delegated to unlicensed personnel, the comprehensive home care provider
392.5 must ensure that the registered nurse has:

392.6 (1) instructed the unlicensed personnel in the proper methods to administer the
392.7 medications with respect to each client, and the unlicensed personnel has demonstrated
392.8 ability to competently follow the procedures;

392.9 (2) specified, in writing, specific instructions for each client and documented those
392.10 instructions in the client's records; and

392.11 (3) communicated with the unlicensed personnel about the individual needs of
392.12 the client.

392.13 Subd. 8. **Documentation of administration of medications.** Each medication
392.14 administered by comprehensive home care provider staff must be documented in the
392.15 client's record. The documentation must include the signature and title of the person
392.16 who administered the medication. The documentation must include the medication
392.17 name, dosage, date and time administered, and method and route of administration. The
392.18 staff must document the reason why medication administration was not completed as
392.19 prescribed and document any follow-up procedures that were provided to meet the client's
392.20 needs when medication was not administered as prescribed and in compliance with the
392.21 client's medication management plan.

392.22 Subd. 9. **Documentation of medication set up.** Documentation of dates of
392.23 medication set up, name of medication, quantity of dose, times to be administered, route
392.24 of administration, and name of person completing medication set up must be done at
392.25 time of set up.

392.26 Subd. 10. **Medications when client is away from home.** (a) A home care provider
392.27 providing medication management services must develop a policy and procedures for the
392.28 issuance of medications to clients for planned and unplanned times the client will be
392.29 away from home and need to have their medications with them which complies with
392.30 the following:

392.31 (1) for planned time away, the medications must be obtained from the pharmacy or
392.32 set up by the registered nurse according to appropriate state and federal laws and nurse
392.33 standards of practice; and

392.34 (2) for unplanned times away from home for temporary periods when an adequate
392.35 medication supply cannot be obtained from the pharmacy or set up by the registered nurse in
392.36 a timely manner, the provider may allow an unlicensed personnel to set up the medications.

393.1 (b) The task of medication set up may be done by an unlicensed personnel who is
393.2 trained and has been determined competent according to subdivisions 6 and 7. Prior
393.3 to providing the medications to the client, the unlicensed personnel must speak with
393.4 the registered nurse to ensure that all appropriate precautions are taken. The unlicensed
393.5 personnel may provide the client or the client's representative up to a 72-hour supply of
393.6 the client's medications.

393.7 (c) When preparing the medications, the medications must be taken from the
393.8 original containers prepared by the pharmacist and then placed in a suitable container. The
393.9 container must be labeled with the client's name; the medication name, strength, dose, and
393.10 route of administration; and the dates and times the medications are to be taken by the
393.11 client and any other information that the client should know regarding the medications.
393.12 For those medications which cannot be prepared in advance, the client must be given
393.13 the original container and complete directions and information for the administration
393.14 of that medication.

393.15 (d) The client or client's representative must also be provided in writing with the home
393.16 care provider's name and contact information for the home care provider's registered nurse.
393.17 The unlicensed personnel must document in the client's record the date the medications
393.18 were provided to the client; the name of medication; the medication's strength, dose, and
393.19 routes and administration times; the amounts of medications that were provided to the
393.20 client and to whom the medications were given. The registered nurse must review the
393.21 set up of medication and documentation to ensure that the issuance of medications by the
393.22 unlicensed personnel was handled appropriately.

393.23 Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home
393.24 care provider must determine whether it will require a prescription for all medications it
393.25 manages. The comprehensive home care provider must inform the client or the client's
393.26 representative whether the comprehensive home care provider requires a prescription
393.27 for all over-the-counter and dietary supplements before the comprehensive home care
393.28 provider will agree to manage those medications.

393.29 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.**
393.30 A comprehensive home care provider providing medication management services for
393.31 over-the-counter drugs or dietary supplements must retain those items in the original labeled
393.32 container with directions for use prior to setting up for immediate or later administration.
393.33 The provider must verify that the medications are up-to-date and stored as appropriate.

393.34 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
393.35 prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed
393.36 medications that the comprehensive home care provider is managing for the client.

394.1 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least
394.2 every 12 months or more frequently as indicated by the assessment in subdivision 2.
394.3 Prescriptions for controlled substances must comply with chapter 152.

394.4 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an
394.5 authorized prescriber must be received by a nurse or pharmacist. The order must be
394.6 handled according to Minnesota Rules, part 6800.6200.

394.7 Subd. 16. **Written or electronic prescription.** When a written or electronic
394.8 prescription is received, it must be communicated to the registered nurse in charge and
394.9 recorded or placed in the client's record.

394.10 Subd. 17. **Records confidential.** A prescription or order received verbally, in
394.11 writing, or electronically must be kept confidential according to sections 144.291 to
394.12 144.298 and 144A.44.

394.13 Subd. 18. **Medications provided by client or family members.** When the
394.14 comprehensive home care provider is aware of any medications or dietary supplements
394.15 that are being used by the client and are not included in the assessment for medication
394.16 management services, the staff must advise the registered nurse and document that in
394.17 the client's record.

394.18 Subd. 19. **Storage of drugs.** A comprehensive home care provider providing
394.19 storage of medications outside of the client's private living space must store all prescription
394.20 drugs in securely locked and substantially constructed compartments according to the
394.21 manufacturer's directions and permit only authorized personnel to have access.

394.22 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for
394.23 immediate or later administration, must be kept in the original container in which it was
394.24 dispensed by the pharmacy bearing the original prescription label with legible information
394.25 including the expiration or beyond-use date of a time-dated drug.

394.26 Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or
394.27 saved for use by anyone other than the client.

394.28 Subd. 22. **Disposition of drugs.** (a) Any current medications being managed by the
394.29 comprehensive home care provider must be given to the client or the client's representative
394.30 when the client's service plan ends or medication management services are no longer part
394.31 of the service plan. Medications that have been stored in the client's private living space
394.32 for a client that is deceased or that have been discontinued or that have expired may be
394.33 given to the client or the client's representative for disposal.

394.34 (b) The comprehensive home care provider will dispose of any medications
394.35 remaining with the comprehensive home care provider that are discontinued or expired or

395.1 upon the termination of the service contract or the client's death according to state and
395.2 federal regulations for disposition of drugs and controlled substances.

395.3 (c) Upon disposition, the comprehensive home care provider must document in the
395.4 client's record the disposition of the medications including the medication's name, strength,
395.5 prescription number as applicable, quantity, to whom the medications were given, date of
395.6 disposition, and names of staff and other individuals involved in the disposition.

395.7 Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing
395.8 medication management must develop and implement procedures for loss or spillage of all
395.9 controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must
395.10 require that when a spillage of a controlled substance occurs, a notation must be made
395.11 in the client's record explaining the spillage and the actions taken. The notation must
395.12 be signed by the person responsible for the spillage and include verification that any
395.13 contaminated substance was disposed of according to state or federal regulations.

395.14 (b) The procedures must require the comprehensive home care provider of
395.15 medication management to investigate any known loss or unaccounted for prescription
395.16 drugs and take appropriate action required under state or federal regulations and document
395.17 the investigation in required records.

395.18 Sec. 19. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT**
395.19 **SERVICES.**

395.20 Subdivision 1. **Providers with a comprehensive home care license.** This section
395.21 applies only to home care providers with a comprehensive home care license that provide
395.22 treatment or therapy management services to clients. Treatment or therapy management
395.23 services cannot be provided by a home care provider that has a basic home care license.

395.24 Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who
395.25 provides treatment and therapy management services must develop, implement, and
395.26 maintain up-to-date written treatment or therapy management policies and procedures.
395.27 The policies and procedures must be developed under the supervision and direction of
395.28 a registered nurse or appropriate licensed health professional consistent with current
395.29 practice standards and guidelines.

395.30 (b) The written policies and procedures must address requesting and receiving
395.31 orders or prescriptions for treatments or therapies, providing the treatment or therapy,
395.32 documenting of treatment or therapy activities, educating and communicating with clients
395.33 about treatments or therapy they are receiving, monitoring and evaluating the treatment
395.34 and therapy, and communicating with the prescriber.

396.1 Subd. 3. **Individualized treatment or therapy management plan.** For each
396.2 client receiving management of ordered or prescribed treatments or therapy services, the
396.3 comprehensive home care provider must include in the service plan a written management
396.4 plan which contains at least the following provisions:
396.5 (1) a statement of the type of services that will be provided;
396.6 (2) procedures for documenting treatments or therapies the client is receiving;
396.7 (3) procedures for monitoring treatments or therapy to prevent possible
396.8 complications or adverse reactions;
396.9 (4) identification of treatment or therapy tasks that will be delegated to unlicensed
396.10 personnel; and
396.11 (5) procedures for notifying a registered nurse or appropriate licensed health
396.12 professional when a problem arises with treatments or therapy services.
396.13 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed
396.14 treatments or therapies must be administered by a nurse, physician, or other licensed health
396.15 professional authorized to perform the treatment or therapy, or may be delegated or assigned
396.16 to unlicensed personnel by the licensed health professional according to the appropriate
396.17 practice standards for delegation or assignment. When administration of a treatment or
396.18 therapy is delegated or assigned to unlicensed personnel, the home care provider must
396.19 ensure that the registered nurse or authorized licensed health professional has:
396.20 (1) instructed the unlicensed personnel in the proper methods with respect to each
396.21 client and has demonstrated their ability to competently follow the procedures;
396.22 (2) specified, in writing, specific instructions for each client and documented those
396.23 instructions in the client's record; and
396.24 (3) communicated with the unlicensed personnel about the individual needs of
396.25 the client.
396.26 Subd. 5. **Documentation of administration of treatments and therapies.** Each
396.27 treatment or therapy administered by a comprehensive home care provider must be
396.28 documented in the client's record. The documentation must include the signature and title
396.29 of the person who administered the treatment or therapy and must include the date and
396.30 time of administration. When treatment or therapies are not administered as ordered or
396.31 prescribed, the provider must document the reason why it was not administered and any
396.32 follow-up procedures that were provided to meet the client's needs.
396.33 Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or
396.34 electronically recorded order or prescription for all treatments and therapies. The order
396.35 must contain the name of the client, description of the treatment or therapy to be provided,
396.36 and the frequency and other information needed to administer the treatment or therapy.

397.1 Sec. 20. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

397.2 Subdivision 1. **Client record.** (a) The home care provider must maintain records
397.3 for each client for whom it is providing services. Entries in the client records must be
397.4 current, legible, permanently recorded, dated, and authenticated with the name and title
397.5 of the person making the entry.

397.6 (b) Client records, whether written or electronic, must be protected against loss,
397.7 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
397.8 relevant federal and state laws. The home care provider shall establish and implement
397.9 written procedures to control use, storage, and security of client's records and establish
397.10 criteria for release of client information.

397.11 (c) The home care provider may not disclose to any other person any personal,
397.12 financial, medical, or other information about the client, except:

397.13 (1) as may be required by law;

397.14 (2) to employees or contractors of the home care provider, another home care
397.15 provider, other health care practitioner or provider, or inpatient facility needing
397.16 information in order to provide services to the client, but only such information that
397.17 is necessary for the provision of services;

397.18 (3) to persons authorized in writing by the client or the client's representative to
397.19 receive the information, including third-party payers; and

397.20 (4) to representatives of the commissioner authorized to survey or investigate home
397.21 care providers under this chapter or federal laws.

397.22 Subd. 2. **Access to records.** The home care provider must ensure that the
397.23 appropriate records are readily available to employees or contractors authorized to access
397.24 the records. Client records must be maintained in a manner that allows for timely access,
397.25 printing, or transmission of the records.

397.26 Subd. 3. **Contents of client record.** Contents of a client record include the
397.27 following for each client:

397.28 (1) identifying information, including the client's name, date of birth, address, and
397.29 telephone number;

397.30 (2) the name, address, and telephone number of an emergency contact, family
397.31 members, client's representative, if any, or others as identified;

397.32 (3) names, addresses, and telephone numbers of the client's health and medical
397.33 service providers and other home care providers, if known;

397.34 (4) health information, including medical history, allergies, and when the provider
397.35 is managing medications, treatments or therapies that require documentation, and other
397.36 relevant health records;

398.1 (5) client's advance directives, if any;
398.2 (6) the home care provider's current and previous assessments and service plans;
398.3 (7) all records of communications pertinent to the client's home care services;
398.4 (8) documentation of significant changes in the client's status and actions taken in
398.5 response to the needs of the client including reporting to the appropriate supervisor or
398.6 health care professional;
398.7 (9) documentation of incidents involving the client and actions taken in response
398.8 to the needs of the client including reporting to the appropriate supervisor or health
398.9 care professional;
398.10 (10) documentation that services have been provided as identified in the service plan;
398.11 (11) documentation that the client has received and reviewed the home care bill
398.12 of rights;
398.13 (12) documentation that the client has been provided the statement of disclosure on
398.14 limitations of services under section 144A.4791, subdivision 3;
398.15 (13) documentation of complaints received and resolution;
398.16 (14) discharge summary, including service termination notice and related
398.17 documentation, when applicable; and
398.18 (15) other documentation required under this chapter and relevant to the client's
398.19 services or status.
398.20 Subd. 4. **Transfer of client records.** If a client transfers to another home care
398.21 provider or other health care practitioner or provider, or is admitted to an inpatient facility,
398.22 the home care provider, upon request of the client or the client's representative, shall take
398.23 steps to ensure a coordinated transfer including sending a copy or summary of the client's
398.24 record to the new home care provider, facility, or the client, as appropriate.
398.25 Subd. 5. **Record retention.** Following the client's discharge or termination of
398.26 services, a home care provider must retain a client's record for at least five years, or as
398.27 otherwise required by state or federal regulations. Arrangements must be made for secure
398.28 storage and retrieval of client records if the home care provider ceases business.

398.29 Sec. 21. **[144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**
398.30 Subdivision 1. **Qualifications, training, and competency.** All staff providing
398.31 home care services must be trained and competent in the provision of home care services
398.32 consistent with current practice standards appropriate to the client's needs.
398.33 Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health
398.34 professionals and nurses providing home care services as an employee of a licensed home
398.35 care provider must possess current Minnesota license or registration to practice.

399.1 (b) Licensed health professionals and registered nurses must be competent in
399.2 assessing client needs, planning appropriate home care services to meet client needs,
399.3 implementing services, and supervising staff if assigned.
399.4 (c) Nothing in this section limits or expands the rights of nurses or licensed health
399.5 professionals to provide services within the scope of their licenses or registrations, as
399.6 provided by law.
399.7 Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home
399.8 care services must have:
399.9 (1) successfully completed a training and competency evaluation appropriate to
399.10 the services provided by the home care provider and the topics listed in subdivision 7,
399.11 paragraph (b); or
399.12 (2) demonstrated competency by satisfactorily completing a written or oral test on
399.13 the tasks the unlicensed personnel will perform and in the topics listed in subdivision
399.14 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7,
399.15 paragraph (b), clauses (5), (7), and (8), by a practical skills test.
399.16 Unlicensed personnel providing home care services for a basic home care provider may
399.17 not perform delegated nursing or therapy tasks.
399.18 (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive
399.19 home care provider must have:
399.20 (1) successfully completed training and demonstrated competency by successfully
399.21 completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and
399.22 a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7),
399.23 and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; or
399.24 (2) satisfy the current requirements of Medicare for training or competency of home
399.25 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
399.26 section 483 or section 484.36; or
399.27 (3) before April 19, 1993, completed a training course for nursing assistants that was
399.28 approved by the commissioner.
399.29 (c) Unlicensed personnel performing therapy or treatment tasks delegated or
399.30 assigned by a licensed health professional must meet the requirements for delegated
399.31 tasks in subdivision 4 and any other training or competency requirements within the
399.32 licensed health professional scope of practice relating to delegation or assignment of tasks
399.33 to unlicensed personnel.
399.34 Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health
399.35 professional may delegate tasks only to staff that are competent and possess the knowledge
399.36 and skills consistent with the complexity of the tasks and according to the appropriate

400.1 Minnesota Practice Act. The comprehensive home care provider must establish and
400.2 implement a system to communicate up-to-date information to the registered nurse or
400.3 licensed health professional regarding the current available staff and their competency so
400.4 the registered nurse or licensed health professional has sufficient information to determine
400.5 the appropriateness of delegating tasks to meet individual client needs and preferences.
400.6 Subd. 5. **Individual contractors.** When a home care provider contracts with an
400.7 individual contractor excluded from licensure under section 144A.471 to provide home
400.8 care services, the contractor must meet the same requirements required by this section for
400.9 personnel employed by the home care provider.
400.10 Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary
400.11 staffing agency excluded from licensure under section 144A.471, those individuals must
400.12 meet the same requirements required by this section for personnel employed by the home
400.13 care provider and shall be treated as if they are staff of the home care provider.
400.14 Subd. 7. **Requirements for instructors, training content, and competency**
400.15 **evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must
400.16 meet the following requirements:
400.17 (1) training and competency evaluations of unlicensed personnel providing basic
400.18 home care services must be conducted by individuals with work experience and training in
400.19 providing home care services listed in section 144A.471, subdivisions 6 and 7; and
400.20 (2) training and competency evaluations of unlicensed personnel providing
400.21 comprehensive home care services must be conducted by a registered nurse, or another
400.22 instructor may provide training in conjunction with the registered nurse. If the home care
400.23 provider is providing services by licensed health professionals only, then that specific
400.24 training and competency evaluation may be conducted by the licensed health professionals
400.25 as appropriate.
400.26 (b) Training and competency evaluations for all unlicensed personnel must include
400.27 the following:
400.28 (1) documentation requirements for all services provided;
400.29 (2) reports of changes in the client's condition to the supervisor designated by the
400.30 home care provider;
400.31 (3) basic infection control, including blood-borne pathogens;
400.32 (4) maintenance of a clean and safe environment;
400.33 (5) appropriate and safe techniques in personal hygiene and grooming, including:
400.34 (i) hair care and bathing;
400.35 (ii) care of teeth, gums, and oral prosthetic devices;
400.36 (iii) care and use of hearing aids; and

401.1 (iv) dressing and assisting with toileting;
401.2 (6) training on the prevention of falls for providers working with the elderly or
401.3 individuals at risk of falls;
401.4 (7) standby assistance techniques and how to perform them;
401.5 (8) medication, exercise, and treatment reminders;
401.6 (9) basic nutrition, meal preparation, food safety, and assistance with eating;
401.7 (10) preparation of modified diets as ordered by a licensed health professional;
401.8 (11) communication skills that include preserving the dignity of the client and
401.9 showing respect for the client and the client's preferences, cultural background, and family;
401.10 (12) awareness of confidentiality and privacy;
401.11 (13) understanding appropriate boundaries between staff and clients and the client's
401.12 family;
401.13 (14) procedures to utilize in handling various emergency situations; and
401.14 (15) awareness of commonly used health technology equipment and assistive devices.
401.15 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
401.16 personnel providing comprehensive home care services must include:
401.17 (1) observation, reporting, and documenting of client status;
401.18 (2) basic knowledge of body functioning and changes in body functioning, injuries,
401.19 or other observed changes that must be reported to appropriate personnel;
401.20 (3) reading and recording temperature, pulse, and respirations of the client;
401.21 (4) recognizing physical, emotional, cognitive, and developmental needs of the client;
401.22 (5) safe transfer techniques and ambulation;
401.23 (6) range of motioning and positioning; and
401.24 (7) administering medications or treatments as required.
401.25 (d) When the registered nurse or licensed health professional delegates tasks, they
401.26 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
401.27 methods to perform the tasks or procedures for each client and are able to demonstrate
401.28 the ability to competently follow the procedures and perform the tasks. If an unlicensed
401.29 personnel has not regularly performed the delegated home care task for a period of 24
401.30 consecutive months, the unlicensed personnel must demonstrate competency in the task
401.31 to the registered nurse or appropriate licensed health professional. The registered nurse
401.32 or licensed health professional must document instructions for the delegated tasks in
401.33 the client's record.

401.34 Sec. 22. **[144A.4796] ORIENTATION AND ANNUAL TRAINING**
401.35 **REQUIREMENTS.**

402.1 Subdivision 1. **Orientation of staff and supervisors to home care.** All staff
402.2 providing and supervising direct home care services must complete an orientation to home
402.3 care licensing requirements and regulations before providing home care services to clients.
402.4 The orientation may be incorporated into the training required under subdivision 6. The
402.5 orientation need only be completed once for each staff person and is not transferable
402.6 to another home care provider.

402.7 Subd. 2. **Content.** The orientation must contain the following topics:

402.8 (1) an overview of sections 144A.43 to 144A.4798;

402.9 (2) introduction and review of all the provider's policies and procedures related to
402.10 the provision of home care services;

402.11 (3) handling of emergencies and use of emergency services;

402.12 (4) compliance with and reporting the maltreatment of minors or vulnerable adults
402.13 under sections 626.556 and 626.557;

402.14 (5) home care bill of rights, under section 144A.44;

402.15 (6) handling of clients' complaints; reporting of complaints and where to report
402.16 complaints including information on the Office of Health Facility Complaints and the
402.17 Common Entry Point;

402.18 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
402.19 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
402.20 Ombudsman at the Department of Human Services, county managed care advocates,
402.21 or other relevant advocacy services; and

402.22 (8) review of the types of home care services the employee will be providing and
402.23 the provider's scope of licensure.

402.24 Subd. 3. **Verification and documentation of orientation.** Each home care provider
402.25 shall retain evidence in the employee record of each staff person having completed the
402.26 orientation required by this section.

402.27 Subd. 4. **Orientation to client.** Staff providing home care services must be oriented
402.28 specifically to each individual client and the services to be provided. This orientation may
402.29 be provided in person, orally, in writing, or electronically.

402.30 Subd. 5. **Training required relating to Alzheimer's disease and related**
402.31 **disorders.** For home care providers that market, promote, or provide services for persons
402.32 with Alzheimer's or related disorders, all direct care staff and their supervisors must
402.33 receive training that includes a current explanation of Alzheimer's disease and related
402.34 disorders, how to assist clients with activities of daily living, effective approaches to
402.35 use to problem solve when working with a client's challenging behaviors, and how to
402.36 communicate with clients who have Alzheimer's or related disorders.

403.1 Subd. 6. **Required annual training.** All staff that perform direct home care
403.2 services must complete at least eight hours of annual training for each 12 months of
403.3 employment. The training may be obtained from the home care provider or another source
403.4 and must include topics relevant to the provision of home care services. The annual
403.5 training must include:

403.6 (1) training on reporting of maltreatment of minors under section 626.556 and
403.7 maltreatment of vulnerable adults under section 626.557, whichever is applicable to the
403.8 services provided;

403.9 (2) review of the home care bill of rights in section 144A.44;

403.10 (3) review of infection control techniques used in the home and implementation of
403.11 infection control standards including a review of hand washing techniques; the need for
403.12 and use of protective gloves, gowns, and masks; appropriate disposal of contaminated
403.13 materials and equipment, such as dressings, needles, syringes, and razor blades;
403.14 disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of
403.15 communicable diseases; and

403.16 (4) review of the provider's policies and procedures relating to the provision of home
403.17 care services and how to implement those policies and procedures.

403.18 Subd. 7. **Documentation.** A home care provider must retain documentation in the
403.19 employee records of the staff that have satisfied the orientation and training requirements
403.20 of this section.

403.21 Sec. 23. **[144A.4797] PROVISION OF SERVICES.**

403.22 Subdivision 1. **Availability of contact person to staff.** (a) A home care provider
403.23 with a basic home care license must have a person available to staff for consultation on
403.24 items relating to the provision of services or about the client.

403.25 (b) A home care provider with a comprehensive home care license must have a
403.26 registered nurse available for consultation to staff performing delegated nursing tasks
403.27 and must have an appropriate licensed health professional available if performing other
403.28 delegated services such as therapies.

403.29 (c) The appropriate contact person must be readily available either in person, by
403.30 telephone, or by other means to the staff at times when the staff is providing services.

403.31 Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform
403.32 basic home care services must be supervised periodically where the services are being
403.33 provided to verify that the work is being performed competently and to identify problems
403.34 and solutions to address issues relating to the staff's ability to provide the services. The
403.35 supervision of the unlicensed personnel must be done by staff of the home care provider

404.1 having the authority, skills, and ability to provide the supervision of unlicensed personnel
404.2 and who can implement changes as needed, and train staff.
404.3 (b) Supervision includes direct observation of unlicensed personnel while they
404.4 are providing the services and may also include indirect methods of gaining input such
404.5 as gathering feedback from the client. Supervisory review of staff must be provided at a
404.6 frequency based on the staff person's competency and performance.
404.7 (c) For an individual who is licensed as a home care provider, this section does
404.8 not apply.
404.9 Subd. 3. **Supervision of staff providing delegated nursing or therapy home**
404.10 **care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be
404.11 supervised by an appropriate licensed health professional or a registered nurse periodically
404.12 where the services are being provided to verify that the work is being performed
404.13 competently and to identify problems and solutions related to the staff person's ability to
404.14 perform the tasks. Supervision of staff performing medication or treatment administration
404.15 shall be provided by a registered nurse or appropriate licensed health professional and
404.16 must include observation of the staff administering the medication or treatment and the
404.17 interaction with the client.
404.18 (b) The direct supervision of staff performing delegated tasks must be provided
404.19 within 30 days after the individual begins working for the home care provider and
404.20 thereafter as needed based on performance. This requirement also applies to staff who
404.21 have not performed delegated tasks for one year or longer.
404.22 Subd. 4. **Documentation.** A home care provider must retain documentation of
404.23 supervision activities in the personnel records.
404.24 Subd. 5. **Exemption.** This section does not apply to an individual licensed under
404.25 sections 144A.43 to 144A.4799.

404.26 Sec. 24. **[144A.4798] EMPLOYEE HEALTH STATUS.**
404.27 Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider
404.28 must establish and maintain a TB prevention and control program based on the most
404.29 current guidelines issued by the Centers for Disease Control and Prevention (CDC).
404.30 Components of a TB prevention and control program include screening all staff providing
404.31 home care services, both paid and unpaid, at the time of hire for active TB disease and
404.32 latent TB infection, and developing and implementing a written TB infection control plan.
404.33 The commissioner shall make the most recent CDC standards available to home care
404.34 providers on the department's Web site.

405.1 Subd. 2. **Communicable diseases.** A home care provider must follow
405.2 current federal or state guidelines for prevention, control, and reporting of human
405.3 immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other
405.4 communicable diseases as defined in Minnesota Rules, part 4605.7040.

405.5 Sec. 25. **[144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE**
405.6 **PROVIDER ADVISORY COUNCIL.**

405.7 Subdivision 1. **Membership.** The commissioner of health shall appoint eight
405.8 persons to a home care provider advisory council consisting of the following:
405.9 (1) three public members as defined in section 214.02 who shall be either persons
405.10 who are currently receiving home care services or have family members receiving home
405.11 care services, or persons who have family members who have received home care services
405.12 within five years of the application date;
405.13 (2) three Minnesota home care licensees representing basic and comprehensive
405.14 levels of licensure who may be a managerial official, an administrator, a supervising
405.15 registered nurse, or an unlicensed personnel performing home care tasks;
405.16 (3) one member representing the Minnesota Board of Nursing; and
405.17 (4) one member representing the ombudsman for long-term care.
405.18 Subd. 2. **Organizations and meetings.** The advisory council shall be organized
405.19 and administered under section 15.059 with per diems and costs paid within the limits of
405.20 available appropriations. Meetings will be held quarterly and hosted by the department.
405.21 Subcommittees may be developed as necessary by the commissioner. Advisory council
405.22 meetings are subject to the Open Meeting Law under chapter 13D.
405.23 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide
405.24 advice regarding regulations of Department of Health licensed home care providers in
405.25 this chapter such as:
405.26 (1) advice to the commissioner regarding community standards for home care
405.27 practices;
405.28 (2) advice to the commissioner on enforcement of licensing standards and whether
405.29 certain disciplinary actions are appropriate;
405.30 (3) advice to the commissioner about ways of distributing information to licensees
405.31 and consumers of home care;
405.32 (4) advice to the commissioner about training standards;
405.33 (5) identify emerging issues and opportunities in the home care field, including the
405.34 use of technology in home and telehealth capabilities; and
405.35 (6) perform other duties as directed by the commissioner.

406.1 Sec. 26. **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR**
406.2 **NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

406.3 Subdivision 1. **Initial home care licenses and changes of ownership.** (a)
406.4 Beginning October 1, 2013, all initial license applicants must apply for either a temporary
406.5 basic or comprehensive home care license.

406.6 (b) Initial home care temporary licenses or licenses issued beginning October 1,
406.7 2013, will be issued according to the provisions in sections 144A.43 to 144A.4799 and
406.8 fees in section 144A.472 and will be required to comply with this chapter.

406.9 (c) No initial temporary licenses or initial licenses will be accepted or issued
406.10 between July 1, 2013, and October 1, 2013.

406.11 (d) Beginning July 1, 2013, changes in ownership applications will require payment
406.12 of the new fees listed in section 144A.472.

406.13 Subd. 2. **Current home care licensees with licenses on July 1, 2013.** (a)
406.14 Beginning October 1, 2013, department licensed home care providers who are licensed
406.15 on July 1, 2013, must apply for either the basic or comprehensive home care license
406.16 on their regularly scheduled renewal date.

406.17 (b) By September 30, 2014, all home care providers must either have a basic or
406.18 comprehensive home care license or temporary license.

406.19 Sec. 27. **[144A.4811] APPLICATION OF HOME CARE LICENSURE DURING**
406.20 **TRANSITION PERIOD.**

406.21 Renewal of home care licenses issued beginning October 1, 2013, will be issued
406.22 according to sections 144A.43 to 144A.4799 and, upon license renewal, providers must
406.23 comply with sections 144A.43 to 144A.4799. Prior to renewal, providers must comply
406.24 with the home care licensure law in effect on June 30, 2013.

406.25 Sec. 28. **[144A.482] REGISTRATION OF HOME MANAGEMENT**
406.26 **PROVIDERS.**

406.27 (a) For purposes of this section, a home management provider is an individual or
406.28 organization that provides at least two of the following services: housekeeping, meal
406.29 preparation, and shopping, to a person who is unable to perform these activities due to
406.30 illness, disability, or physical condition.

406.31 (b) A person or organization that provides only home management services may not
406.32 operate in the state without a current certificate of registration issued by the commissioner
406.33 of health. To obtain a certificate of registration, the person or organization must annually
406.34 submit to the commissioner the name, mailing and physical address, e-mail address, and

407.1 telephone number of the individual or organization and a signed statement declaring that
407.2 the individual or organization is aware that the home care bill of rights applies to their
407.3 clients and that the person or organization will comply with the home care bill of rights
407.4 provisions contained in section 144A.44. An individual or organization applying for a
407.5 certificate must also provide the name, business address, and telephone number of each of
407.6 the individuals responsible for the management or direction of the organization.

407.7 (c) The commissioner shall charge an annual registration fee of $20 for individuals
407.8 and $50 for organizations. The registration fee shall be deposited in the state treasury and
407.9 credited to the state government special revenue fund.

407.10 (d) A home care provider that provides home management services and other home
407.11 care services must be licensed, but licensure requirements other than the home care bill of
407.12 rights do not apply to those employees or volunteers who provide only home management
407.13 services to clients who do not receive any other home care services from the provider.
407.14 A licensed home care provider need not be registered as a home management service
407.15 provider, but must provide an orientation on the home care bill of rights to its employees
407.16 or volunteers who provide home management services.

407.17 (e) An individual who provides home management services under this section must,
407.18 within 120 days after beginning to provide services, attend an orientation session approved
407.19 by the commissioner that provides training on the home care bill of rights and an orientation
407.20 on the aging process and the needs and concerns of elderly and disabled persons.

407.21 (f) The commissioner may suspend or revoke a provider's certificate of registration
407.22 or assess fines for violation of the home care bill of rights. Any fine assessed for a
407.23 violation of the home care bill of rights by a provider registered under this section shall be
407.24 in the amount established in the licensure rules for home care providers. As a condition
407.25 of registration, a provider must cooperate fully with any investigation conducted by the
407.26 commissioner, including providing specific information requested by the commissioner on
407.27 clients served and the employees and volunteers who provide services. Fines collected
407.28 under this paragraph shall be deposited in the state treasury and credited to the fund
407.29 specified in the statute or rule in which the penalty was established.

407.30 (g) The commissioner may use any of the powers granted in sections 144A.43 to
407.31 144A.4799 to administer the registration system and enforce the home care bill of rights
407.32 under this section.

407.33 Sec. 29. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
407.34 **AND COMMUNITY-BASED SERVICES.**

408.1 (a) The Department of Health Compliance Monitoring Division and the Department
408.2 of Human Services Licensing Division shall jointly develop an integrated licensing system
408.3 for providers of both home care services subject to licensure under Minnesota Statutes,
408.4 chapter 144A, and for home and community-based services subject to licensure under
408.5 Minnesota Statutes, chapter 245D. The integrated licensing system shall:
408.6 (1) require only one license of any provider of services under Minnesota Statutes,
408.7 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;
408.8 (2) promote quality services that recognize a person's individual needs and protect
408.9 the person's health, safety, rights, and well-being;
408.10 (3) promote provider accountability through application requirements, compliance
408.11 inspections, investigations, and enforcement actions;
408.12 (4) reference other applicable requirements in existing state and federal laws,
408.13 including the federal Affordable Care Act;
408.14 (5) establish internal procedures to facilitate ongoing communications between the
408.15 agencies, and with providers and services recipients about the regulatory activities;
408.16 (6) create a link between the agency Web sites so that providers and the public can
408.17 access the same information regardless of which Web site is accessed initially; and
408.18 (7) collect data on identified outcome measures as necessary for the agencies to
408.19 report to the Centers for Medicare and Medicaid Services.
408.20 (b) The joint recommendations for legislative changes to implement the integrated
408.21 licensing system are due to the legislature by February 15, 2014.
408.22 (c) Before implementation of the integrated licensing system, providers licensed as
408.23 home care providers under Minnesota Statutes, chapter 144A, may also provide home
408.24 and community-based services subject to licensure under Minnesota Statutes, chapter
408.25 245D, without obtaining a home and community-based services license under Minnesota
408.26 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
408.27 apply to these providers:
408.28 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
408.29 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;
408.30 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
408.31 enforced by the Department of Health under the enforcement authority set forth in
408.32 Minnesota Statutes, section 144A.475; and
408.33 (3) the Department of Health will provide information to the Department of Human
408.34 Services about each provider licensed under this section, including the provider's license
408.35 application, licensing documents, inspections, information about complaints received, and
408.36 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

409.1 Sec. 30. **REPEALER.**

409.2 (a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

409.3 (b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
409.4 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040;
409.5 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
409.6 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170;
409.7 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240;
409.8 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830;
409.9 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
409.10 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

409.11 Sec. 31. **EFFECTIVE DATE.**

409.12 Sections 1 to 30 are effective the day following final enactment.

409.13 **ARTICLE 13**

409.14 **HEALTH DEPARTMENT**

409.15 Section 1. Minnesota Statutes 2012, section 103I.005, is amended by adding a
409.16 subdivision to read:

409.17 Subd. 1a. **Bored geothermal heat exchanger.** "Bored geothermal heat exchanger"
409.18 means an earth-coupled heating or cooling device consisting of a sealed closed-loop
409.19 piping system installed in a boring in the ground to transfer heat to or from the surrounding
409.20 earth with no discharge.

409.21 Sec. 2. Minnesota Statutes 2012, section 103I.521, is amended to read:

409.22 **103I.521 FEES ~~DEPOSITED WITH COMMISSIONER OF MANAGEMENT~~**
409.23 **~~AND BUDGET~~.**

409.24 Unless otherwise specified, fees collected ~~for licenses or registration~~ by the
409.25 commissioner under this chapter shall be deposited in the state treasury and credited to
409.26 the state government special revenue fund.

409.27 Sec. 3. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

409.28 ~~Subdivision 1.~~ **~~Who must pay.~~** Except for the limitation contained in this section,
409.29 the commissioner of health ~~shall charge a handling fee~~ may enter into a contractual
409.30 agreement to recover costs incurred for analysis for diagnostic purposes for each specimen
409.31 submitted to the Department of Health ~~for analysis for diagnostic purposes~~ by any hospital,

~~private~~ laboratory, ~~private~~ clinic, or physician. ~~No fee shall be charged to any entity which receives direct or indirect financial assistance from state or federal funds administered by the Department of Health, including any public health department, nonprofit community clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged~~ The commissioner shall not charge for any biological materials submitted to the Department of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological materials requested by the department to gather information for disease prevention or control purposes. The commissioner of health may establish other exceptions to the handling fee as may be necessary to protect the public's health. ~~All fees collected pursuant to this section shall be deposited in the state treasury and credited to the state government special revenue fund.~~ Funds generated in a contractual agreement made pursuant to this section shall be deposited in a special account and are appropriated to the commissioner for purposes of providing the services specified in the contracts. All such contractual agreements shall be processed in accordance with the provisions of chapter 16C.

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

Sec. 4. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. ~~The commissioner shall charge a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders, including hearing loss detected through the early hearing detection and intervention program under section 144.966.~~ The fee ~~is $101 per specimen. Effective July 1, 2010, the fee shall be increased to $106~~ to support the newborn screening program including tests administered under this section and section 144.966 is $140 per specimen. ~~The increased fee amount shall be deposited in the general fund.~~ Of the total fee amount, $5 shall be deposited in the general fund to offset the cost of the support services provided under section 144.966, subdivision 3a. The remaining fee amount shall be deposited in the state treasury and credited to the state government special revenue fund. Costs associated

411.1 with capital expenditures and the development of new procedures may be prorated over a
411.2 three-year period when calculating the amount of the fees.

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

411.4 Sec. 5. **[144.554] HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL**
411.5 **AND FEES.**

411.6 For hospitals, nursing homes, boarding care homes, residential hospices, supervised
411.7 living facilities, freestanding outpatient surgical centers, and end-stage renal disease
411.8 facilities, the commissioner shall collect a fee for the review and approval of architectural,
411.9 mechanical, and electrical plans and specifications submitted before construction begins
411.10 for each project relative to construction of new buildings, additions to existing buildings,
411.11 or for remodeling or alterations of existing buildings. All fees collected in this section
411.12 shall be deposited in the state treasury and credited to the state government special revenue
411.13 fund. Fees must be paid at the time of submission of final plans for review and are not
411.14 refundable. The fee is calculated as follows:

	Construction project total estimated cost	Fee
411.15		
411.16	$0 - $10,000	$30
411.17	$10,001 - $50,000	$150
411.18	$50,001 - $100,000	$300
411.19	$100,001 - $150,000	$450
411.20	$150,001 - $200,000	$600
411.21	$200,001 - $250,000	$750
411.22	$250,001 - $300,000	$900
411.23	$300,001 - $350,000	$1,050
411.24	$350,001 - $400,000	$1,200
411.25	$400,001 - $450,000	$1,350
411.26	$450,001 - $500,000	$1,500
411.27	$500,001 - $550,000	$1,650
411.28	$550,001 - $600,000	$1,800
411.29	$600,001 - $650,000	$1,950
411.30	$650,001 - $700,000	$2,100
411.31	$700,001 - $750,000	$2,250
411.32	$750,001 - $800,000	$2,400
411.33	$800,001 - $850,000	$2,550
411.34	$850,001 - $900,000	$2,700
411.35	$900,001 - $950,000	$2,850
411.36	$950,001 - $1,000,000	$3,000
411.37	$1,000,001 - $1,050,000	$3,150
411.38	$1,050,001 - $1,100,000	$3,300
411.39	$1,100,001 - $1,150,000	$3,450

412.1 $1,150,001 - $1,200,000	$3,600
412.2 $1,200,001 - $1,250,000	$3,750
412.3 $1,250,001 - $1,300,000	$3,900
412.4 $1,300,001 - $1,350,000	$4,050
412.5 $1,350,001 - $1,400,000	$4,200
412.6 $1,400,001 - $1,450,000	$4,350
412.7 $1,450,001 - $1,500,000	$4,500
412.8 $1,500,001 and over	$4,800

412.9 Sec. 6. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

412.10 Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must
412.11 be accompanied by the annual fees specified in this subdivision. The annual fees include:

412.12 (1) base accreditation fee, ~~$1,500~~ $600;

412.13 (2) sample preparation techniques fee, $200 per technique;

412.14 (3) an administrative fee for laboratories located outside this state, ~~$3,750~~ $2,000; and

412.15 (4) test category fees.

412.16 (b) For the programs in subdivision 3a, the commissioner may accredit laboratories
412.17 for fields of testing under the categories listed in clauses (1) to (10) upon completion of
412.18 the application requirements provided by subdivision 6 and receipt of the fees for each
412.19 category under each program that accreditation is requested. The categories offered and
412.20 related fees include:

412.21 (1) microbiology, ~~$450~~ $200;

412.22 (2) inorganics, ~~$450~~ $200;

412.23 (3) metals, ~~$1,000~~ $500;

412.24 (4) volatile organics, ~~$1,300~~ $1,000;

412.25 (5) other organics, ~~$1,300~~ $1,000;

412.26 (6) radiochemistry, ~~$1,500~~ $750;

412.27 (7) emerging contaminants, ~~$1,500~~ $1,000;

412.28 (8) agricultural contaminants, ~~$1,250~~ $1,000;

412.29 (9) toxicity (bioassay), ~~$1,000~~ $500; and

412.30 (10) physical characterization, $250.

412.31 (c) The total annual fee includes the base fee, the sample preparation techniques
412.32 fees, the test category fees per program, and, when applicable, an administrative fee for
412.33 out-of-state laboratories.

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

412.35 Sec. 7. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

413.1 Subd. 5. **State government special revenue fund.** Fees collected by the
413.2 commissioner under this section must be deposited in the state treasury and credited to
413.3 the state government special revenue fund.

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

413.5 Sec. 8. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
413.6 to read:

413.7 Subd. 10. **Establishing a selection committee.** (a) The commissioner shall
413.8 establish a selection committee for the purpose of recommending approval of qualified
413.9 laboratory assessors and assessment bodies. Committee members shall demonstrate
413.10 competence in assessment practices. The committee shall initially consist of seven
413.11 members appointed by the commissioner as follows:

413.12 (1) one member from a municipal laboratory accredited by the commissioner;

413.13 (2) one member from an industrial treatment laboratory accredited by the
413.14 commissioner;

413.15 (3) one member from a commercial laboratory located in this state and accredited by
413.16 the commissioner;

413.17 (4) one member from a commercial laboratory located outside the state and
413.18 accredited by the commissioner;

413.19 (5) one member from a nongovernmental client of environmental laboratories;

413.20 (6) one member from a professional organization with a demonstrated interest in
413.21 environmental laboratory data and accreditation; and

413.22 (7) one employee of the laboratory accreditation program administered by the
413.23 department.

413.24 (b) Committee appointments begin on January 1 and end on December 31 of the
413.25 same year.

413.26 (c) The commissioner shall appoint persons to fill vacant committee positions,
413.27 expand the total number of appointed positions, or change the designated positions upon
413.28 the advice of the committee.

413.29 (d) The commissioner shall rescind the appointment of a selection committee
413.30 member for sufficient cause as the commissioner determines, such as:

413.31 (1) neglect of duty;

413.32 (2) failure to notify the commissioner of a real or perceived conflict of interest;

413.33 (3) nonconformance with committee procedures;

413.34 (4) failure to demonstrate competence in assessment practices; or

413.35 (5) official misconduct.

414.1 (e) Members of the selection committee shall be compensated according to the
414.2 provisions in section 15.059, subdivision 3.

414.3 Sec. 9. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
414.4 to read:

414.5 Subd. 11. **Activities of the selection committee.** (a) The selection committee
414.6 will determine assessor and assessment body application requirements, the frequency
414.7 of application submittal, and the application review schedule. The commissioner shall
414.8 publish the application requirements and procedures on the accreditation program Web site.
414.9 (b) In its selection process, the committee shall ensure its application requirements
414.10 and review process:
414.11 (1) meet the standards implemented in subdivision 2a;
414.12 (2) ensure assessors have demonstrated competence in technical disciplines offered
414.13 for accreditation by the commissioner; and
414.14 (3) consider any history of repeated nonconformance or complaints regarding
414.15 assessors or assessment bodies.
414.16 (c) The selection committee shall consider an application received from qualified
414.17 applicants and shall supply a list of recommended assessors and assessment bodies to
414.18 the commissioner of health no later than 90 days after the commissioner notifies the
414.19 committee of the need for review of applications.

414.20 Sec. 10. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
414.21 to read:

414.22 Subd. 12. **Commissioner approval of assessors and scheduling of assessments.**
414.23 (a) The commissioner shall approve assessors who:
414.24 (1) are employed by the commissioner for the purpose of accrediting laboratories
414.25 and demonstrate competence in assessment practices for environmental laboratories; or
414.26 (2) are employed by a state or federal agency with established agreements for
414.27 mutual assistance or recognition with the commissioner and demonstrate competence in
414.28 assessment practices for environmental laboratories.
414.29 (b) The commissioner may approve other assessors or assessment bodies who are
414.30 recommended by the selection committee according to subdivision 11, paragraph (c). The
414.31 commissioner shall publish the list of assessors and assessment bodies approved from the
414.32 recommendations.
414.33 (c) The commissioner shall rescind approval for an assessor or assessment body for
414.34 sufficient cause as the commissioner determines, such as:

415.1 (1) failure to meet the minimum qualifications for performing assessments;

415.2 (2) lack of availability;

415.3 (3) nonconformance with the applicable laws, rules, standards, policies, and
415.4 procedures;

415.5 (4) misrepresentation of application information regarding qualifications and
415.6 training; or

415.7 (5) excessive cost to perform the assessment activities.

415.8 Sec. 11. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
415.9 to read:

415.10 Subd. 13. **Laboratory requirements for assessor selection and scheduling**
415.11 **assessments.** (a) A laboratory accredited or seeking accreditation that requires an
415.12 assessment by the commissioner must select an assessor, group of assessors, or an
415.13 assessment body from the published list specified in subdivision 12, paragraph (b). An
415.14 accredited laboratory must complete an assessment and make all corrective actions at least
415.15 once every 24 months. Unless the commissioner grants interim accreditation, a laboratory
415.16 seeking accreditation must complete an assessment and make all corrective actions
415.17 prior to, but no earlier than, 18 months prior to the date the application is submitted to
415.18 the commissioner.

415.19 (b) A laboratory shall not select the same assessor more than twice in succession
415.20 for assessments of the same facility unless the laboratory receives written approval
415.21 from the commissioner for the selection. The laboratory must supply a written request
415.22 to the commissioner for approval and must justify the reason for the request and provide
415.23 the alternate options considered.

415.24 (c) A laboratory must select assessors appropriate to the size and scope of the
415.25 laboratory's application or existing accreditation.

415.26 (d) A laboratory must enter into its own contract for direct payment of the assessors
415.27 or assessment body. The contract must authorize the assessor, assessment body, or
415.28 subcontractors to release all records to the commissioner regarding the assessment activity,
415.29 when the assessment is performed in compliance with this statute.

415.30 (e) A laboratory must agree to permit other assessors as selected by the commissioner
415.31 to participate in the assessment activities.

415.32 (f) If the laboratory determines no approved assessor is available to perform
415.33 the assessment, the laboratory must notify the commissioner in writing and provide a
415.34 justification for the determination. If the commissioner confirms no approved assessor
415.35 is available, the commissioner may designate an alternate assessor from those approved

416.1 in subdivision 12, paragraph (a), or the commissioner may delay the assessment until
416.2 an assessor is available. If an approved alternate assessor performs the assessment, the
416.3 commissioner may collect fees equivalent to the cost of performing the assessment
416.4 activities.

416.5 (g) Fees collected under this section are deposited in a special account and are
416.6 annually appropriated to the commissioner for the purpose of performing assessment
416.7 activities.

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

416.9 Sec. 12. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:

416.10 Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an
416.11 order requiring violations to be corrected and administratively assessing monetary
416.12 penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The
416.13 procedures in section 144.991 must be followed when issuing administrative penalty
416.14 orders. Except in the case of repeated or serious violations, the penalty assessed in the
416.15 order must be forgiven if the person who is subject to the order demonstrates in writing
416.16 to the commissioner before the 31st day after receiving the order that the person has
416.17 corrected the violation or has developed a corrective plan acceptable to the commissioner.
416.18 The maximum amount of an administrative penalty order is $10,000 for each violator for
416.19 all violations by that violator identified in an inspection or review of compliance.

416.20 (b) Notwithstanding paragraph (a), the commissioner may issue to a large public
416.21 water supply, serving a population of more than 10,000 persons, an administrative penalty
416.22 order imposing a penalty of at least $1,000 per day per violation, not to exceed $10,000
416.23 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

416.24 (c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead
416.25 firm or person performing regulated lead work, an administrative penalty order imposing a
416.26 penalty of at least $5,000 per violation per day, not to exceed $10,000 for each violation of
416.27 sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from
416.28 monetary penalties in this section shall be deposited in the state treasury and credited to
416.29 the state government special revenue fund.

416.30 Sec. 13. Minnesota Statutes 2012, section 145.986, is amended to read:

416.31 **145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

416.32 Subdivision 1. ~~**Grants to local communities**~~ **Purpose.** The purpose of the statewide
416.33 health improvement program is to:

(1) address the top three leading preventable causes of illness and death: tobacco use and exposure, poor diet, and lack of regular physical activity;

(2) promote the development, availability, and use of evidence-based, community level, comprehensive strategies to create healthy communities; and

(3) measure the impact of the evidence-based, community health improvement practices which over time work to contain health care costs and reduce chronic diseases.

Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner of health shall award competitive grants to community health boards established pursuant to section 145A.09 and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, worksite, and health care settings; ~~and~~

(5) be focused on policy, systems, and environmental changes that support healthy behaviors~~.~~; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the ~~interventions~~ strategies, and modify or discontinue ~~interventions~~ strategies found to be ineffective.

~~(f) By January 15, 2011, the commissioner of health shall recommend whether any funding should be distributed to community health boards and tribal governments based on health disparities demonstrated in the populations served.~~

418.1 ~~(g)~~ (f) Grant recipients shall report their activities and their progress toward the
418.2 outcomes established under subdivision 2 to the commissioner in a format and at a time
418.3 specified by the commissioner.

418.4 ~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward
418.5 the measurable outcomes established in subdivision 2. The commissioner shall require a
418.6 corrective action plan and may reduce the funding level of grant recipients that do not
418.7 make adequate progress toward the measurable outcomes.

418.8 (h) Notwithstanding paragraph (a), the commissioner may award funding to
418.9 convene, coordinate, and implement evidence-based strategies targeted at reducing other
418.10 risk factors, aside from tobacco use and exposure, poor diet, and lack of regular physical
418.11 activity, that are associated with chronic disease and may impact public health. The
418.12 commissioner shall develop a criteria and procedures to allocate funding under this section.

418.13 Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet
418.14 the goals specified in subdivision 1, and annually review the progress of grant recipients
418.15 in meeting the outcomes.

418.16 (b) The commissioner shall measure current public health status, using existing
418.17 measures and data collection systems when available, to determine baseline data against
418.18 which progress shall be monitored.

418.19 Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide
418.20 content expertise, technical expertise, ~~and~~ training to grant recipients and advice on
418.21 evidence-based strategies, including those based on populations and types of communities
418.22 served. The commissioner shall ensure that the statewide health improvement program
418.23 meets the outcomes established under subdivision 2 by conducting a comprehensive
418.24 statewide evaluation and assisting grant recipients to modify or discontinue interventions
418.25 found to be ineffective.

418.26 (b) For the purposes of carrying out the grant program under this section, including
418.27 for administrative purposes, the commissioner shall award contracts to appropriate entities
418.28 to assist in training and provide technical assistance to grantees.

418.29 (c) Contracts awarded under paragraph (b) may be used to provide technical
418.30 assistance and training in the areas of:

418.31 (1) community engagement and capacity building;

418.32 (2) tribal support;

418.33 (3) community asset building and risk behavior reduction;

418.34 (4) legal;

418.35 (5) communications;

418.36 (6) community, school, health care, work site, and other site-specific strategies; and

419.1 (7) health equity.

419.2 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision
419.3 3, the commissioner shall conduct ~~a biennial~~ an evaluation of the statewide health
419.4 improvement program funded under this section. Grant recipients shall cooperate with
419.5 the commissioner in the evaluation and provide the commissioner with the information
419.6 necessary to conduct the evaluation.

419.7 (b) Grant recipients will collect, monitor, and submit to the Department of Health
419.8 baseline and annual data, and provide information to improve the quality and impact of
419.9 community health improvement strategies.

419.10 (c) For the purposes of carrying out the grant program under this section, including
419.11 for administrative purposes, the commissioner shall award contracts to appropriate entities
419.12 to assist in designing and implementing evaluation systems.

419.13 (d) Contracts awarded under paragraph (c) may be used to:

419.14 (1) develop grantee monitoring and reporting systems to track grantee progress,
419.15 including aggregated and disaggregated data;

419.16 (2) manage, analyze, and report program evaluation data results; and

419.17 (3) utilize innovative support tools to analyze and predict the impact of prevention
419.18 strategies on health outcomes and state health care costs over time.

419.19 Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature
419.20 on the statewide health improvement program funded under this section. These reports
419.21 must include information on grant recipients, activities that were conducted using grant
419.22 funds, evaluation data, and outcome measures, if available. In addition, the commissioner
419.23 shall provide recommendations on future areas of focus for health improvement. These
419.24 reports are due by January 15 of every other year, beginning in 2010. ~~In the report due~~
419.25 ~~on January 15, 2010, the commissioner shall include recommendations on a sustainable~~
419.26 ~~funding source for the statewide health improvement program other than the health care~~
419.27 ~~access fund.~~

419.28 Subd. 6. **Supplantation of existing funds.** Community health boards and tribal
419.29 governments must use funds received under this section to develop new programs, expand
419.30 current programs that work to reduce the percentage of Minnesotans who are obese or
419.31 overweight or who use tobacco, or replace discontinued state or federal funds previously
419.32 used to reduce the percentage of Minnesotans who are obese or overweight or who use
419.33 tobacco. Funds must not be used to supplant current state or local funding to community
419.34 health boards or tribal governments used to reduce the percentage of Minnesotans who are
419.35 obese or overweight or to reduce tobacco use.

Sec. 14. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead human body to essential elements through ~~exposure to a combination of heat and alkaline hydrolysis and the repositioning or movement of the body during the process to facilitate reduction,~~ a water-based dissolution process using alkaline chemicals, heat, agitation, and pressure to accelerate natural decomposition; the processing of the hydrolyzed remains after removal from the alkaline hydrolysis ~~chamber,~~ vessel; placement of the processed remains in a hydrolyzed remains container~~,~~; and release of the hydrolyzed remains to an appropriate party. Alkaline hydrolysis is a form of final disposition.

Sec. 15. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1b. **Alkaline hydrolysis container.** "Alkaline hydrolysis container" means a hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily fluids that encases the body and into which a dead human body is placed prior to insertion into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or biodegradable alternative containers or caskets.

Sec. 16. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1c. **Alkaline hydrolysis facility.** "Alkaline hydrolysis facility" means a building or structure containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead human bodies.

Sec. 17. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1d. **Alkaline hydrolysis vessel.** "Alkaline hydrolysis vessel" means the container in which the alkaline hydrolysis of a dead human body is performed.

Sec. 18. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:

Subd. 2. **Alternative container.** "Alternative container" means a nonmetal receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed for the encasement of dead human bodies and is made of hydrolyzable or biodegradable materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

Sec. 19. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:

421.1 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means
421.2 any action normally taken by a funeral provider in anticipation of or preparation for the
421.3 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

421.4 Sec. 20. Minnesota Statutes 2012, section 149A.02, is amended by adding a
421.5 subdivision to read:
421.6 Subd. 3c. **Branch funeral establishment.** "Branch funeral establishment" means
421.7 any place or premise used as the office or place of business that provides funeral goods
421.8 or services, except on-site preparation of the body, to the public. A branch funeral
421.9 establishment is subject to the licensing requirements of sections 149A.50 and 149A.51,
421.10 except section 149A.50, subdivision 2, clause (1). A branch funeral establishment must be
421.11 associated through a majority ownership of a licensed funeral establishment which meets
421.12 the requirements of sections 149A.50 and 149A.92, subdivisions 2 to 10.

421.13 Sec. 21. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:
421.14 Subd. 4. **Cash advance item.** "Cash advance item" means any item of service
421.15 or merchandise described to a purchaser as a "cash advance," "accommodation," "cash
421.16 disbursement," or similar term. A cash advance item is also any item obtained from a
421.17 third party and paid for by the funeral provider on the purchaser's behalf. Cash advance
421.18 items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services,
421.19 pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary
421.20 notices, gratuities, and death records.

421.21 Sec. 22. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:
421.22 Subd. 5. **Casket.** "Casket" means a rigid container which is designed for the
421.23 encasement of a dead human body and is usually constructed of hydrolyzable or
421.24 biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented
421.25 and lined with fabric.

421.26 Sec. 23. Minnesota Statutes 2012, section 149A.02, is amended by adding a
421.27 subdivision to read:
421.28 Subd. 12a. **Crypt.** "Crypt" means a space in a mausoleum of sufficient size, used or
421.29 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

421.30 Sec. 24. Minnesota Statutes 2012, section 149A.02, is amended by adding a
421.31 subdivision to read:

422.1 Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a
422.2 final disposition of a dead human body by alkaline hydrolysis, without formal viewing,
422.3 visitation, or ceremony with the body present.

422.4 Sec. 25. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:
422.5 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
422.6 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

422.7 Sec. 26. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:
422.8 Subd. 23. **Funeral services.** "Funeral services" means any services which may
422.9 be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis,
422.10 cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral
422.11 ceremony or the final disposition of dead human bodies.

422.12 Sec. 27. Minnesota Statutes 2012, section 149A.02, is amended by adding a
422.13 subdivision to read:
422.14 Subd. 24a. **Holding facility.** "Holding facility" means a secure enclosed room or
422.15 confined area within a funeral establishment, branch funeral establishment, crematory,
422.16 or alkaline hydrolysis facility used for temporary storage of human remains awaiting
422.17 final disposition.

422.18 Sec. 28. Minnesota Statutes 2012, section 149A.02, is amended by adding a
422.19 subdivision to read:
422.20 Subd. 24b. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a
422.21 dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not
422.22 include pacemakers, prostheses, or similar foreign materials.

422.23 Sec. 29. Minnesota Statutes 2012, section 149A.02, is amended by adding a
422.24 subdivision to read:
422.25 Subd. 24c. **Hydrolyzed remains container.** "Hydrolyzed remains container" means
422.26 a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a
422.27 hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage
422.28 jewelry.

422.29 Sec. 30. Minnesota Statutes 2012, section 149A.02, is amended by adding a
422.30 subdivision to read:

423.1 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains
423.2 in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

423.3 Sec. 31. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:
423.4 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued
423.5 a license to practice mortuary science, to operate a funeral establishment, to operate an
423.6 alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner
423.7 of health.

423.8 Sec. 32. Minnesota Statutes 2012, section 149A.02, is amended by adding a
423.9 subdivision to read:
423.10 Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be
423.11 used, for the placement of hydrolyzed or cremated remains.

423.12 Sec. 33. Minnesota Statutes 2012, section 149A.02, is amended by adding a
423.13 subdivision to read:
423.14 Subd. 32a. **Placement.** "Placement" means the placing of a container holding
423.15 hydrolyzed or cremated remains in a crypt, vault, or niche.

423.16 Sec. 34. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:
423.17 Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of
423.18 the body into an appropriate cremation or alkaline hydrolysis container, embalming of
423.19 the body or such items of care as washing, disinfecting, shaving, positioning of features,
423.20 restorative procedures, application of cosmetics, dressing, and casketing.

423.21 Sec. 35. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:
423.22 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
423.23 cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means
423.24 including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance
423.25 appropriate for final disposition.

423.26 Sec. 36. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:
423.27 Subd. 37. **Public transportation.** "Public transportation" means all manner of
423.28 transportation via common carrier available to the general public including airlines, buses,
423.29 railroads, and ships. For purposes of this chapter, a livery service providing transportation

424.1 to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public
424.2 transportation.

424.3 Sec. 37. Minnesota Statutes 2012, section 149A.02, is amended by adding a
424.4 subdivision to read:

424.5 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed
424.6 or cremated remains in a defined area of a dedicated cemetery or in areas where no local
424.7 prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable
424.8 to the public, are not in a container, and that the person who has control over disposition
424.9 of the hydrolyzed or cremated remains has obtained written permission of the property
424.10 owner or governing agency to scatter on the property.

424.11 Sec. 38. Minnesota Statutes 2012, section 149A.02, is amended by adding a
424.12 subdivision to read:

424.13 Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or
424.14 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.
424.15 Vault may also mean a sealed and lined casket enclosure.

424.16 Sec. 39. Minnesota Statutes 2012, section 149A.03, is amended to read:

424.17 **149A.03 DUTIES OF COMMISSIONER.**

424.18 The commissioner shall:

424.19 (1) enforce all laws and adopt and enforce rules relating to the:

424.20 (i) removal, preparation, transportation, arrangements for disposition, and final
424.21 disposition of dead human bodies;

424.22 (ii) licensure and professional conduct of funeral directors, morticians, interns,
424.23 practicum students, and clinical students;

424.24 (iii) licensing and operation of a funeral establishment; ~~and~~

424.25 (iv) licensing and operation of an alkaline hydrolysis facility; and

424.26 ~~(iv)~~ (v) licensing and operation of a crematory;

424.27 (2) provide copies of the requirements for licensure and permits to all applicants;

424.28 (3) administer examinations and issue licenses and permits to qualified persons
424.29 and other legal entities;

424.30 (4) maintain a record of the name and location of all current licensees and interns;

424.31 (5) perform periodic compliance reviews and premise inspections of licensees;

424.32 (6) accept and investigate complaints relating to conduct governed by this chapter;

424.33 (7) maintain a record of all current preneed arrangement trust accounts;

425.1 (8) maintain a schedule of application, examination, permit, and licensure fees,
425.2 initial and renewal, sufficient to cover all necessary operating expenses;
425.3 (9) educate the public about the existence and content of the laws and rules for
425.4 mortuary science licensing and the removal, preparation, transportation, arrangements
425.5 for disposition, and final disposition of dead human bodies to enable consumers to file
425.6 complaints against licensees and others who may have violated those laws or rules;
425.7 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary
425.8 science in order to refine the standards for licensing and to improve the regulatory and
425.9 enforcement methods used; and
425.10 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in
425.11 the laws, rules, or procedures governing the practice of mortuary science and the removal,
425.12 preparation, transportation, arrangements for disposition, and final disposition of dead
425.13 human bodies.

425.14 Sec. 40. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS**
425.15 **FACILITY.**
425.16 Subdivision 1. **License requirement.** Except as provided in section 149A.01,
425.17 subdivision 3, a place or premise shall not be maintained, managed, or operated which
425.18 is devoted to or used in the holding and alkaline hydrolysis of a dead human body
425.19 without possessing a valid license to operate an alkaline hydrolysis facility issued by the
425.20 commissioner of health.
425.21 Subd. 2. **Requirements for an alkaline hydrolysis facility.** (a) An alkaline
425.22 hydrolysis facility licensed under this section must consist of:
425.23 (1) a building or structure that complies with applicable local and state building
425.24 codes, zoning laws and ordinances, wastewater management and environmental standards,
425.25 containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead
425.26 human bodies;
425.27 (2) a method approved by the commissioner of health to dry the hydrolyzed remains
425.28 and which is located within the licensed facility;
425.29 (3) a means approved by the commissioner of health for refrigeration of dead human
425.30 bodies awaiting alkaline hydrolysis;
425.31 (4) an appropriate means of processing hydrolyzed remains to a granulated
425.32 appearance appropriate for final disposition; and
425.33 (5) an appropriate holding facility for dead human bodies awaiting alkaline
425.34 hydrolysis.

426.1 (b) An alkaline hydrolysis facility licensed under this section may also contain a
426.2 display room for funeral goods.

426.3 Subd. 3. **Application procedure; documentation; initial inspection.** An
426.4 application for licensing an alkaline hydrolysis facility shall be submitted to the
426.5 commissioner of health. A completed application includes:

426.6 (1) a completed application form, as provided by the commissioner;

426.7 (2) proof of business form and ownership;

426.8 (3) proof of liability insurance coverage or other financial documentation, as
426.9 determined by the commissioner, that demonstrates the applicant's ability to respond in
426.10 damages for liability arising from the ownership, maintenance management, or operation
426.11 of an alkaline hydrolysis facility; and

426.12 (4) copies of wastewater and other environmental regulatory permits and
426.13 environmental regulatory licenses necessary to conduct operations.

426.14 Upon receipt of the application and appropriate fee, the commissioner shall review and
426.15 verify all information. Upon completion of the verification process and resolution of any
426.16 deficiencies in the application information, the commissioner shall conduct an initial
426.17 inspection of the premises to be licensed. After the inspection and resolution of any
426.18 deficiencies found and any reinspections as may be necessary, the commissioner shall
426.19 make a determination, based on all the information available, to grant or deny licensure. If
426.20 the commissioner's determination is to grant the license, the applicant shall be notified and
426.21 the license shall issue and remain valid for a period prescribed on the license, but not to
426.22 exceed one calendar year from the date of issuance of the license. If the commissioner's
426.23 determination is to deny the license, the commissioner must notify the applicant in writing
426.24 of the denial and provide the specific reason for denial.

426.25 Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis
426.26 facility is not assignable or transferable and shall not be valid for any entity other than the
426.27 one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the
426.28 location identified on the license. A 50 percent or more change in ownership or location of
426.29 the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall
426.30 be required of two or more persons or other legal entities operating from the same location.

426.31 Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis
426.32 facility must be conspicuously displayed in the alkaline hydrolysis facility at all times.
426.33 Conspicuous display means in a location where a member of the general public within the
426.34 alkaline hydrolysis facility will be able to observe and read the license.

427.1 Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility
427.2 issued by the commissioner are valid for a period of one calendar year beginning on July 1
427.3 and ending on June 30, regardless of the date of issuance.
427.4 Subd. 7. **Reporting changes in license information.** Any change of license
427.5 information must be reported to the commissioner, on forms provided by the
427.6 commissioner, no later than 30 calendar days after the change occurs. Failure to report
427.7 changes is grounds for disciplinary action.
427.8 Subd. 8. **Notification to the commissioner.** If the licensee is operating under a
427.9 wastewater or an environmental permit or license that is subsequently revoked, denied,
427.10 or terminated, the licensee shall notify the commissioner.
427.11 Subd. 9. **Application information.** All information submitted to the commissioner
427.12 for a license to operate an alkaline hydrolysis facility is classified as licensing data under
427.13 section 13.41, subdivision 5.

427.14 Sec. 41. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE**
427.15 **HYDROLYSIS FACILITY.**
427.16 Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis
427.17 facility issued by the commissioner expire on June 30 following the date of issuance of the
427.18 license and must be renewed to remain valid.
427.19 Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew
427.20 their licenses must submit to the commissioner a completed renewal application no later
427.21 than June 30 following the date the license was issued. A completed renewal application
427.22 includes:
427.23 (1) a completed renewal application form, as provided by the commissioner; and
427.24 (2) proof of liability insurance coverage or other financial documentation, as
427.25 determined by the commissioner, that demonstrates the applicant's ability to respond in
427.26 damages for liability arising from the ownership, maintenance, management, or operation
427.27 of an alkaline hydrolysis facility.
427.28 Upon receipt of the completed renewal application, the commissioner shall review and
427.29 verify the information. Upon completion of the verification process and resolution of
427.30 any deficiencies in the renewal application information, the commissioner shall make a
427.31 determination, based on all the information available, to reissue or refuse to reissue the
427.32 license. If the commissioner's determination is to reissue the license, the applicant shall
427.33 be notified and the license shall issue and remain valid for a period prescribed on the
427.34 license, but not to exceed one calendar year from the date of issuance of the license. If

428.1 the commissioner's determination is to refuse to reissue the license, section 149A.09,
428.2 subdivision 2, applies.

428.3 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration
428.4 date of a license will result in the assessment of a late filing penalty. The late filing penalty
428.5 must be paid before the reissuance of the license and received by the commissioner no
428.6 later than 31 calendar days after the expiration date of the license.

428.7 Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities
428.8 shall automatically lapse when a completed renewal application is not received by the
428.9 commissioner within 31 calendar days after the expiration data of a license, or a late
428.10 filing penalty assessed under subdivision 3 is not received by the commissioner within 31
428.11 calendar days after the expiration of a license.

428.12 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom
428.13 the license was issued is no longer licensed to operate an alkaline hydrolysis facility in
428.14 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
428.15 license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue
428.16 any additional lawful remedies as justified by the case.

428.17 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed
428.18 license upon receipt and review of a completed renewal application, receipt of the late
428.19 filing penalty, and reinspection of the premises, provided that the receipt is made within
428.20 one calendar year from the expiration date of the lapsed license and the cease and desist
428.21 order issued by the commissioner has not been violated. If a lapsed license is not restored
428.22 within one calendar year from the expiration date of the lapsed license, the holder of the
428.23 lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

428.24 Subd. 7. **Reporting changes in license information.** Any change of license
428.25 information must be reported to the commissioner, on forms provided by the
428.26 commissioner, no later than 30 calendar days after the change occurs. Failure to report
428.27 changes is grounds for disciplinary action.

428.28 Subd. 8. **Application information.** All information submitted to the commissioner
428.29 by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is
428.30 classified as licensing data under section 13.41, subdivision 5.

428.31 Sec. 42. Minnesota Statutes 2012, section 149A.65, is amended by adding a
428.32 subdivision to read:

428.33 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline
428.34 hydrolysis facility is $300. The late fee charge for a license renewal is $25.

429.1 Sec. 43. Minnesota Statutes 2012, section 149A.65, is amended by adding a
429.2 subdivision to read:
429.3 Subd. 7. **State government special revenue fund.** Fees collected by the
429.4 commissioner under this section must be deposited in the state treasury and credited to
429.5 the state government special revenue fund.

429.6 Sec. 44. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:
429.7 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice
429.8 mortuary science issued by the commissioner may use the title of mortician, funeral
429.9 director, or any other title implying that the licensee is engaged in the business or practice
429.10 of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis
429.11 facility issued by the commissioner may use the title of alkaline hydrolysis facility, water
429.12 cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or
429.13 any other title, word, or term implying that the licensee operates an alkaline hydrolysis
429.14 facility. Only the holder of a valid license to operate a funeral establishment issued by the
429.15 commissioner may use the title of funeral home, funeral chapel, funeral service, or any
429.16 other title, word, or term implying that the licensee is engaged in the business or practice
429.17 of mortuary science. Only the holder of a valid license to operate a crematory issued by
429.18 the commissioner may use the title of crematory, crematorium, green-cremation, or any
429.19 other title, word, or term implying that the licensee operates a crematory or crematorium.

429.20 Sec. 45. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:
429.21 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or
429.22 crematory shall not do business in a location that is not licensed as a funeral establishment,
429.23 alkaline hydrolysis facility, or crematory and shall not advertise a service that is available
429.24 from an unlicensed location.

429.25 Sec. 46. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:
429.26 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern
429.27 shall publish or disseminate false, misleading, or deceptive advertising. False, misleading,
429.28 or deceptive advertising includes, but is not limited to:
429.29 (1) identifying, by using the names or pictures of, persons who are not licensed to
429.30 practice mortuary science in a way that leads the public to believe that those persons will
429.31 provide mortuary science services;
429.32 (2) using any name other than the names under which the funeral establishment,
429.33 alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

430.1 (3) using a surname not directly, actively, or presently associated with a licensed
430.2 funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had
430.3 been previously and continuously used by the licensed funeral establishment, alkaline
430.4 hydrolysis facility, or crematory; and
430.5 (4) using a founding or establishing date or total years of service not directly or
430.6 continuously related to a name under which the funeral establishment, alkaline hydrolysis
430.7 facility, or crematory is currently or was previously licensed.
430.8 Any advertising or other printed material that contains the names or pictures of
430.9 persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory
430.10 shall state the position held by the persons and shall identify each person who is licensed
430.11 or unlicensed under this chapter.

430.12 Sec. 47. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:
430.13 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum
430.14 student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other
430.15 reimbursement in consideration for recommending or causing a dead human body to
430.16 be disposed of by a specific body donation program, funeral establishment, alkaline
430.17 hydrolysis facility, crematory, mausoleum, or cemetery.

430.18 Sec. 48. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:
430.19 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or
430.20 practices, the requirements of this subdivision must be met.
430.21 (b) Funeral providers must tell persons who ask by telephone about the funeral
430.22 provider's offerings or prices any accurate information from the price lists described in
430.23 paragraphs (c) to (e) and any other readily available information that reasonably answers
430.24 the questions asked.
430.25 (c) Funeral providers must make available for viewing to people who inquire in
430.26 person about the offerings or prices of funeral goods or burial site goods, separate printed
430.27 or typewritten price lists using a ten-point font or larger. Each funeral provider must have a
430.28 separate price list for each of the following types of goods that are sold or offered for sale:
430.29 (1) caskets;
430.30 (2) alternative containers;
430.31 (3) outer burial containers;
430.32 (4) alkaline hydrolysis containers;
430.33 ~~(4)~~ (5) cremation containers;
430.34 (6) hydrolyzed remains containers;

431.1 ~~(5)~~ (7) cremated remains containers;
431.2 ~~(6)~~ (8) markers; and
431.3 ~~(7)~~ (9) headstones.
431.4 (d) Each separate price list must contain the name of the funeral provider's place
431.5 of business, address, and telephone number and a caption describing the list as a price
431.6 list for one of the types of funeral goods or burial site goods described in paragraph (c),
431.7 clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion
431.8 of, but in any event before showing, the specific funeral goods or burial site goods and
431.9 must provide a photocopy of the price list, for retention, if so asked by the consumer. The
431.10 list must contain, at least, the retail prices of all the specific funeral goods and burial site
431.11 goods offered which do not require special ordering, enough information to identify each,
431.12 and the effective date for the price list. However, funeral providers are not required to
431.13 make a specific price list available if the funeral providers place the information required
431.14 by this paragraph on the general price list described in paragraph (e).
431.15 (e) Funeral providers must give a printed price list, for retention, to persons who
431.16 inquire in person about the funeral goods, funeral services, burial site goods, or burial site
431.17 services or prices offered by the funeral provider. The funeral provider must give the list
431.18 upon beginning discussion of either the prices of or the overall type of funeral service or
431.19 disposition or specific funeral goods, funeral services, burial site goods, or burial site
431.20 services offered by the provider. This requirement applies whether the discussion takes
431.21 place in the funeral establishment or elsewhere. However, when the deceased is removed
431.22 for transportation to the funeral establishment, an in-person request for authorization to
431.23 embalm does not, by itself, trigger the requirement to offer the general price list. If the
431.24 provider, in making an in-person request for authorization to embalm, discloses that
431.25 embalming is not required by law except in certain special cases, the provider is not
431.26 required to offer the general price list. Any other discussion during that time about prices
431.27 or the selection of funeral goods, funeral services, burial site goods, or burial site services
431.28 triggers the requirement to give the consumer a general price list. The general price list
431.29 must contain the following information:
431.30 (1) the name, address, and telephone number of the funeral provider's place of
431.31 business;
431.32 (2) a caption describing the list as a "general price list";
431.33 (3) the effective date for the price list;
431.34 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per
431.35 hour, mile, or other unit of computation, and other information described as follows:

432.1 (i) forwarding of remains to another funeral establishment, together with a list of
432.2 the services provided for any quoted price;
432.3 (ii) receiving remains from another funeral establishment, together with a list of
432.4 the services provided for any quoted price;
432.5 (iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral
432.6 provider, with the price including an alternative container or alkaline hydrolysis or
432.7 cremation container, any alkaline hydrolysis or crematory charges, and a description of the
432.8 services and container included in the price, where applicable, and the price of alkaline
432.9 hydrolysis or cremation where the purchaser provides the container;
432.10 (iv) separate prices for each immediate burial offered by the funeral provider,
432.11 including a casket or alternative container, and a description of the services and container
432.12 included in that price, and the price of immediate burial where the purchaser provides the
432.13 casket or alternative container;
432.14 (v) transfer of remains to the funeral establishment or other location;
432.15 (vi) embalming;
432.16 (vii) other preparation of the body;
432.17 (viii) use of facilities, equipment, or staff for viewing;
432.18 (ix) use of facilities, equipment, or staff for funeral ceremony;
432.19 (x) use of facilities, equipment, or staff for memorial service;
432.20 (xi) use of equipment or staff for graveside service;
432.21 (xii) hearse or funeral coach;
432.22 (xiii) limousine; and
432.23 (xiv) separate prices for all cemetery-specific goods and services, including all goods
432.24 and services associated with interment and burial site goods and services and excluding
432.25 markers and headstones;
432.26 (5) the price range for the caskets offered by the funeral provider, together with the
432.27 statement "A complete price list will be provided at the funeral establishment or casket
432.28 sale location." or the prices of individual caskets, as disclosed in the manner described
432.29 in paragraphs (c) and (d);
432.30 (6) the price range for the alternative containers offered by the funeral provider,
432.31 together with the statement "A complete price list will be provided at the funeral
432.32 establishment or alternative container sale location." or the prices of individual alternative
432.33 containers, as disclosed in the manner described in paragraphs (c) and (d);
432.34 (7) the price range for the outer burial containers offered by the funeral provider,
432.35 together with the statement "A complete price list will be provided at the funeral

433.1 establishment or outer burial container sale location." or the prices of individual outer
433.2 burial containers, as disclosed in the manner described in paragraphs (c) and (d);
433.3 (8) the price range for the alkaline hydrolysis container offered by the funeral
433.4 provider, together with the statement: "A complete price list will be provided at the funeral
433.5 establishment or alkaline hydrolysis container sale location.", or the prices of individual
433.6 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c)
433.7 and (d);
433.8 (9) the price range for the hydrolyzed remains container offered by the funeral
433.9 provider, together with the statement: "A complete price list will be provided at the
433.10 funeral establishment or hydrolyzed remains container sale location.", or the prices
433.11 of individual hydrolyzed remains container, as disclosed in the manner described in
433.12 paragraphs (c) and (d);
433.13 ~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider,
433.14 together with the statement "A complete price list will be provided at the funeral
433.15 establishment or cremation container sale location." or the prices of individual cremation
433.16 containers ~~and cremated remains containers~~, as disclosed in the manner described in
433.17 paragraphs (c) and (d);
433.18 ~~(9)~~ (11) the price range for the cremated remains containers offered by the funeral
433.19 provider, together with the statement, "A complete price list will be provided at the funeral
433.20 establishment or ~~cremation~~ cremated remains container sale location," or the prices of
433.21 individual cremation containers as disclosed in the manner described in paragraphs (c)
433.22 and (d);
433.23 ~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a
433.24 list of the principal basic services provided for any quoted price and, if the charge cannot
433.25 be declined by the purchaser, the statement "This fee for our basic services will be added
433.26 to the total cost of the funeral arrangements you select. (This fee is already included in
433.27 our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding
433.28 or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted
433.29 price shall include all charges for the recovery of unallocated funeral provider overhead,
433.30 and funeral providers may include in the required disclosure the phrase "and overhead"
433.31 after the word "services." This services fee is the only funeral provider fee for services,
433.32 facilities, or unallocated overhead permitted by this subdivision to be nondeclinable,
433.33 unless otherwise required by law;
433.34 ~~(11)~~ (13) the price range for the markers and headstones offered by the funeral
433.35 provider, together with the statement "A complete price list will be provided at the funeral

434.1 establishment or marker or headstone sale location." or the prices of individual markers
434.2 and headstones, as disclosed in the manner described in paragraphs (c) and (d); and

434.3 ~~(12)~~ (14) any package priced funerals offered must be listed in addition to and
434.4 following the information required in paragraph (e) and must clearly state the funeral
434.5 goods and services being offered, the price being charged for those goods and services,
434.6 and the discounted savings.

434.7 (f) Funeral providers must give an itemized written statement, for retention, to each
434.8 consumer who arranges an at-need funeral or other disposition of human remains at the
434.9 conclusion of the discussion of the arrangements. The itemized written statement must be
434.10 signed by the consumer selecting the goods and services as required in section 149A.80.
434.11 If the statement is provided by a funeral establishment, the statement must be signed by
434.12 the licensed funeral director or mortician planning the arrangements. If the statement is
434.13 provided by any other funeral provider, the statement must be signed by an authorized
434.14 agent of the funeral provider. The statement must list the funeral goods, funeral services,
434.15 burial site goods, or burial site services selected by that consumer and the prices to be paid
434.16 for each item, specifically itemized cash advance items (these prices must be given to the
434.17 extent then known or reasonably ascertainable if the prices are not known or reasonably
434.18 ascertainable, a good faith estimate shall be given and a written statement of the actual
434.19 charges shall be provided before the final bill is paid), and the total cost of goods and
434.20 services selected. At the conclusion of an at-need arrangement, the funeral provider is
434.21 required to give the consumer a copy of the signed itemized written contract that must
434.22 contain the information required in this paragraph.

434.23 (g) Upon receiving actual notice of the death of an individual with whom a funeral
434.24 provider has entered a preneed funeral agreement, the funeral provider must provide
434.25 a copy of all preneed funeral agreement documents to the person who controls final
434.26 disposition of the human remains or to the designee of the person controlling disposition.
434.27 The person controlling final disposition shall be provided with these documents at the time
434.28 of the person's first in-person contact with the funeral provider, if the first contact occurs
434.29 in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place
434.30 of business of the funeral provider. If the contact occurs by other means or at another
434.31 location, the documents must be provided within 24 hours of the first contact.

434.32 Sec. 49. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

434.33 Subd. 4. **Casket, alternate container, alkaline hydrolysis containers, and**
434.34 **cremation container sales; records; required disclosures.** Any funeral provider who
434.35 sells or offers to sell a casket, alternate container, alkaline hydrolysis container, hydrolyzed

435.1 remains container, or cremation container, or cremated remains container to the public
435.2 must maintain a record of each sale that includes the name of the purchaser, the purchaser's
435.3 mailing address, the name of the decedent, the date of the decedent's death, and the place
435.4 of death. These records shall be open to inspection by the regulatory agency. Any funeral
435.5 provider selling a casket, alternate container, or cremation container to the public, and not
435.6 having charge of the final disposition of the dead human body, shall provide a copy of the
435.7 statutes and rules controlling the removal, preparation, transportation, arrangements for
435.8 disposition, and final disposition of a dead human body. This subdivision does not apply to
435.9 morticians, funeral directors, funeral establishments, crematories, or wholesale distributors
435.10 of caskets, alternate containers, alkaline hydrolysis containers, or cremation containers.

435.11 Sec. 50. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:
435.12 Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts**
435.13 **or practices.** In selling or offering to sell funeral goods or funeral services to the public, it
435.14 is a deceptive act or practice for a funeral provider to represent that a casket is required for
435.15 alkaline hydrolysis or cremations by state or local law or otherwise.

435.16 Sec. 51. Minnesota Statutes 2012, section 149A.72, is amended by adding a
435.17 subdivision to read:
435.18 Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To
435.19 prevent deceptive acts or practices, funeral providers must place the following disclosure
435.20 in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota
435.21 law does not require you to purchase a casket for alkaline hydrolysis. If you want to
435.22 arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline
435.23 hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant
435.24 to leakage of bodily fluids that encases the body and into which a dead human body is
435.25 placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide
435.26 are (specify containers provided)." This disclosure is required only if the funeral provider
435.27 arranges alkaline hydrolysis.

435.28 Sec. 52. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:
435.29 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods,
435.30 funeral services, burial site goods, or burial site services to the public, it is a deceptive act
435.31 or practice for a funeral provider to represent that federal, state, or local laws, or particular
435.32 cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral
435.33 goods, funeral services, burial site goods, or burial site services when that is not the case.

436.1 Sec. 53. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

436.2 Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive**
436.3 **acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site
436.4 goods, or burial site services to the public, it is a deceptive act or practice for a funeral
436.5 provider to require that a casket be purchased for alkaline hydrolysis or cremation.

436.6 Sec. 54. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

436.7 Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.**
436.8 To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline
436.9 hydrolysis or cremations, they must make ~~a~~ an alkaline hydrolysis container or cremation
436.10 container available for alkaline hydrolysis or cremations.

436.11 Sec. 55. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

436.12 Subd. 4. **Required purchases of funeral goods or services; preventive**
436.13 **requirements.** To prevent unfair or deceptive acts or practices, funeral providers must
436.14 place the following disclosure in the general price list, immediately above the prices
436.15 required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods
436.16 and services shown below are those we can provide to our customers. You may choose
436.17 only the items you desire. If legal or other requirements mean that you must buy any items
436.18 you did not specifically ask for, we will explain the reason in writing on the statement we
436.19 provide describing the funeral goods, funeral services, burial site goods, and burial site
436.20 services you selected." However, if the charge for "services of funeral director and staff"
436.21 cannot be declined by the purchaser, the statement shall include the sentence "However,
436.22 any funeral arrangements you select will include a charge for our basic services." between
436.23 the second and third sentences of the sentences specified in this subdivision. The statement
436.24 may include the phrase "and overhead" after the word "services" if the fee includes a
436.25 charge for the recovery of unallocated funeral overhead. If the funeral provider does
436.26 not include this disclosure statement, then the following disclosure statement must be
436.27 placed in the statement of funeral goods, funeral services, burial site goods, and burial site
436.28 services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges
436.29 are only for those items that you selected or that are required. If we are required by law or
436.30 by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain
436.31 the reasons in writing below." A funeral provider is not in violation of this subdivision by
436.32 failing to comply with a request for a combination of goods or services which would be
436.33 impossible, impractical, or excessively burdensome to provide.

437.1 Sec. 56. Minnesota Statutes 2012, section 149A.74, is amended to read:

437.2 **149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.**

437.3 Subdivision 1. **Services provided without prior approval; deceptive acts or**
437.4 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it
437.5 is a deceptive act or practice for any funeral provider to embalm a dead human body
437.6 unless state or local law or regulation requires embalming in the particular circumstances
437.7 regardless of any funeral choice which might be made, or prior approval for embalming
437.8 has been obtained from an individual legally authorized to make such a decision. In
437.9 seeking approval to embalm, the funeral provider must disclose that embalming is not
437.10 required by law except in certain circumstances; that a fee will be charged if a funeral
437.11 is selected which requires embalming, such as a funeral with viewing; and that no
437.12 embalming fee will be charged if the family selects a service which does not require
437.13 embalming, such as direct alkaline hydrolysis, direct cremation, or immediate burial.

437.14 Subd. 2. **Services provided without prior approval; preventive requirement.**
437.15 To prevent unfair or deceptive acts or practices, funeral providers must include on
437.16 the itemized statement of funeral goods or services, as described in section 149A.71,
437.17 subdivision 2, paragraph (f), the statement "If you selected a funeral that may require
437.18 embalming, such as a funeral with viewing, you may have to pay for embalming. You do
437.19 not have to pay for embalming you did not approve if you selected arrangements such
437.20 as direct alkaline hydrolysis, direct cremation, or immediate burial. If we charged for
437.21 embalming, we will explain why below."

437.22 Sec. 57. Minnesota Statutes 2012, section 149A.90, subdivision 8, is amended to read:

437.23 Subd. 8. **Proper holding facility required.** The funeral establishment to which a
437.24 dead human body is taken shall have an appropriate holding facility for storing the body
437.25 while awaiting final disposition. The holding facility must be secure from access by
437.26 anyone except the authorized personnel of the funeral establishment, preserve the dignity
437.27 of the remains, and protect the health and safety of the funeral establishment personnel. A
437.28 holding facility may not be used for preparation or embalming of the body.

437.29 Sec. 58. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:

437.30 Subd. 9. **~~Embalmed~~ Bodies awaiting final disposition.** All ~~embalmed~~ bodies
437.31 awaiting final disposition shall be kept in an appropriate holding facility or preparation
437.32 and embalming room. The holding facility must be secure from access by anyone except
437.33 the authorized personnel of the funeral establishment, preserve the dignity and integrity of
437.34 the body, and protect the health and safety of the personnel of the funeral establishment.

438.1 Sec. 59. Minnesota Statutes 2012, section 149A.92, subdivision 1, is amended to read:

438.2 Subdivision 1. ~~**Exemption**~~ **Exemptions.** (a) All funeral establishments having a
438.3 preparation and embalming room that has not been used for the preparation or embalming
438.4 of a dead human body in the 12 calendar months prior to July 1, 1997, are exempt from
438.5 the minimum requirements in subdivisions 2 to 6, except as provided in this section. At
438.6 the time that ownership of a funeral establishment changes, the physical location of the
438.7 establishment changes, or the building housing the funeral establishment or business space
438.8 of the establishment is remodeled the existing preparation and embalming room must be
438.9 brought into compliance with the minimum standards in this section.

438.10 (b) Funeral establishments are not required to contain a preparation and embalming
438.11 room when it is a branch funeral establishment of a Minnesota licensed funeral
438.12 establishment that has a preparation and embalming room meeting the standards set forth
438.13 in subdivisions 2 to 10.

438.14 Sec. 60. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:

438.15 Subd. 3. **Disposition permit.** A disposition permit is required before a body can
438.16 be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be
438.17 issued until a fact of death record has been completed and filed with the local or state
438.18 registrar of vital statistics.

438.19 Sec. 61. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:

438.20 Subd. 6. **Conveyances permitted for transportation.** A dead human body may be
438.21 transported by means of private vehicle or private aircraft, provided that the body must be
438.22 encased in an appropriate container, that meets the following standards:

438.23 (1) promotes respect for and preserves the dignity of the dead human body;

438.24 (2) shields the body from being viewed from outside of the conveyance;

438.25 (3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket,
438.26 alternative container, alkaline hydrolysis container, or cremation container in a horizontal
438.27 position;

438.28 (4) is designed to permit loading and unloading of the body without excessive tilting
438.29 of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container,
438.30 or cremation container; and

438.31 (5) if used for the transportation of more than one dead human body at one time,
438.32 the vehicle must be designed so that a body or container does not rest directly on top of
438.33 another body or container and that each body or container is secured to prevent the body
438.34 or container from excessive movement within the conveyance.

439.1 A vehicle that is a dignified conveyance and was specified for use by the deceased
439.2 or by the family of the deceased may be used to transport the body to the place of final
439.3 disposition.

439.4 Sec. 62. Minnesota Statutes 2012, section 149A.94, is amended to read:

439.5 **149A.94 FINAL DISPOSITION.**

439.6 Subdivision 1. **Generally.** Every dead human body lying within the state, except
439.7 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
439.8 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
439.9 the state for the purpose of disposition elsewhere; and the remains of any dead human
439.10 body after dissection or anatomical study, shall be decently buried, or entombed in a
439.11 public or private cemetery, alkaline hydrolyzed or cremated, within a reasonable time
439.12 after death. Where final disposition of a body will not be accomplished within 72 hours
439.13 following death or release of the body by a competent authority with jurisdiction over the
439.14 body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body
439.15 may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry
439.16 ice for a period that exceeds four calendar days, from the time of death or release of the
439.17 body from the coroner or medical examiner.

439.18 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or
439.19 cremated without a disposition permit. The disposition permit must be filed with the person
439.20 in charge of the place of final disposition. Where a dead human body will be transported out
439.21 of this state for final disposition, the body must be accompanied by a certificate of removal.

439.22 Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or
439.23 cremated remains and release to an appropriate party is considered final disposition and no
439.24 further permits or authorizations are required for transportation, interment, entombment, or
439.25 placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

439.26 Sec. 63. **[149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE**
439.27 **HYDROLYSIS.**

439.28 Subdivision 1. **License required.** A dead human body may only be hydrolyzed in
439.29 this state at an alkaline hydrolysis facility licensed by the commissioner of health.

439.30 Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis
439.31 facility must comply with all applicable local and state building codes, zoning laws and
439.32 ordinances, wastewater management regulations, and environmental statutes, rules, and
439.33 standards. An alkaline hydrolysis facility must have, on site, a purpose built human
439.34 alkaline hydrolysis system approved by the commissioner of health, a system approved by

440.1 the commissioner of health for drying the hydrolyzed remains, a motorized mechanical
440.2 device approved by the commissioner of health for processing hydrolyzed remains and
440.3 must have in the building a holding facility approved by the commissioner of health for
440.4 the retention of dead human bodies awaiting alkaline hydrolysis. The holding facility
440.5 must be secure from access by anyone except the authorized personnel of the alkaline
440.6 hydrolysis facility, preserve the dignity of the remains, and protect the health and safety of
440.7 the alkaline hydrolysis facility personnel.

440.8 Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel
440.9 is located and the room where the chemical storage takes place shall be properly lit and
440.10 ventilated with an exhaust fan that provides at least 12 air changes per hour.

440.11 Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines,
440.12 plumbing vents, and waste drains shall be properly vented and connected pursuant to the
440.13 Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a
440.14 functional sink with hot and cold running water.

440.15 Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the
440.16 alkaline hydrolysis vessel is located and the room where the chemical storage takes place
440.17 shall have nonporous flooring, so that a sanitary condition is provided. The walls and
440.18 ceiling of the room where the alkaline hydrolysis vessel is located and the room where
440.19 the chemical storage takes place shall run from floor to ceiling and be covered with tile,
440.20 or by plaster or sheetrock painted with washable paint or other appropriate material so
440.21 that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be
440.22 constructed to prevent odors from entering any other part of the building. All windows
440.23 or other openings to the outside must be screened and all windows must be treated in a
440.24 manner that prevents viewing into the room where the alkaline hydrolysis vessel is located
440.25 and the room where the chemical storage takes place. A viewing window for authorized
440.26 family members or their designees is not a violation of this subdivision.

440.27 Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a
440.28 functional emergency eye wash and quick drench shower.

440.29 Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is
440.30 located and the room where the chemical storage takes place must be private and have no
440.31 general passageway through it. The room shall, at all times, be secure from the entrance of
440.32 unauthorized persons. Authorized persons are:

440.33 (1) licensed morticians;

440.34 (2) registered interns or students as described in section 149A.91, subdivision 6;

440.35 (3) public officials or representatives in the discharge of their official duties;

440.36 (4) trained alkaline hydrolysis facility operators; and

441.1 (5) the person(s) with the right to control the dead human body as defined in section
441.2 149A.80, subdivision 2, and their designees.
441.3 (b) Each door allowing ingress or egress shall carry a sign that indicates that the
441.4 room is private and access is limited. All authorized persons who are present in or enter
441.5 the room where the alkaline hydrolysis vessel is located while a body is being prepared for
441.6 final disposition must be attired according to all applicable state and federal regulations
441.7 regarding the control of infectious disease and occupational and workplace health and
441.8 safety.
441.9 Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline
441.10 hydrolysis vessel is located and the room where the chemical storage takes place and all
441.11 fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies
441.12 stored or used in the room must be maintained in a clean and sanitary condition at all times.
441.13 Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline
441.14 hydrolysis vessel for its operation, all state and local regulations for that boiler must be
441.15 followed.
441.16 Subd. 10. **Occupational and workplace safety.** All applicable provisions of state
441.17 and federal regulations regarding exposure to workplace hazards and accidents shall be
441.18 followed in order to protect the health and safety of all authorized persons at the alkaline
441.19 hydrolysis facility.
441.20 Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ
441.21 a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body.
441.22 It is the duty of the licensed alkaline hydrolysis facility to provide proper training which
441.23 includes a certified operators training approved by the commissioner of health for all
441.24 personnel and the licensed alkaline hydrolysis facility shall be strictly accountable for
441.25 compliance with this chapter and other applicable state and federal regulations regarding
441.26 occupational and workplace health and safety.
441.27 Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility
441.28 shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part
441.29 without receiving written authorization to do so from the person or persons who have the
441.30 legal right to control disposition as described in section 149A.80 or the person's legal
441.31 designee. The written authorization must include:
441.32 (1) the name of the deceased and the date of death of the deceased;
441.33 (2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;
441.34 (3) the name, address, telephone number, relationship to the deceased, and signature
441.35 of the person or persons with legal right to control final disposition or a legal designee;

442.1 (4) directions for the disposition of any nonhydrolyzed materials or items recovered
442.2 from the alkaline hydrolysis vessel;
442.3 (5) acknowledgment that the hydrolyzed remains will be dried and mechanically
442.4 reduced to a granulated appearance and place in an appropriate container and authorization
442.5 to place any hydrolyzed remains that a selected urn or container will not accommodate
442.6 into a temporary container;
442.7 (6) acknowledgment that, even with the exercise of reasonable care, it is not possible
442.8 to recover all particles of the hydrolyzed remains and that some particles may inadvertently
442.9 become commingled with particles of other hydrolyzed remains that remain in the alkaline
442.10 hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;
442.11 (7) directions for the ultimate disposition of the hydrolyzed remains; and
442.12 (8) a statement that includes, but is not limited to, the following information:
442.13 "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an
442.14 alkaline solution is used to chemically break down the human tissue and the hydrolyzable
442.15 alkaline hydrolysis container. After the process is complete, the liquid effluent solution
442.16 contains the chemical by-products of the alkaline hydrolysis process except for the
442.17 deceased's bone fragments. The solution is cooled and released according to local
442.18 environmental regulations. A water rinse is applied to the hydrolyzed remains which are
442.19 then dried and processed to facilitate inurnment or scattering."
442.20 Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in
442.21 good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an
442.22 authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from
442.23 civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis
442.24 facility.
442.25 Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be
442.26 accepted for final disposition by alkaline hydrolysis unless:
442.27 (1) encased in an appropriate alkaline hydrolysis container;
442.28 (2) accompanied by a disposition permit issued pursuant to section 149A.93,
442.29 subdivision 3, including a photocopy of the completed death record or a signed release
442.30 authorizing alkaline hydrolysis of the body received from the coroner or medical
442.31 examiner; and
442.32 (3) accompanied by an alkaline hydrolysis authorization that complies with
442.33 subdivision 4.
442.34 (b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline
442.35 hydrolysis container where there is:
442.36 (1) evidence of leakage of fluids from the alkaline hydrolysis container;

443.1 (2) a known dispute concerning hydrolysis of the body delivered;
443.2 (3) a reasonable basis for questioning any of the representations made on the written
443.3 authorization to hydrolyze; or
443.4 (4) any other lawful reason.
443.5 Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed
443.6 within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of
443.7 the body.
443.8 Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.**
443.9 All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for
443.10 dead human bodies shall use universal precautions and otherwise exercise all reasonable
443.11 precautions to minimize the risk of transmitting any communicable disease from the body.
443.12 No dead human body shall be removed from the container in which it is delivered.
443.13 Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall
443.14 develop, implement, and maintain an identification procedure whereby dead human
443.15 bodes can be identified from the time the alkaline hydrolysis facility accepts delivery
443.16 of the remains until the hydrolyzed remains are released to an authorized party. After
443.17 hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the
443.18 hydrolyzed remains container before the hydrolyzed remains are released from the alkaline
443.19 hydrolysis facility. Each identification disk, tab, or label shall have a number that shall
443.20 be recorded on all paperwork regarding the decedent. This procedure shall be designed
443.21 to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains
443.22 are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the
443.23 inability to individually identify the hydrolyzed remains is a violation of this subdivision.
443.24 Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline
443.25 hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains
443.26 in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for
443.27 infectious disease control.
443.28 Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of
443.29 dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is
443.30 written authorization from the person with the legal right to control the disposition,
443.31 only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline
443.32 hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting
443.33 alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline
443.34 hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.
443.35 Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains**
443.36 **prohibited.** Except with the express written permission of the person with the legal right

444.1 to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one
444.2 dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce
444.3 a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have
444.4 been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze
444.5 a dead human body and other human remains at the same time and in the same alkaline
444.6 hydrolysis vessel. This section does not apply where commingling of human remains
444.7 during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental
444.8 and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is
444.9 not a violation of this subdivision.

444.10 Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis**
444.11 **vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be
444.12 made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed
444.13 remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be
444.14 made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed
444.15 human remains and dispose of these materials in a lawful manner, by the alkaline
444.16 hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate
444.17 container to be transported to the processing area.

444.18 Subd. 22. **Drying device or mechanical processor procedures; commingling of**
444.19 **hydrolyzed remains prohibited.** Except with the express written permission of the
444.20 person with the legal right to control the final disposition or otherwise provided by
444.21 law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed
444.22 human remains of more than one body at a time in the same drying device or mechanical
444.23 processor, or introduce the hydrolyzed human remains of a second body into a drying
444.24 device or mechanical processor until processing of any preceding hydrolyzed human
444.25 remains has been terminated and reasonable efforts have been employed to remove all
444.26 fragments of the preceding hydrolyzed remains. The fact that there is incidental and
444.27 unavoidable residue in the drying device, the mechanical processor, or any container used
444.28 in a prior alkaline hydrolysis process, is not a violation of this provision.

444.29 Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The
444.30 hydrolyzed human remains shall be dried and then reduced by a motorized mechanical
444.31 device to a granulated appearance appropriate for final disposition and placed in an alkaline
444.32 hydrolysis remains container along with the appropriate identifying disk, tab, or permanent
444.33 label. Processing must take place within the licensed alkaline hydrolysis facility. Dental
444.34 gold, silver or amalgam, jewelry, or mementos, to the extent that they can be identified, may
444.35 be removed by certified alkaline hydrolysis facility staff prior to processing the hydrolyzed
444.36 remains; however, any dental gold and silver, jewelry, or mementos that are removed shall

445.1 be returned to the hydrolyzed remains container unless otherwise directed by the person or
445.2 persons having the right to control the final disposition. Every person who removes or
445.3 possesses dental gold or silver, jewelry, or mementos from any hydrolyzed remains without
445.4 specific written permission of the person or persons having the right to control those
445.5 remains is guilty of a misdemeanor. The fact that residue and any unavoidable dental gold
445.6 or dental silver, or other precious metals remain in the alkaline hydrolysis vessel or other
445.7 equipment or any container used in a prior hydrolysis is not a violation of this section.

445.8 Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.**
445.9 If a hydrolyzed remains container is of insufficient capacity to accommodate all
445.10 hydrolyzed remains of a given dead human body, subject to directives provided in the
445.11 written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess
445.12 hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the
445.13 second container, in a manner so as not to be easily detached through incidental contact, to
445.14 the primary alkaline hydrolysis remains container. The secondary container shall contain a
445.15 duplicate of the identification disk, tab, or permanent label that was placed in the primary
445.16 container and all paperwork regarding the given body shall include a notation that the
445.17 hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature
445.18 hydrolyzed remains containers are not subject to the requirements of this subdivision.

445.19 Subd. 25. **Disposition procedures; commingling of hydrolyzed remains**
445.20 **prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in
445.21 a location where the hydrolyzed remains are commingled with those of another person
445.22 without the express written permission of the person with the legal right to control
445.23 disposition or as otherwise provided by law. This subdivision does not apply to the
445.24 scattering or burial of hydrolyzed remains at sea or in a body of water from individual
445.25 containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to
445.26 the disposal in a dedicated cemetery of accumulated residue removed from an alkaline
445.27 hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members
445.28 of the same family in a common container designed for the hydrolyzed remains of more
445.29 than one body, or to the inurnment in a container or interment in a space that has been
445.30 previously designated, at the time of sale or purchase, as being intended for the inurnment
445.31 or interment of the hydrolyzed remains of more than one person.

445.32 Subd. 26. **Alkaline hydrolysis procedures; disposition of accumulated residue.**
445.33 Every alkaline hydrolysis facility shall provide for the removal and disposition in a
445.34 dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel,
445.35 drying device, mechanical processor, container, or other equipment used in alkaline

446.1 hydrolysis. Disposition of accumulated residue shall be according to the regulations of the
446.2 dedicated cemetery and any applicable local ordinances.

446.3 Subd. 27. **Alkaline hydrolysis procedures; release of hydrolyzed remains.**
446.4 Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be
446.5 released according to the instructions given on the written authorization to hydrolyze. If
446.6 the hydrolyzed remains are to be shipped, they must be securely packaged and transported
446.7 by a method which has an internal tracing system available and which provides for a
446.8 receipt signed by the person accepting delivery. Where there is a dispute over release
446.9 or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit
446.10 the hydrolyzed remains with a court of competent jurisdiction pending resolution of the
446.11 dispute or retain the hydrolyzed remains until the person with the legal right to control
446.12 disposition presents satisfactory indication that the dispute is resolved.

446.13 Subd. 28. **Unclaimed hydrolyzed remains.** If, after 30 calendar days following
446.14 the inurnment, the hydrolyzed remains are not claimed or disposed of according to the
446.15 written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment
446.16 may give written notice, by certified mail, to the person with the legal right to control
446.17 the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and
446.18 requesting further release directions. Should the hydrolyzed remains be unclaimed 120
446.19 calendar days following the mailing of the written notification, the alkaline hydrolysis
446.20 facility or funeral establishment may dispose of the hydrolyzed remains in any lawful
446.21 manner deemed appropriate.

446.22 Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and
446.23 maintain on its premises or other business location in Minnesota an accurate record of
446.24 every hydrolyzation provided. The record shall include all of the following information
446.25 for each hydrolyzation:

446.26 (1) the name of the person or funeral establishment delivering the body for alkaline
446.27 hydrolysis;

446.28 (2) the name of the deceased and the identification number assigned to the body;

446.29 (3) the date of acceptance of delivery;

446.30 (4) the names of the alkaline hydrolysis vessel, drying device, and mechanical
446.31 processor operator;

446.32 (5) the time and date that the body was placed in and removed from the alkaline
446.33 hydrolysis vessel;

446.34 (6) the time and date that processing and inurnment of the hydrolyzed remains
446.35 was completed;

446.36 (7) the time, date, and manner of release of the hydrolyzed remains;

447.1 (8) the name and address of the person who signed the authorization to hydrolyze;
447.2 (9) all supporting documentation, including any transit or disposition permits, a
447.3 photocopy of the death record, and the authorization to hydrolyze; and
447.4 (10) the type of alkaline hydrolysis container.
447.5 Subd. 30. **Retention of records.** Records required under subdivision 20 shall be
447.6 maintained for a period of three calendar years after the release of the hydrolyzed remains.
447.7 Following this period and subject to any other laws requiring retention of records, the
447.8 alkaline hydrolysis facility may then place the records in storage or reduce them to
447.9 microfilm, microfiche, laser disc, or any other method that can produce an accurate
447.10 reproduction of the original record, for retention for a period of ten calendar years from
447.11 the date of release of the hydrolyzed remains. At the end of this period and subject to any
447.12 other laws requiring retention of records, the alkaline hydrolysis facility may destroy
447.13 the records by shredding, incineration, or any other manner that protects the privacy of
447.14 the individuals identified.

447.15 Sec. 64. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:
447.16 Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95,
447.17 subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an
447.18 appropriate party is considered final disposition and no further permits or authorizations
447.19 are required for disinterment, transportation, or placement of the hydrolyzed or cremated
447.20 remains.

447.21 Sec. 65. **REVISOR'S INSTRUCTION.**
447.22 The revisor shall substitute the term "vertical heat exchangers" or "vertical
447.23 heat exchanger" with "bored geothermal heat exchangers" or "bored geothermal heat
447.24 exchanger" wherever it appears in Minnesota Statutes, sections 103I.005, subdivisions
447.25 2 and 12; 103I.101, subdivisions 2 and 5; 103I.105; 103I.205, subdivision 4; 103I.208,
447.26 subdivision 2; 103I.501; 103I.531, subdivision 5; and 103I.641, subdivisions 1, 2, and 3.

447.27 Sec. 66. **REPEALER.**
447.28 (a) Minnesota Statutes 2012, sections 103I.005, subdivision 20; 149A.025; 149A.20,
447.29 subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6;
447.30 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53,
447.31 subdivision 9; and 485.14, are repealed.
447.32 (b) Minnesota Statutes 2012, section 144.123, subdivision 2, is repealed effective
447.33 July 1, 2014.

448.1 ARTICLE 14

448.2 HEALTH AND HUMAN SERVICES APPROPRIATIONS

448.3 Section 1. **SUMMARY OF APPROPRIATIONS.**

448.4 The amounts shown in this section summarize direct appropriations, by fund, made
448.5 in this article.

		2014		2015		Total
448.6		**2014**		**2015**		**Total**
448.7 General	$	5,647,668,000	$	5,977,548,000	$	11,625,215,000
448.8 State Government Special 448.9 Revenue		70,308,000		73,019,000		143,327,000
448.10 Health Care Access		621,234,000		249,410,000		870,644,000
448.11 Federal TANF		269,532,000		268,427,000		537,959,000
448.12 Lottery Prize Fund		1,665,000		1,665,000		3,330,000
448.13 **Total**	**$**	**6,610,407,000**	**$**	**6,570,069,000**	**$**	**13,180,475,000**

448.14 Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

448.15 The sums shown in the columns marked "Appropriations" are appropriated to the
448.16 agencies and for the purposes specified in this article. The appropriations are from the
448.17 general fund, or another named fund, and are available for the fiscal years indicated
448.18 for each purpose. The figures "2014" and "2015" used in this article mean that the
448.19 appropriations listed under them are available for the fiscal year ending June 30, 2014, or
448.20 June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal
448.21 year 2015. "The biennium" is fiscal years 2014 and 2015.

448.22 **APPROPRIATIONS**
448.23 **Available for the Year**
448.24 **Ending June 30**
448.25 **2014** **2015**

448.26 Sec. 3. **COMMISSIONER OF HUMAN**
448.27 **SERVICES**

448.28 Subdivision 1. **Total Appropriation** **$ 6,418,000,000 $ 6,382,943,000**

448.29 Appropriations by Fund

	2014	2015
448.30	2014	2015
448.31 General	5,564,459,000	5,899,531,000
448.32 State Government 448.33 Special Revenue	4,065,000	6,265,000
448.34 Health Care Access	589,992,000	218,768,000
448.35 Federal TANF	257,819,000	256,714,000
448.36 Lottery Prize Fund	1,665,000	1,665,000

449.1 **Receipts for Systems Projects.**
449.2 Appropriations and federal receipts for
449.3 information systems projects for MAXIS,
449.4 PRISM, MMIS, and SSIS must be deposited
449.5 in the state system account authorized
449.6 in Minnesota Statutes, section 256.014.
449.7 Money appropriated for computer projects
449.8 approved by the commissioner of Minnesota
449.9 information technology services, funded
449.10 by the legislature, and approved by the
449.11 commissioner of management and budget,
449.12 may be transferred from one project to
449.13 another and from development to operations
449.14 as the commissioner of human services
449.15 considers necessary. Any unexpended
449.16 balance in the appropriation for these
449.17 projects does not cancel but is available for
449.18 ongoing development and operations.

449.19 **Nonfederal Share Transfers.** The
449.20 nonfederal share of activities for which
449.21 federal administrative reimbursement is
449.22 appropriated to the commissioner may be
449.23 transferred to the special revenue fund.

449.24 **ARRA Supplemental Nutrition Assistance**
449.25 **Benefit Increases.** The funds provided for
449.26 food support benefit increases under the
449.27 Supplemental Nutrition Assistance Program
449.28 provisions of the American Recovery and
449.29 Reinvestment Act (ARRA) of 2009 must be
449.30 used for benefit increases beginning July 1,
449.31 2009.

449.32 **Supplemental Nutrition Assistance**
449.33 **Program Employment and Training.**
449.34 (1) Notwithstanding Minnesota Statutes,
449.35 sections 256D.051, subdivisions 1a, 6b,

450.1 and 6c, and 256J.626, federal Supplemental
450.2 Nutrition Assistance employment and
450.3 training funds received as reimbursement of
450.4 MFIP consolidated fund grant expenditures
450.5 for diversionary work program participants
450.6 and child care assistance program
450.7 expenditures must be deposited in the general
450.8 fund. The amount of funds must be limited to
450.9 $4,900,000 per year in fiscal years 2014 and
450.10 2015, and to $4,400,000 per year in fiscal
450.11 years 2016 and 2017, contingent on approval
450.12 by the federal Food and Nutrition Service.

450.13 (2) Consistent with the receipt of the federal
450.14 funds, the commissioner may adjust the
450.15 level of working family credit expenditures
450.16 claimed as TANF maintenance of effort.
450.17 Notwithstanding any contrary provision in
450.18 this article, this rider expires June 30, 2017.

450.19 **TANF Maintenance of Effort.** (a) In order
450.20 to meet the basic maintenance of effort
450.21 (MOE) requirements of the TANF block grant
450.22 specified under Code of Federal Regulations,
450.23 title 45, section 263.1, the commissioner may
450.24 only report nonfederal money expended for
450.25 allowable activities listed in the following
450.26 clauses as TANF/MOE expenditures:

450.27 (1) MFIP cash, diversionary work program,
450.28 and food assistance benefits under Minnesota
450.29 Statutes, chapter 256J;

450.30 (2) the child care assistance programs
450.31 under Minnesota Statutes, sections 119B.03
450.32 and 119B.05, and county child care
450.33 administrative costs under Minnesota
450.34 Statutes, section 119B.15;

451.1 (3) state and county MFIP administrative
451.2 costs under Minnesota Statutes, chapters
451.3 256J and 256K;

451.4 (4) state, county, and tribal MFIP
451.5 employment services under Minnesota
451.6 Statutes, chapters 256J and 256K;

451.7 (5) expenditures made on behalf of legal
451.8 noncitizen MFIP recipients who qualify for
451.9 the MinnesotaCare program under Minnesota
451.10 Statutes, chapter 256L;

451.11 (6) qualifying working family credit
451.12 expenditures under Minnesota Statutes,
451.13 section 290.0671;

451.14 (7) qualifying Minnesota education credit
451.15 expenditures under Minnesota Statutes,
451.16 section 290.0674; and

451.17 (8) qualifying Head Start expenditures under
451.18 Minnesota Statutes, section 119A.50.

451.19 (b) The commissioner shall ensure that
451.20 sufficient qualified nonfederal expenditures
451.21 are made each year to meet the state's
451.22 TANF/MOE requirements. For the activities
451.23 listed in paragraph (a), clauses (2) to
451.24 (8), the commissioner may only report
451.25 expenditures that are excluded from the
451.26 definition of assistance under Code of
451.27 Federal Regulations, title 45, section 260.31.

451.28 (c) For fiscal years beginning with state fiscal
451.29 year 2003, the commissioner shall ensure
451.30 that the maintenance of effort used by the
451.31 commissioner of management and budget
451.32 for the February and November forecasts
451.33 required under Minnesota Statutes, section
451.34 16A.103, contains expenditures under

452.1 paragraph (a), clause (1), equal to at least 16
452.2 percent of the total required under Code of
452.3 Federal Regulations, title 45, section 263.1.

452.4 (d) The requirement in Minnesota Statutes,
452.5 section 256.011, subdivision 3, that federal
452.6 grants or aids secured or obtained under that
452.7 subdivision be used to reduce any direct
452.8 appropriations provided by law, do not apply
452.9 if the grants or aids are federal TANF funds.

452.10 (e) For the federal fiscal years beginning on
452.11 or after October 1, 2007, the commissioner
452.12 may not claim an amount of TANF/MOE in
452.13 excess of the 75 percent standard in Code
452.14 of Federal Regulations, title 45, section
452.15 263.1(a)(2), except:

452.16 (1) to the extent necessary to meet the 80
452.17 percent standard under Code of Federal
452.18 Regulations, title 45, section 263.1(a)(1),
452.19 if it is determined by the commissioner
452.20 that the state will not meet the TANF work
452.21 participation target rate for the current year;

452.22 (2) to provide any additional amounts
452.23 under Code of Federal Regulations, title 45,
452.24 section 264.5, that relate to replacement of
452.25 TANF funds due to the operation of TANF
452.26 penalties; and

452.27 (3) to provide any additional amounts that
452.28 may contribute to avoiding or reducing
452.29 TANF work participation penalties through
452.30 the operation of the excess MOE provisions
452.31 of Code of Federal Regulations, title 45,
452.32 section 261.43(a)(2).

452.33 For the purposes of clauses (1) to (3),
452.34 the commissioner may supplement the
452.35 MOE claim with working family credit

453.1 expenditures or other qualified expenditures
453.2 to the extent such expenditures are otherwise
453.3 available after considering the expenditures
453.4 allowed in this subdivision and subdivisions
453.5 2 and 3.

453.6 (f) Notwithstanding any contrary provision
453.7 in this article, paragraphs (a) to (e) expire
453.8 June 30, 2017.

453.9 **Working Family Credit Expenditures**
453.10 **as TANF/MOE.** The commissioner may
453.11 claim as TANF maintenance of effort up to
453.12 $6,707,000 per year of working family credit
453.13 expenditures in each fiscal year.

453.14 Subd. 2. **Working Family Credit to be Claimed**
453.15 **for TANF/MOE**

453.16 The commissioner may count the following
453.17 amounts of working family credit
453.18 expenditures as TANF/MOE:

453.19 (1) fiscal year 2014, $43,576,000; and

453.20 (2) fiscal year 2015, $43,548,000.

453.21 Subd. 3. **TANF Transfer to Federal Child Care**
453.22 **and Development Fund**

453.23 (a) The following TANF fund amounts
453.24 are appropriated to the commissioner for
453.25 purposes of MFIP/transition year child care
453.26 assistance under Minnesota Statutes, section
453.27 119B.05:

453.28 (1) fiscal year 2014; $14,020,000; and

453.29 (2) fiscal year 2015, $14,020,000.

453.30 (b) The commissioner shall authorize the
453.31 transfer of sufficient TANF funds to the
453.32 federal child care and development fund to
453.33 meet this appropriation and shall ensure that
453.34 all transferred funds are expended according

454.1 to federal child care and development fund
454.2 regulations.

454.3 Subd. 4. **Central Office**

454.4 The amounts that may be spent from this
454.5 appropriation for each purpose are as follows:

454.6 **(a) Operations**

454.7	Appropriations by Fund		
454.8	General	96,928,000	91,123,000
454.9–454.10	State Government Special Revenue	3,940,000	6,140,000
454.11	Health Care Access	12,453,000	12,453,000
454.12	Federal TANF	100,000	100,000

454.13 **Reform 2020 Contingency.** The
454.14 appropriation from the general fund may
454.15 be adjusted as provided in article 2, section
454.16 49, in order to implement Reform 2020 and
454.17 systems modernization.

454.18 **DHS Receipt Center Accounting.** The
454.19 commissioner is authorized to transfer
454.20 appropriations to, and account for DHS
454.21 receipt center operations in, the special
454.22 revenue fund.

454.23 **Administrative Recovery; Set-Aside.** The
454.24 commissioner may invoice local entities
454.25 through the SWIFT accounting system as an
454.26 alternative means to recover the actual cost
454.27 of administering the following provisions:

454.28 (1) Minnesota Statutes, section 125A.744,
454.29 subdivision 3;

454.30 (2) Minnesota Statutes, section 245.495,
454.31 paragraph (b);

454.32 (3) Minnesota Statutes, section 256B.0625,
454.33 subdivision 20, paragraph (k);

455.1 (4) Minnesota Statutes, section 256B.0924,
455.2 subdivision 6, paragraph (g);

455.3 (5) Minnesota Statutes, section 256B.0945,
455.4 subdivision 4, paragraph (d); and

455.5 (6) Minnesota Statutes, section 256F.10,
455.6 subdivision 6, paragraph (b).

455.7 **Systems Modernization.** The following
455.8 amounts are appropriated for transfer to
455.9 the state systems account authorized in
455.10 Minnesota Statutes, section 256.014:

455.11 (1) $1,883,000 in fiscal year 2014 and
455.12 $2,347,000 in fiscal year 2015 is for the
455.13 state share of Medicaid-allocated costs of
455.14 the health insurance exchange information
455.15 technology and operational structure. The
455.16 funding base is $3,219,000 in fiscal year 2016
455.17 and $3,062,000 in fiscal year 2017 but shall
455.18 not be included in the base thereafter; and

455.19 (2) $6,085,000 in fiscal year 2014 is for the
455.20 modernization and streamlining of agency
455.21 eligibility and child support systems. The
455.22 funding base is $5,921,000 in fiscal year
455.23 2016 and $1,792,000 in fiscal year 2017 but
455.24 shall not be included in the base thereafter.

455.25 The unexpended balance of the $6,085,000
455.26 appropriation must be transferred from
455.27 the Department of Human Services state
455.28 systems account to the Office of Enterprise
455.29 Technology when the Office of Enterprise
455.30 Technology has negotiated a federally
455.31 approved internal service fund rates and
455.32 billing process with sufficient internal
455.33 accounting controls to properly maximize
455.34 federal reimbursement to Minnesota for

456.1 human services system modernization
456.2 projects, but not later than June 30, 2015.

456.3 If contingent funding is fully or partially
456.4 disbursed under article 2, section 49, and
456.5 transferred to the state systems account, the
456.6 unexpended balance of that appropriation
456.7 must be transferred to the Office of Enterprise
456.8 Technology in accordance with this clause.
456.9 Contingent funding must not exceed
456.10 $18,814,000 for the biennium.

456.11 **Base Adjustment.** The general fund base is
456.12 increased by $6,813,000 in fiscal year 2016
456.13 and $2,672,000 in fiscal year 2017.

456.14 **(b) Children and Families**

456.15 Appropriations by Fund

456.16 General	7,967,000	7,910,000
456.17 Federal TANF	2,282,000	2,282,000

456.18 **Reform 2020 Contingency.** The
456.19 appropriation from the general fund may be
456.20 adjusted as provided in article 2, section 49,
456.21 in order to implement Reform 2020.

456.22 **Financial Institution Data Match and**
456.23 **Payment of Fees.** The commissioner is
456.24 authorized to allocate up to $310,000 each
456.25 year in fiscal years 2014 and 2015 from the
456.26 PRISM special revenue account to make
456.27 payments to financial institutions in exchange
456.28 for performing data matches between account
456.29 information held by financial institutions
456.30 and the public authority's database of child
456.31 support obligors as authorized by Minnesota
456.32 Statutes, section 13B.06, subdivision 7.

456.33 **Base Adjustment.** The general fund base
456.34 is decreased by $94,000 in fiscal years 2016
456.35 and 2017, and the federal TANF fund base is

457.1 increased by $300,000 in fiscal years 2016
457.2 and 2017.

457.3 **(c) Health Care**

457.4	Appropriations by Fund		
457.5	General	13,817,000	13,530,000
457.6	Health Care Access	24,602,000	22,634,000

457.7 **Base Adjustment.** The health care access
457.8 fund base is increased by $1,842,000 in fiscal
457.9 year 2016.

457.10 **(d) Continuing Care**

457.11	Appropriations by Fund		
457.12	General	19,414,000	20,769,000
457.13 457.14	State Government Special Revenue	125,000	125,000

457.15 **Reform 2020 Contingency.** The
457.16 appropriation from the general fund may be
457.17 adjusted as provided in article 2, section 49,
457.18 in order to implement Reform 2020.

457.19 **Base Adjustment.** The general fund base is
457.20 increased by $9,207,000 in fiscal year 2016
457.21 and by $9,182,000 in fiscal year 2017.

457.22 **(e) Chemical and Mental Health**

457.23	Appropriations by Fund		
457.24	General	4,482,000	4,282,000
457.25	Lottery Prize Fund	157,000	157,000

457.26 Subd. 5. **Forecasted Programs**

457.27 The amounts that may be spent from this
457.28 appropriation for each purpose are as follows:

457.29 **(a) MFIP/DWP**

457.30	Appropriations by Fund		
457.31	General	77,783,000	75,831,000
457.32	Federal TANF	77,846,000	78,452,000

457.33 **(b) MFIP Child Care Assistance** 58,771,000 63,383,000

458.1 **(c) General Assistance**	54,259,000	55,566,000

458.2 **General Assistance Standard.** The
458.3 commissioner shall set the monthly standard
458.4 of assistance for general assistance units
458.5 consisting of an adult recipient who is
458.6 childless and unmarried or living apart
458.7 from parents or a legal guardian at $203.
458.8 The commissioner may reduce this amount
458.9 according to Laws 1997, chapter 85, article
458.10 3, section 54.

458.11 **Emergency General Assistance.** The
458.12 amount appropriated for emergency general
458.13 assistance funds is limited to no more
458.14 than $6,729,812 in fiscal year 2014 and
458.15 $6,729,812 in fiscal year 2015. Funds
458.16 to counties shall be allocated by the
458.17 commissioner using the allocation method in
458.18 Minnesota Statutes, section 256D.06.

458.19 **(d) MN Supplemental Assistance**	38,642,000	39,814,000
458.20 **(e) Group Residential Housing**	138,614,000	148,515,000

458.21 **Reform 2020 Contingency.** The
458.22 appropriation from the general fund may be
458.23 adjusted as provided in article 2, section 49,
458.24 in order to implement Reform 2020.

458.25 **(f) MinnesotaCare**

458.26 Health Care Access	233,186,000	38,928,000

458.27 **Health Care Access Fund Reserve for**
458.28 **Demonstration Waiver.** In fiscal year 2015,
458.29 a reserve of $300,223,000 is created in the
458.30 health care access fund for purposes of article
458.31 1, section 2.

458.32 **(g) Medical Assistance**

459.1 Appropriations by Fund

General	4,362,916,000	4,676,238,000
Health Care Access	318,811,000	143,813,000

459.4 **Reform 2020 Contingency.** The
459.5 appropriation from the general fund may be
459.6 adjusted as provided in article 2, section 49,
459.7 in order to implement Reform 2020.

459.8 **(h) Alternative Care** 46,452,000 44,650,000

459.9 **Reform 2020 Contingency.** The
459.10 appropriation from the general fund may be
459.11 adjusted as provided in article 2, section 49,
459.12 in order to implement Reform 2020.

459.13 **Alternative Care Transfer.** Any money
459.14 allocated to the alternative care program that
459.15 is not spent for the purposes indicated does
459.16 not cancel but shall be transferred to the
459.17 medical assistance account.

459.18 **(i) CD Treatment Fund** 79,807,000 81,169,000

459.19 **Balance Transfer.** The commissioner must
459.20 transfer $18,188,000 from the consolidated
459.21 chemical dependency treatment fund to the
459.22 general fund by September 30, 2013.

459.23 Subd. 6. **Grant Programs**

459.24 The amounts that may be spent from this
459.25 appropriation for each purpose are as follows:

459.26 **(a) Support Services Grants**

459.27 Appropriations by Fund

General	9,833,000	11,633,000
Federal TANF	98,111,000	96,311,000

459.30 **Paid Work Experience.** $668,000 each year
459.31 is from the general fund, and $1,500,000
459.32 each year is from the federal TANF fund,
459.33 for paid work experience for long-term

460.1 MFIP recipients. Paid work includes full
460.2 and partial wage subsidies and other related
460.3 services such as job development, marketing,
460.4 preworksite training, job coaching, and
460.5 postplacement services. These are onetime
460.6 appropriations. Unexpended funds for fiscal
460.7 year 2014 do not cancel but are available to
460.8 the commissioner for this purpose in fiscal
460.9 year 2015.

460.10 **Work Study Funding for MFIP**
460.11 **Participants.** $250,000 each year is from
460.12 the general fund to pilot work study jobs for
460.13 MFIP recipients in approved postsecondary
460.14 education programs. This is a onetime
460.15 appropriation. Unexpended funds for fiscal
460.16 year 2014 do not cancel but are available for
460.17 this purpose in fiscal year 2015.

460.18 **Local Strategies to Reduce Disparities.**
460.19 $2,000,000 in fiscal year 2014 is from the
460.20 federal TANF fund, and $2,000,000 in
460.21 fiscal year 2015 is from the general fund,
460.22 for local projects that focus on services
460.23 for subgroups within the MFIP caseload
460.24 who are experiencing poor employment
460.25 outcomes. These are onetime appropriations.
460.26 Unexpended funds for fiscal year 2014 do not
460.27 cancel but are available to the commissioner
460.28 for this purpose in fiscal year 2015.

460.29 **Home Visiting Collaborations for MFIP**
460.30 **Teen Parents.** $200,000 in fiscal year 2014
460.31 is from the general fund, and $200,000 in
460.32 fiscal year 2015 is from the federal TANF
460.33 fund, for technical assistance and training
460.34 to support local collaborations that provide
460.35 home visiting services for MFIP teen parents.

461.1 The general fund appropriation is onetime.
461.2 The federal TANF fund appropriation is
461.3 added to the base.

461.4 **Performance Bonus Funds for Counties.**
461.5 The TANF fund base is increased by
461.6 $1,500,000 each year in fiscal years 2016
461.7 and 2017. The commissioner must allocate
461.8 this amount each year to counties that exceed
461.9 their expected range of performance on the
461.10 annualized three-year self-support index
461.11 as defined in Minnesota Statutes, section
461.12 256J.751, subdivision 2, clause (6). This is a
461.13 permanent base adjustment. Notwithstanding
461.14 any contrary provisions in this article, this
461.15 provision expires June 30, 2016.

461.16 **Base Adjustment.** The general fund base is
461.17 decreased by $2,918,000 in fiscal years 2016
461.18 and 2017.

461.19 **(b) Basic Sliding Fee Child Care Assistance** 461.20 **Grants**	39,900,000	42,894,000

461.21 **Base Adjustment.** The general fund base is
461.22 increased by $1,442,000 in fiscal year 2016
461.23 and by $1,552,000 in fiscal year 2017.

461.24 **(c) Child Care Development Grants**	1,737,000	1,987,000
461.25 **(d) Child Support Enforcement Grants**	50,000	50,000

461.26 **Federal Child Support Demonstration**
461.27 **Grants.** Federal administrative
461.28 reimbursement resulting from the federal
461.29 child support grant expenditures authorized
461.30 under United States Code, title 42, section
461.31 1315, is appropriated to the commissioner
461.32 for this activity.

461.33 **(e) Children's Services Grants**

462.1 Appropriations by Fund

462.2 General	49,688,000	52,337,000
462.3 Federal TANF	140,000	140,000

462.4 **Adoption Assistance and Relative Custody**
462.5 **Assistance.** The commissioner may transfer
462.6 unencumbered appropriation balances for
462.7 adoption assistance and relative custody
462.8 assistance between fiscal years and between
462.9 programs.

462.10 **Privatized Adoption Grants.** Federal
462.11 reimbursement for privatized adoption grant
462.12 and foster care recruitment grant expenditures
462.13 is appropriated to the commissioner for
462.14 adoption grants and foster care and adoption
462.15 administrative purposes.

462.16 **Adoption Assistance Incentive Grants.**
462.17 Federal funds available during fiscal years
462.18 2014 and 2015 for adoption incentive grants
462.19 are appropriated to the commissioner for
462.20 these purposes.

462.21 **Base Adjustment.** The general fund base is
462.22 increased by $5,139,000 in fiscal year 2016
462.23 and by $9,155,000 in fiscal year 2017.

462.24 **(f) Child and Community Service Grants**	53,301,000	53,301,000

462.25 **Reform 2020 Contingency.** The
462.26 appropriation from the general fund may be
462.27 adjusted as provided in article 2, section 49,
462.28 in order to implement Reform 2020.

462.29 **Base Adjustment.** The general fund base is
462.30 increased by $3,000,000 in fiscal years 2016
462.31 and 2017.

462.32 **(g) Child and Economic Support Grants**	16,222,000	16,223,000

462.33 **Minnesota Food Assistance Program.**
462.34 Unexpended funds for the Minnesota food

463.1 assistance program for fiscal year 2014 do
463.2 not cancel but are available for this purpose
463.3 in fiscal year 2015.

463.4 **(h) Health Care Grants**

463.5	Appropriations by Fund		
463.6	General	90,000	90,000
463.7	Health Care Access	190,000	190,000

463.8	**(i) Aging and Adult Services Grants**	22,143,000	23,009,000

463.9 **Reform 2020 Contingency.** The
463.10 appropriation from the general fund may be
463.11 adjusted as provided in article 2, section 49,
463.12 in order to implement Reform 2020.

463.13 **Gaps Analysis.** In fiscal year 2014, and
463.14 in each even-numbered year thereafter,
463.15 $435,000 is appropriated to conduct an
463.16 analysis of gaps in long-term care services
463.17 under Minnesota Statutes, section 144A.351.
463.18 This is a biennial appropriation. The base is
463.19 increased by $435,000 in fiscal year 2016.
463.20 Notwithstanding any contrary provisions in
463.21 this article, this provision does not expire.

463.22 **Base Adjustment.** The general fund base is
463.23 increased by $3,501,000 in fiscal year 2016
463.24 and by $3,128,000 in fiscal year 2017.

463.25	**(j) Deaf and Hard-of-Hearing Grants**	1,767,000	1,767,000
463.26	**(k) Disabilities Grants**	17,895,000	18,271,000

463.27 **Reform 2020 Contingency.** The
463.28 appropriation from the general fund may be
463.29 adjusted as provided in article 2, section 49,
463.30 in order to implement Reform 2020.

463.31 **Base Adjustment.** The general fund base is
463.32 increased by $1,016,000 in fiscal year 2016
463.33 and by $1,190,000 in fiscal year 2017.

464.1 **(l) Adult Mental Health Grants**

464.2	Appropriations by Fund		
464.3	General	70,617,000	68,310,000
464.4	Health Care Access	750,000	750,000
464.5	Lottery Prize	1,508,000	1,508,000

464.6 **Funding Usage.** Up to 75 percent of a fiscal
464.7 year's appropriations for adult mental health
464.8 grants may be used to fund allocations in that
464.9 portion of the fiscal year ending December
464.10 31.

464.11 **Base Adjustment.** The general fund base is
464.12 decreased by $5,802,000 in fiscal years 2016
464.13 and 2017.

464.14 **(m) Child Mental Health Grants** 17,599,000 19,988,000

464.15 **Funding Usage.** Up to 75 percent of a fiscal
464.16 year's appropriation for child mental health
464.17 grants may be used to fund allocations in that
464.18 portion of the fiscal year ending December
464.19 31.

464.20 **(n) CD Treatment Support Grants** 1,636,000 1,636,000

464.21 **SBIRT Training.** $300,000 each year is
464.22 for grants to train primary care clinicians to
464.23 provide substance abuse brief intervention
464.24 and referral to treatment (SBIRT). This is a
464.25 onetime appropriation.

464.26 **Base Adjustment.** The general fund base is
464.27 decreased by $300,000 in fiscal years 2016
464.28 and 2017.

464.29 Subd. 7. **State-Operated Services** 185,420,000 185,420,000

464.30 **Transfer Authority Related to**
464.31 **State-Operated Services.** Money
464.32 appropriated for state-operated services
464.33 may be transferred between fiscal years

465.1 of the biennium with the approval of the
465.2 commissioner of management and budget.

465.3 The amounts that may be spent from the
465.4 appropriation for each purpose are as follows:

465.5 **(a) SOS Mental Health**	115,838,000	115,838,000

465.6 **Dedicated Receipts Available.** Of the
465.7 revenue received under Minnesota Statutes,
465.8 section 246.18, subdivision 8, paragraph
465.9 (a), $2,000,000 each year is available for
465.10 the purposes of paragraph (b), clause (1), of
465.11 that subdivision, and $1,000,000 each year
465.12 is available to transfer to the adult mental
465.13 health budget activity for the purposes of
465.14 paragraph (b), clause (2), of that subdivision.

465.15 **(b) SOS MN Security Hospital**	69,582,000	69,582,000
465.16 Subd. 8. **Sex Offender Program**	76,769,000	79,745,000

465.17 **Transfer Authority Related to Minnesota**
465.18 **Sex Offender Program.** Money
465.19 appropriated for the Minnesota sex offender
465.20 program may be transferred between fiscal
465.21 years of the biennium with the approval of the
465.22 commissioner of management and budget.

465.23 Subd. 9. **Technical Activities**	79,340,000	79,429,000

465.24 This appropriation is from the federal TANF
465.25 fund.

465.26 **Base Adjustment.** The federal TANF fund
465.27 base is decreased by $22,000 in fiscal year
465.28 2016 and by $49,000 in fiscal year 2017.

465.29 Sec. 4. **COMMISSIONER OF HEALTH**

465.30 Subdivision 1. **Total Appropriation**	**$**	**170,327,000**	**$**	**165,095,000**

465.31 Appropriations by Fund

	2014	2015
465.32		
465.33 General	77,857,000	72,664,000

466.1 State Government 466.2 Special Revenue	49,515,000	50,076,000
466.3 Health Care Access	31,242,000	30,642,000
466.4 Federal TANF	11,713,000	11,713,000

466.5 The amounts that may be spent for each
466.6 purpose are specified in the following
466.7 subdivisions.

466.8 Subd 2. **Health Improvement**

466.9	Appropriations by Fund	
466.10 General	51,245,000	46,052,000
466.11 State Government 466.12 Special Revenue	1,033,000	1,033,000
466.13 Health Care Access	21,719,000	21,719,000
466.14 Federal TANF	11,713,000	11,713,000

466.15 **Statewide Health Improvement Program.**
466.16 $20,000,000 in fiscal year 2014 and
466.17 $20,000,000 in fiscal year 2015 are
466.18 appropriated from the health care access
466.19 fund for the statewide health improvement
466.20 program under Minnesota Statutes, section
466.21 145.986.

466.22 **Statewide Cancer Surveillance System.**
466.23 Of the general fund appropriation, $350,000
466.24 in fiscal year 2014 and $350,000 in fiscal
466.25 year 2015 are appropriated to develop and
466.26 implement a new cancer reporting system
466.27 under Minnesota Statutes, sections 144.671
466.28 to 144.69. Any information technology
466.29 development or support costs necessary
466.30 for the cancer surveillance system must
466.31 be incorporated into the agency's service
466.32 level agreement and paid to the Office of
466.33 Enterprise Technology.

466.34 **TANF Appropriations.** (1) $1,156,000 of
466.35 the TANF funds is appropriated each year of
466.36 the biennium to the commissioner for family

467.1 planning grants under Minnesota Statutes,
467.2 section 145.925.

467.3 (2) $3,579,000 of the TANF funds is
467.4 appropriated each year of the biennium to
467.5 the commissioner for home visiting and
467.6 nutritional services listed under Minnesota
467.7 Statutes, section 145.882, subdivision 7,
467.8 clauses (6) and (7). Funds must be distributed
467.9 to community health boards according to
467.10 Minnesota Statutes, section 145A.131,
467.11 subdivision 1.

467.12 (3) $2,000,000 of the TANF funds is
467.13 appropriated each year of the biennium to
467.14 the commissioner for decreasing racial and
467.15 ethnic disparities in infant mortality rates
467.16 under Minnesota Statutes, section 145.928,
467.17 subdivision 7.

467.18 (4) $4,978,000 of the TANF funds is
467.19 appropriated each year of the biennium to the
467.20 commissioner for the family home visiting
467.21 grant program according to Minnesota
467.22 Statutes, section 145A.17. $4,000,000 of the
467.23 funding must be distributed to community
467.24 health boards according to Minnesota
467.25 Statutes, section 145A.131, subdivision 1.
467.26 $978,000 of the funding must be distributed
467.27 to tribal governments based on Minnesota
467.28 Statutes, section 145A.14, subdivision 2a.

467.29 (5) The commissioner may use up to 6.23
467.30 percent of the funds appropriated each fiscal
467.31 year to conduct the ongoing evaluations
467.32 required under Minnesota Statutes, section
467.33 145A.17, subdivision 7, and training and
467.34 technical assistance as required under

468.1 Minnesota Statutes, section 145A.17,
468.2 subdivisions 4 and 5.

468.3 **TANF Carryforward.** Any unexpended
468.4 balance of the TANF appropriation in the
468.5 first year of the biennium does not cancel but
468.6 is available for the second year.

468.7 Subd. 3. **Policy Quality and Compliance**

	Appropriations by Fund	
468.9 General	9,391,000	9,391,000
468.10 State Government 468.11 Special Revenue	15,849,000	16,407,000
468.12 Health Care Access	9,523,000	8,923,000

468.13 **Base Level Adjustment.** The state
468.14 government special revenue fund base shall
468.15 be reduced by $20,000 in fiscal years 2016
468.16 and 2017. The health care access base shall
468.17 be increased by $600,000 in fiscal year 2015.

468.18 Subd. 4. **Health Protection**

	Appropriations by Fund	
468.20 General	9,449,000	9,449,000
468.21 State Government 468.22 Special Revenue	32,633,000	32,636,000

468.23 **Infectious Disease Laboratory.** Of the
468.24 general fund appropriation, $200,000 in
468.25 fiscal year 2014 and $200,000 in fiscal year
468.26 2015 are appropriated to the commissioner
468.27 to monitor infectious disease trends and
468.28 investigate infectious disease outbreaks.

468.29 **Surveillance for Elevated Blood Lead**
468.30 **Levels.** Of the general fund appropriation,
468.31 $100,000 in fiscal year 2014 and $100,000
468.32 in fiscal year 2015 are appropriated to the
468.33 commissioner for the blood lead surveillance
468.34 system under Minnesota Statutes, section
468.35 144.9502.

469.1 **Base Level Adjustment.** The state
469.2 government special revenue base is increased
469.3 by $6,000 in fiscal year 2016 and by $27,000
469.4 in fiscal year 2017.

469.5 Subd. 5. **Administrative Support Services**	7,772,000	7,772,000

469.6 **Regional Support for Local Public Health**
469.7 **Departments.** $350,000 in fiscal year
469.8 2014 and $350,000 in fiscal year 2015
469.9 are appropriated to the commissioner for
469.10 regional staff who provide specialized
469.11 expertise to local public health departments.

469.12 Sec. 5. **HEALTH-RELATED BOARDS**

469.13 Subdivision 1. **Total Appropriation**	**$ 16,728,000**	**$ 16,678,000**

469.14 This appropriation is from the state
469.15 government special revenue fund. The
469.16 amounts that may be spent for each purpose
469.17 are specified in the following subdivisions.

469.18 Subd. 2.**Board of Chiropractic Examiners**	470,000	470,000
469.19 Subd. 3. **Board of Dentistry**	1,820,000	1,820,000

469.20 **Health Professional Services Program.** Of
469.21 this appropriation, $704,000 in fiscal year
469.22 2014 and $704,000 in fiscal year 2015 from
469.23 the state government special revenue fund are
469.24 for the health professional services program.

469.25 Subd. 4. **Board of Dietetic and Nutrition** 469.26 **Practice**	111,000	111,000
469.27 Subd. 5. **Board of Marriage and Family** 469.28 **Therapy**	168,000	168,000
469.29 Subd. 6. **Board of Medical Practice**	3,867,000	3,867,000
469.30 Subd. 7. **Board of Nursing**	3,637,000	3,637,000
469.31 Subd. 8. **Board of Nursing Home** 469.32 **Administrators**	1,235,000	1,185,000

470.1 **Administrative Services Unit - Operating**
470.2 **Costs.** Of this appropriation, $676,000
470.3 in fiscal year 2014 and $626,000 in
470.4 fiscal year 2015 are for operating costs
470.5 of the administrative services unit. The
470.6 administrative services unit may receive
470.7 and expend reimbursements for services
470.8 performed by other agencies.

470.9 **Administrative Services Unit - Volunteer**
470.10 **Health Care Provider Program.** Of this
470.11 appropriation, $150,000 in fiscal year 2014
470.12 and $150,000 in fiscal year 2015 are to pay
470.13 for medical professional liability coverage
470.14 required under Minnesota Statutes, section
470.15 214.40.

470.16 **Administrative Services Unit - Contested**
470.17 **Cases and Other Legal Proceedings.** Of
470.18 this appropriation, $200,000 in fiscal year
470.19 2014 and $200,000 in fiscal year 2015 are
470.20 for costs of contested case hearings and other
470.21 unanticipated costs of legal proceedings
470.22 involving health-related boards funded
470.23 under this section. Upon certification of a
470.24 health-related board to the administrative
470.25 services unit that the costs will be incurred
470.26 and that there is insufficient money available
470.27 to pay for the costs out of money currently
470.28 available to that board, the administrative
470.29 services unit is authorized to transfer money
470.30 from this appropriation to the board for
470.31 payment of those costs with the approval
470.32 of the commissioner of management and
470.33 budget. This appropriation does not cancel.
470.34 Any unencumbered and unspent balances
470.35 remain available for these expenditures in
470.36 subsequent fiscal years.

471.1 Subd. 9. **Board of Optometry**	107,000	107,000
471.2 Subd. 10. **Board of Pharmacy**	2,345,000	2,345,000

471.3 **Prescription Electronic Reporting.** Of
471.4 this appropriation, $356,000 in fiscal year
471.5 2014 and $356,000 in fiscal year 2015 from
471.6 the state government special revenue fund
471.7 are to the board to operate the prescription
471.8 electronic reporting system in Minnesota
471.9 Statutes, section 152.126.

471.10 Subd. 11. **Board of Physical Therapy**	346,000	346,000
471.11 Subd. 12. **Board of Podiatry**	76,000	76,000
471.12 Subd. 13. **Board of Psychology**	847,000	847,000
471.13 Subd. 14. **Board of Social Work**	1,054,000	1,054,000
471.14 Subd. 15. **Board of Veterinary Medicine**	230,000	230,000
471.15 Subd. 16. **Board of Behavioral Health and** 471.16 **Therapy**	415,000	415,000

471.17 Sec. 6. **EMERGENCY MEDICAL SERVICES** 471.18 **REGULATORY BOARD**	**$ 2,741,000**	**$ 2,741,000**

471.19 **Regional Grants.** $585,000 in fiscal year
471.20 2014 and $585,000 in fiscal year 2015 are
471.21 for regional emergency medical services
471.22 programs, to be distributed equally to the
471.23 eight emergency medical service regions.

471.24 **Cooper/Sams Volunteer Ambulance**
471.25 **Program.** $700,000 in fiscal year 2014 and
471.26 $700,000 in fiscal year 2015 are for the
471.27 Cooper/Sams volunteer ambulance program
471.28 under Minnesota Statutes, section 144E.40.

471.29 (a) Of this amount, $611,000 in fiscal year
471.30 2014 and $611,000 in fiscal year 2015
471.31 are for the ambulance service personnel

472.1 longevity award and incentive program under
472.2 Minnesota Statutes, section 144E.40.

472.3 (b) Of this amount, $89,000 in fiscal year
472.4 2014 and $89,000 in fiscal year 2015 are
472.5 for the operations of the ambulance service
472.6 personnel longevity award and incentive
472.7 program under Minnesota Statutes, section
472.8 144E.40.

472.9 **Ambulance Training Grant.** $361,000 in
472.10 fiscal year 2014 and $361,000 in fiscal year
472.11 2015 are for training grants.

472.12 **EMSRB Board Operations.** $1,095,000 in
472.13 fiscal year 2014 and $1,095,000 in fiscal year
472.14 2015 are for operations.

Line	Section				
472.15–472.16	Sec. 7. **NURSING HOME ADMINISTRATORS BOARD**	**$**	**10,000**	**$**	**10,000**
472.17	Sec. 8. **COUNCIL ON DISABILITY**	**$**	**614,000**	**$**	**614,000**
472.18–472.20	Sec. 9. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$**	**1,654,000**	**$**	**1,654,000**
472.21	Sec. 10. **OMBUDSPERSON FOR FAMILIES**	**$**	**333,000**	**$**	**334,000**

472.22 Sec. 11. Minnesota Statutes 2012, section 256.01, subdivision 34, is amended to read:
472.23 Subd. 34. **Federal administrative reimbursement dedicated.** Federal
472.24 administrative reimbursement resulting from the following activities is appropriated to the
472.25 commissioner for the designated purposes:
472.26 (1) reimbursement for the Minnesota senior health options project; ~~and~~
472.27 (2) reimbursement related to prior authorization and inpatient admission certification
472.28 by a professional review organization. A portion of these funds must be used for activities
472.29 to decrease unnecessary pharmaceutical costs in medical assistance~~.~~; and
472.30 (3) reimbursement resulting from the federal child support grant expenditures
472.31 authorized under United States Code, title 42, section 1315.

473.1 Sec. 12. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
473.2 to read:

473.3 Subd. 35. **Federal reimbursement for privatized adoption grants.** Federal
473.4 reimbursement for privatized adoption grant and foster care recruitment grant expenditures
473.5 is appropriated to the commissioner for adoption grants and foster care and adoption
473.6 administrative purposes.

473.7 Sec. 13. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
473.8 to read:

473.9 Subd. 36. **DHS receipt center accounting.** The commissioner may transfer
473.10 appropriations to, and account for DHS receipt center operations in, the special revenue
473.11 fund.

473.12 Sec. 14. **TRANSFERS.**

473.13 Subdivision 1. **Grants.** The commissioner of human services, with the approval of
473.14 the commissioner of management and budget, may transfer unencumbered appropriation
473.15 balances for the biennium ending June 30, 2015, within fiscal years among the MFIP,
473.16 general assistance, general assistance medical care under Minnesota Statutes 2009
473.17 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP
473.18 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental
473.19 aid, group residential housing programs, the entitlement portion of the chemical
473.20 dependency consolidated treatment fund, and between fiscal years of the biennium. The
473.21 commissioner shall inform the chairs and ranking minority members of the senate Health
473.22 and Human Services Finance Division and the house of representatives Health and Human
473.23 Services Finance Committee quarterly about transfers made under this provision.

473.24 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
473.25 money may be transferred within the Departments of Human Services and Health as the
473.26 commissioners consider necessary, with the advance approval of the commissioner of
473.27 management and budget. The commissioner shall inform the chairs and ranking minority
473.28 members of the senate Health and Human Services Finance Division and the house of
473.29 representatives Health and Human Services Finance Committee quarterly about transfers
473.30 made under this provision.

473.31 Sec. 15. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

473.32 The commissioners of health and human services shall not use indirect cost
473.33 allocations to pay for the operational costs of any program for which they are responsible.

474.1 Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

474.2 All uncodified language contained in this article expires on June 30, 2015, unless a
474.3 different expiration date is explicit.

474.4 Sec. 17. **EFFECTIVE DATE.**

474.5 This article is effective July 1, 2013, unless a different effective date is specified.

APPENDIX
Article locations in 13-0169

ARTICLE 1	AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH CARE FOR MORE MINNESOTANS	Page.Ln 2.49
ARTICLE 2	REFORM 2020; REDESIGNING HOME AND COMMUNITY-BASED SERVICES	Page.Ln 21.24
ARTICLE 3	SAFE AND HEALTHY DEVELOPMENT OF CHILDREN	Page.Ln 88.10
ARTICLE 4	STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES	Page.Ln 168.2
ARTICLE 5	DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY	Page.Ln 171.17
ARTICLE 6	2013 MANAGED CARE ORGANIZATIONS RATE CONFORMITY	Page.Ln 186.23
ARTICLE 7	HEALTH CARE	Page.Ln 196.24
ARTICLE 8	CONTINUING CARE	Page.Ln 203.21
ARTICLE 9	WAIVER PROVIDER STANDARDS	Page.Ln 227.24
ARTICLE 10	WAIVER PROVIDER STANDARDS TECHNICAL CHANGES	Page.Ln 322.27
ARTICLE 11	MISCELLANEOUS	Page.Ln 340.15
ARTICLE 12	HOME CARE PROVIDERS	Page.Ln 349.17
ARTICLE 13	HEALTH DEPARTMENT	Page.Ln 409.13
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103I.005 DEFINITIONS.

Subd. 20. **Vertical heat exchanger.** "Vertical heat exchanger" means an earth-coupled heating or cooling device consisting of a sealed closed-loop piping system installed vertically in the ground to transfer heat to or from the surrounding earth with no discharge.

144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES; EXCEPTIONS.

Subd. 2. **Fee amounts.** The commissioner of health shall charge a handling fee prescribed in subdivision 1. The fee shall approximate the costs to the department of handling specimens including reporting, postage, specimen kit preparation, and overhead costs. The fee prescribed in subdivision 1 shall be $25 per specimen.

144A.46 LICENSURE.

Subdivision 1. **License required.** (a) A home care provider may not operate in the state without a current license issued by the commissioner of health. A home care provider may hold a separate license for each class of home care licensure.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122 and information sufficient to show that the applicant meets the requirements of licensure.

Subd. 2. **Exemptions.** The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) a person who is licensed as a registered nurse under sections 148.171 to 148.285 and who independently provides nursing services in the home without any contractual or employment relationship to a home care provider or other organization;

(2) a personal care assistant who provides services to only one individual under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16;

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

(4) a person who is licensed under sections 148.65 to 148.78 and who independently provides physical therapy services in the home without any contractual or employment relationship to a home care provider or other organization;

(5) a provider that is licensed by the commissioner of human services to provide semi-independent living services under Minnesota Rules, parts 9525.0500 to 9525.0660 when providing home care services to a person with a developmental disability;

(6) a provider that is licensed by the commissioner of human services to provide home and community-based services under Minnesota Rules, parts 9525.2000 to 9525.2140 when providing home care services to a person with a developmental disability;

(7) a person or organization that provides only home management services, if the person or organization is registered under section 144A.461; or

(8) a person who is licensed as a social worker under chapter 148D and who provides social work services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

An exemption under this subdivision does not excuse the individual from complying with applicable provisions of the home care bill of rights.

Subd. 3. **Enforcement.** (a) The commissioner may refuse to grant or renew a license, may suspend or revoke a license, or may impose a conditional license for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of the consumer. A suspension may include terms that must be completed before a suspension is lifted. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

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

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

(3) requiring the provider or the provider's employees to obtain training at the cost of the provider;

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

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

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

(b) Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 60 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided: (1) advance notice is given to the provider; (2) after notice, the provider fails to correct the problem; (3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and (4) there is an opportunity for a contested case hearing within the 60 days.

(c) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information: (1) a list of all clients, including full names and all contact information on file; (2) a list of each client's contact person, including full names and all contact information on file; (3) the location of each client; (4) the payor sources for each client, including payor source identification numbers; and (5) for each client, a copy of the client's service agreement, and a list of the types of services being provided. The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the provider must notify and disclose to each of the provider's clients, or the client's contact persons, that the commissioner is taking action against the provider's license by providing a copy of the revocation or suspension notice issued by the commissioner. When the home care provider voluntarily discontinues services, the provider will notify the commissioner, lead agencies, and the ombudsman for long-term care about its clients as required in this section.

(d) The owner and managerial officials, as defined in the home care licensure rules, Minnesota Rules, chapter 4668, of a home care provider whose Minnesota license has not been renewed or has been revoked because of noncompliance with applicable law or rule shall not be eligible to apply for nor will be granted a home care license, including other licenses in this chapter, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services pursuant to section 256B.0659 for five years following the effective date of the nonrenewal or revocation. If the owner and managerial officials already have enrollment status, their enrollment will be terminated by the Department of Human Services.

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

(f) Notwithstanding the provisions of paragraph (a), the commissioner shall not renew, or shall suspend or revoke the license of any home care provider which includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (d) for five years following the effective date of the nonrenewal or revocation. The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of this notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted

in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

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

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

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

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

(g) The provisions contained in paragraphs (d) and (e) shall apply to any nonrenewal or revocation of a home care license occurring after June 1, 1993, the effective date of the home care licensure rules.

(h) For the purposes of this subdivision, owners of a home care provider are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this subdivision, managerial officials are those individuals who had the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider relating to the areas of noncompliance which led to the license revocation or nonrenewal.

Subd. 3a. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a home care provider, or an employee of the home care provider from illegally engaging in activities regulated by sections 144A.43 to 144A.47. The commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which a home care provider is providing services. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a home care provider, or by an employee of the home care provider, would create an imminent risk of harm to a recipient of home care services.

Subd. 3b. **Subpoena.** In matters pending before the commissioner under sections 144A.43 to 144A.47, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district, and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner of health may administer oaths to witnesses, or take their affirmation. Depositions may be taken in or outside the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon a named person anywhere within the state by an officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for process issued out of a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

Subd. 3c. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144A.45, subdivision 2, clause (4), a denial of a waiver or variance, and an action against a license under subdivision 3, a provider must request a hearing no later than 15 days after the provider receives notice of the action.

Subd. 4. **Relation to other regulatory programs.** In the exercise of the authority granted under sections 144A.43 to 144A.47, the commissioner shall not duplicate or replace standards and requirements imposed under another state regulatory program. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of services in the home or to enforce and protect the rights of consumers listed in section 144A.44. The commissioner of health shall not require a home care provider certified under the Medicare program to comply with a rule adopted under section 144A.45 if the home care provider is required to comply with any equivalent federal law or regulation relating to the

same subject matter. The commissioner of health shall specify in the rules those provisions that are not applicable to certified home care providers. To the extent possible, the commissioner shall coordinate the inspections required under sections 144A.45 to 144A.47 with the health facility licensure inspections required under sections 144.50 to 144.58 or 144A.10 when the health care facility is also licensed under the provisions of Laws 1987, chapter 378.

Subd. 5. **Prior criminal convictions.** (a) Before the commissioner issues an initial or renewal license, an owner or managerial official shall be required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a provider, if the person has been disqualified under the provisions of chapter 245C. Individuals disqualified under these provisions can request a reconsideration, and if the disqualification is set aside are then eligible to be involved in the management, operation or control of the provider. For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this section, managerial officials subject to the background check requirement are those individuals who provide "direct contact" as defined in section 245C.02, subdivision 11, or those individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data under section 13.02, subdivision 12.

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

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

144A.461 REGISTRATION.

A person or organization that provides only home management services defined as home care services under section 144A.43, subdivision 3, clause (8), may not operate in the state without a current certificate of registration issued by the commissioner of health. To obtain a certificate of registration, the person or organization must annually submit to the commissioner the name, address, and telephone number of the person or organization and a signed statement declaring that the person or organization is aware that the home care bill of rights applies to their clients and that the person or organization will comply with the bill of rights provisions contained in section 144A.44. A person who provides home management services under this section must, within 120 days after beginning to provide services, attend an orientation session approved by the commissioner that provides training on the bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons. An organization applying for a certificate must also provide the name, business address, and telephone number of each of the individuals responsible for the management or direction of the organization. The commissioner shall charge an annual registration fee of $20 for individuals and $50 for organizations. A home care provider that provides home management services and other home care services must be licensed, but licensure requirements other than the home care bill of rights do not apply to those employees or volunteers who provide only home management services to clients who do not receive any other home care services from the provider. A licensed home care provider need not be registered as a home management service provider, but must provide an orientation on the home care bill of rights to its employees or volunteers who provide home management services. The commissioner may suspend or revoke a provider's certificate of registration or assess fines for violation of the home care bill of rights. Any fine assessed for a violation of the bill of rights by a provider registered under this section shall be in the amount established in the licensure rules for home care providers. As a condition of registration, a provider must cooperate fully with any investigation conducted by the commissioner, including providing specific information requested by the commissioner on clients served and the employees and volunteers who provide services. The commissioner may use any of the powers granted in sections 144A.43 to 144A.47 to administer the registration system and enforce the home care bill of rights under this section.

149A.025 ALKALINE HYDROLYSIS.

For purposes of this chapter, the disposal of a dead human body through the process of alkaline hydrolysis shall be subject to the same licensing requirements and regulations that apply to cremation, crematories, and cremated remains as described in this chapter. The licensing requirements and regulations of this chapter shall also apply to the entities where the process of alkaline hydrolysis occurs and to the remains that result from the alkaline hydrolysis process.

149A.20 LICENSE TO PRACTICE MORTUARY SCIENCE.

Subd. 8. **Fees.** Fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.30 RECIPROCAL LICENSING.

Subd. 2. **Fees.** Fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.40 RENEWAL OF LICENSE TO PRACTICE MORTUARY SCIENCE.

Subd. 8. **Renewal fees.** The renewal fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.45 EMERITUS REGISTRATION FOR MORTUARY SCIENCE PRACTITIONERS.

Subd. 6. **Fees.** The renewal fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

149A.50 LICENSE TO OPERATE A FUNERAL ESTABLISHMENT.

Subd. 6. **Initial licensure and inspection fees.** The licensure and inspection fees shall be paid to the commissioner of management and budget, state of Minnesota, to the credit of the state government special revenue fund in the state treasury.

149A.51 RENEWAL OF LICENSE TO OPERATE A FUNERAL ESTABLISHMENT.

Subd. 7. **Renewal and reinspection fees.** The renewal and reinspection fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.52 LICENSE TO OPERATE A CREMATORY.

Subd. 5a. **Initial licensure and inspection fees.** The licensure and inspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

149A.53 RENEWAL OF LICENSE TO OPERATE CREMATORY.

Subd. 9. **Renewal and reinspection fees.** The renewal and reinspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

245A.655 FEDERAL GRANTS TO ESTABLISH AND MAINTAIN A SINGLE COMMON ENTRY POINT FOR REPORTING MALTREATMENT OF A VULNERABLE ADULT.

(a) The commissioner of human services shall seek federal funding to design, implement, maintain, and evaluate the common entry point for reports of suspected maltreatment made under Minnesota Statutes, section 626.557. The purpose of the federal grant funds is to establish a common entry point with a statewide toll-free telephone number and Web site-based system to report known or suspected abuse, neglect, or exploitation of a vulnerable adult.

(b) A common entry point must be operated in a manner that enables the common entry point staff to:

(1) operate under Minnesota Statutes, section 626.557, subdivision 9, paragraph (b); and subdivision 9a;

(2) when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; and

(3) immediately identify and locate prior reports of abuse, neglect, or exploitation.

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

(1) track critical steps in the investigative process to ensure compliance with all requirements for all reports;

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

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

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

(5) develop a system to manage consumer complaints related to the common entry point.

(d) The commissioner of human services may take the actions necessary to design and implement the common entry point in paragraph (a). Funds awarded by the federal government for the purposes of this section are appropriated to the commissioner of human services.

245B.01 RULE CONSOLIDATION.

This chapter establishes new methods to ensure the quality of services to persons with developmental disabilities, and streamlines and simplifies regulation of services and supports for persons with developmental disabilities. Sections 245B.02 to 245B.07 establish new standards that eliminate duplication and overlap of regulatory requirements by consolidating and replacing rule parts from four program rules. Section 245B.08 authorizes the commissioner of human services to develop and use new regulatory strategies to maintain compliance with the streamlined requirements.

245B.02 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them.

Subd. 2. **Applicant.** "Applicant" has the meaning given in section 245A.02, subdivision 3.

Subd. 3. **Case manager.** "Case manager" means the individual designated by the county board under rules of the commissioner to provide case management services as delineated in section 256B.092 or successor provisions.

Subd. 4. **Consumer.** "Consumer" means a person who has been determined eligible to receive and is receiving services or support for persons with developmental disabilities.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subd. 6. **Day training and habilitation services; developmental disabilities.** "Day training and habilitation services for adults with developmental disabilities" has the meaning given in sections 252.40 to 252.46.

Subd. 7. **Department.** "Department" means the Department of Human Services.

Subd. 8. **Direct service.** "Direct service" means, for a consumer receiving residential-based services, day training and habilitation services, or respite care services, one or more of the following: supervision, assistance, or training.

Subd. 8a. **Emergency.** "Emergency" means any fires, severe weather, natural disasters, power failures, or any event that affects the ordinary daily operation of the program, including, but not limited to, events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site.

Subd. 9. **Health services.** "Health services" means any service or treatment consistent with the health needs of the consumer, such as medication administration and monitoring, medical, dental, nutritional, health monitoring, wellness education, and exercise.

Subd. 10. **Incident.** "Incident" means an occurrence that affects the ordinary provision of services to a person and includes any of the following:

(1) serious injury as determined by section 245.91, subdivision 6;

(2) a consumer's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition, or the mental health status of a person that requires calling 911 or a mental health mobile crisis intervention team, physician treatment, or hospitalization;

(4) a consumer's unauthorized or unexplained absence;

(5) physical aggression by a consumer against another consumer that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;

(6) any sexual activity between consumers involving force or coercion as defined under section 609.341, subdivisions 3 and 14; or

(7) a report of child or vulnerable adult maltreatment under section 626.556 or 626.557.

Subd. 11. **Individual service plan.** "Individual service plan" has the meaning given in section 256B.092 or successor provisions.

Subd. 12. **Individual who is related.** "Individual who is related" has the meaning given in section 245A.02, subdivision 13.

Subd. 12a. **Interdisciplinary team.** "Interdisciplinary team" means a team composed of the case manager, the person, the person's legal representative and advocate, if any, and representatives of providers of the service areas relevant to the needs of the person as described in the individual service plan.

Subd. 13. **Intermediate care facility for persons with developmental disabilities.** "Intermediate care facility for persons with developmental disabilities" or "ICF/MR" means a residential program licensed to provide services to persons with developmental disabilities under section 252.28 and chapter 245A and a physical facility licensed as a supervised living facility under chapter 144, which together are certified by the Department of Health as an intermediate care facility for persons with developmental disabilities.

Subd. 14. **Least restrictive environment.** "Least restrictive environment" means an environment where services:

(1) are delivered with minimum limitation, intrusion, disruption, or departure from typical patterns of living available to persons without disabilities;

(2) do not subject the consumer or others to unnecessary risks to health or safety; and

(3) maximize the consumer's level of independence, productivity, and inclusion in the community.

Subd. 15. **Legal representative.** "Legal representative" means the parent or parents of a consumer who is under 18 years of age or a guardian, conservator, or guardian ad litem authorized by the court, or other legally authorized representative to make decisions about services for a consumer.

Subd. 16. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 17. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 18. **Person with developmental disability.** "Person with developmental disability" means a person who has been diagnosed under section 256B.092 as having substantial limitations in present functioning, manifested as significantly subaverage intellectual functioning, existing concurrently with demonstrated deficits in adaptive behavior, and who manifests these conditions before the person's 22nd birthday. A person with a related condition means a person who meets the diagnostic definition under section 252.27, subdivision 1a.

Subd. 19. **Psychotropic medication use checklist.** "Psychotropic medication use checklist" means the psychotropic medication monitoring checklist and manual used to govern the administration of psychotropic medications. The commissioner may revise or update the psychotropic medication use checklist to comply with legal requirements or to meet professional standards or guidelines in the area of developmental disabilities. For purposes of this chapter, psychotropic medication means any medication prescribed to treat mental illness and associated behaviors or to control or alter behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, antimania, stimulant, and sedative or hypnotic. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Subd. 20. **Residential-based habilitation.** "Residential-based habilitation" means care, supervision, and training provided primarily in the consumer's own home or place of residence but also including community-integrated activities following the individual service plan. Residential habilitation services are provided in coordination with the provision of day training and habilitation services for those persons receiving day training and habilitation services under sections 252.40 to 252.46.

Subd. 21. **Respite care.** "Respite care" has the meaning given in section 245A.02, subdivision 15.

Subd. 22. **Service.** "Service" means care, supervision, activities, or training designed to achieve the outcomes assigned to the license holder.

Subd. 23. **Semi-independent living services or SILS** "Semi-independent living services" or "SILS" has the meaning given in section 252.275.

Subd. 23a. **Supported employment.** "Supported employment" services include individualized counseling, individualized job development and placement that produce an appropriate job match for the individual and the employer, on-the-job training in work and related work skills required for job performance, ongoing supervision and monitoring of the person's performance, long-term support services to assure job retention, training in related skills essential to obtaining and retaining employment such as the effective use of community resources, use of break and lunch areas, transportation and mobility training, and transportation between the individual's place of residence and the work place when other forms of transportation are unavailable or inaccessible.

Subd. 24. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to consumers served by the license holder.

245B.03 APPLICABILITY AND EFFECT.

Subdivision 1. **Applicability.** The standards in this chapter govern services to persons with developmental disabilities receiving services from license holders providing residential-based habilitation; day training and habilitation services for adults; supported employment; semi-independent living services; residential programs that serve more than four consumers, including intermediate care facilities for persons with developmental disabilities; and respite care provided outside the consumer's home for more than four consumers at the same time at a single site.

Subd. 2. **Relationship to other standards governing services at ICF's/MR.** (a) ICF's/MR are exempt from:

(1) section 245B.04;

(2) section 245B.06, subdivisions 4 and 6; and

(3) section 245B.07, subdivisions 4, paragraphs (b) and (c); 7; and 8, paragraph (a), clause (4), and paragraph (b).

(b) License holders also licensed under chapter 144 as a supervised living facility are exempt from section 245B.04.

(c) Residential service sites controlled by license holders licensed under this chapter for home and community-based waivered services for four or fewer adults are exempt from compliance with Minnesota Rules, parts 9543.0040, subpart 2, item C; 9555.5505; 9555.5515, items B and G; 9555.5605; 9555.5705; 9555.6125, subparts 3, item C, subitem (2), and 4 to 6; 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265; and as provided under section 245B.06, subdivision 2, the license holder is exempt from the program abuse prevention plans and individual abuse prevention plans otherwise required under sections 245A.65, subdivision 2, and 626.557, subdivision 14. The commissioner may approve alternative methods of providing overnight supervision using the process and criteria for granting a variance in section 245A.04, subdivision 9. This chapter does not apply to foster care homes that do not provide residential habilitation services funded under the home and community-based waiver programs defined in section 256B.092.

(d) Residential service sites controlled by license holders licensed under this chapter for home and community-based waivered services for four or fewer children are exempt from compliance with Minnesota Rules, parts 2960.3060, subpart 3, items B and C; 2960.3070; 2960.3100, subpart 1, items C, F, and I; and 2960.3210.

(e) The commissioner may exempt license holders from applicable standards of this chapter when the license holder meets the standards under section 245A.09, subdivision 7. License holders that are accredited by an independent accreditation body shall continue to be licensed under this chapter.

(f) License holders governed by sections 245B.02 to 245B.07 must also meet the licensure requirements in chapter 245A.

(g) Nothing in this chapter prohibits license holders from concurrently serving consumers with and without developmental disabilities provided this chapter's standards are met as well as other relevant standards.

(h) The documentation that sections 245B.02 to 245B.07 require of the license holder meets the individual program plan required in section 256B.092 or successor provisions.

Subd. 3. **Continuity of care.** (a) When a consumer changes service to the same type of service provided under a different license held by the same license holder and the policies and

procedures under section 245B.07, subdivision 8, are substantially similar, the license holder is exempt from the requirements in sections 245B.06, subdivisions 2, paragraphs (e) and (f), and 4; and 245B.07, subdivision 9, clause (2).

(b) When a direct service staff person begins providing direct service under one or more licenses other than the license for which the staff person initially received the staff orientation requirements under section 245B.07, subdivision 5, the license holder is exempt from all staff orientation requirements under section 245B.07, subdivision 5, except that:

(1) if the service provision location changes, the staff person must receive orientation regarding any policies or procedures under section 245B.07, subdivision 8, that are specific to the service provision location; and

(2) if the staff person provides direct service to one or more consumers for whom the staff person has not previously provided direct service, the staff person must review each consumer's: (i) service plans and risk management plan in accordance with section 245B.07, subdivision 5, paragraph (b), clause (1); and (ii) medication administration in accordance with section 245B.07, subdivision 5, paragraph (b), clause (6).

245B.031 ACCREDITATION, ALTERNATIVE INSPECTION, AND DEEMED COMPLIANCE.

Subdivision 1. **Day training and habilitation or supported employment services programs; alternative inspection status.** (a) A license holder providing day training and habilitation services or supported employment services according to this chapter, with a three-year accreditation from the Commission on Rehabilitation Facilities, that has had at least one on-site inspection by the commissioner following issuance of the initial license, may request alternative inspection status under this section.

(b) The request for alternative inspection status must be made in the manner prescribed by the commissioner, and must include:

(1) a copy of the license holder's application to the Commission on Rehabilitation Facilities for accreditation;

(2) the most recent Commission on Rehabilitation Facilities accreditation survey report; and

(3) the most recent letter confirming the three-year accreditation and approval of the license holder's quality improvement plan.

Based on the request and the accompanying materials, the commissioner may approve alternative inspection status.

(c) Following approval of alternative inspection status, the commissioner may terminate the alternative inspection status or deny a subsequent alternative inspection status if the commissioner determines that any of the following conditions have occurred after approval of the alternative inspection process:

(1) the license holder has not maintained full three-year accreditation;

(2) the commissioner has substantiated maltreatment for which the license holder or facility is determined to be responsible during the three-year accreditation period; and

(3) during the three-year accreditation period, the license holder has been issued an order for conditional license, a fine, suspension, or license revocation that has not been reversed upon appeal.

(d) The commissioner's decision that the conditions for approval for the alternative licensing inspection status have not been met is final and not subject to appeal under the provisions of chapter 14.

Subd. 2. **Programs with three-year accreditation, exempt from certain statutes.** (a) A license holder approved for alternative inspection status under this section is exempt from the requirements under:

(1) section 245B.04;

(2) section 245B.05, subdivisions 5 and 6;

(3) section 245B.06, subdivisions 1, 3, 4, 5, and 6; and

(4) section 245B.07, subdivisions 1, 4, and 6.

(b) Upon receipt of a complaint regarding a requirement under paragraph (a), the commissioner shall refer the complaint to the Commission on Rehabilitation Facilities for possible follow-up.

Subd. 3. **Programs with three-year accreditation, deemed to be in compliance with nonexempt licensing requirements.** (a) License holders approved for alternative inspection status under this section are required to maintain compliance with all licensing standards from which they are not exempt under subdivision 2, paragraph (a).

(b) License holders approved for alternative inspection status under this section shall be deemed to be in compliance with all nonexempt statutes, and the commissioner shall not perform routine licensing inspections.

(c) Upon receipt of a complaint regarding the services of a license holder approved for alternative inspection under this section that is not related to a licensing requirement from which the license holder is exempt under subdivision 2, the commissioner shall investigate the complaint and may take any action as provided under section 245A.06 or 245A.07.

Subd. 4. **Investigations of alleged maltreatment of minors or vulnerable adults.** Nothing in this section changes the commissioner's responsibilities to investigate alleged or suspected maltreatment of a minor under section 626.556 or vulnerable adult under section 626.557.

Subd. 5. **Request to Commission on Rehabilitation Facilities to expand accreditation survey.** The commissioner shall submit a request to the Commission on Rehabilitation Facilities to routinely inspect for compliance with standards that are similar to the following nonexempt licensing requirements:

(1) section 245A.65;
(2) section 245A.66;
(3) section 245B.05, subdivisions 1, 2, and 7;
(4) section 245B.055;
(5) section 245B.06, subdivisions 2, 7, 9, and 10;
(6) section 245B.07, subdivisions 2, 5, and 8, paragraph (a), clause (7);
(7) section 245C.04, subdivision 1, paragraph (f);
(8) section 245C.07;
(9) section 245C.13, subdivision 2;
(10) section 245C.20; and
(11) Minnesota Rules, parts 9525.2700 to 9525.2810.

245B.04 CONSUMER RIGHTS.

Subdivision 1. **License holder's responsibility for consumers' rights.** The license holder must:

(1) provide the consumer or the consumer's legal representative a copy of the consumer's rights on the day that services are initiated and an explanation of the rights in subdivisions 2 and 3 within five working days of service initiation and annually thereafter. Reasonable accommodations shall be made by the license holder to provide this information in other formats as needed to facilitate understanding of the rights by the consumer and the consumer's legal representative, if any;

(2) document the consumer's or the consumer's legal representative's receipt of a copy of the rights and an explanation of the rights; and

(3) ensure the exercise and protection of the consumer's rights in the services provided by the license holder and authorized in the individual service plan.

Subd. 2. **Service-related rights.** A consumer's service-related rights include the right to:

(1) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(2) know, in advance, limits to the services available from the license holder;

(3) know conditions and terms governing the provision of services, including the license holder's policies and procedures related to initiation and termination;

(4) know what the charges are for services, regardless of who will be paying for the services, and be notified upon request of changes in those charges;

(5) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the consumer or other private party may have to pay; and

(6) receive licensed services from individuals who are competent and trained, who have professional certification or licensure, as required, and who meet additional qualifications identified in the individual service plan.

Subd. 3. **Protection-related rights.** (a) The consumer's protection-related rights include the right to:

(1) have personal, financial, services, and medical information kept private, and be advised of the license holder's policies and procedures regarding disclosure of such information;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be treated with courtesy and respect for the consumer's individuality, mode of communication, and culture, and receive respectful treatment of the consumer's property;

(5) reasonable observance of cultural and ethnic practice and religion;

(6) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(7) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(8) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(9) voice grievances, know the contact persons responsible for addressing problems and how to contact those persons;

(10) any procedures for grievance or complaint resolution and the right to appeal under section 256.045;

(11) know the name and address of the state, county, or advocacy agency to contact for additional information or assistance;

(12) assert these rights personally, or have them asserted by the consumer's family or legal representative, without retaliation;

(13) give or withhold written informed consent to participate in any research or experimental treatment;

(14) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the resident;

(15) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(16) marital privacy for visits with the consumer's spouse and, if both are residents of the site, the right to share a bedroom and bed;

(17) associate with other persons of the consumer's choice;

(18) personal privacy; and

(19) engage in chosen activities.

(b) Restriction of a person's rights under paragraph (a), clauses (13) to (15), or this paragraph is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of these rights must be documented in the service plan for the person and must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative from the date of initial approval; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

245B.05 CONSUMER PROTECTION STANDARDS.

Subdivision 1. **Environment.** The license holder must:

(1) ensure that services are provided in a safe and hazard-free environment when the license holder is the owner, lessor, or tenant of the service site. All other license holders shall inform the consumer or the consumer's legal representative and case manager about any environmental safety concerns in writing;

(2) ensure that doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers only to protect the safety of consumers and not as a substitute for staff supervision or interactions with consumers. If doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers, the license holder must justify and document how this determination was made in consultation with the person or the person's legal representative and how access will otherwise be provided to the person and all other affected persons receiving services;

(3) follow procedures that minimize the consumer's health risk from communicable diseases; and

(4) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition.

Subd. 2. **Licensed capacity for facility-based day training and habilitation services.** The licensed capacity of each day training and habilitation service site must be determined by the amount of primary space available, the scheduling of activities at other service sites, and the space requirements of consumers receiving services at the site. Primary space does not include hallways, stairways, closets, utility areas, bathrooms, kitchens, and floor areas beneath stationary equipment. A facility-based day training and habilitation site must have a minimum of 40 square feet of primary space available for each consumer who is present at the site at any one time. Licensed capacity under this subdivision does not apply to: (1) consumers receiving community-based day training and habilitation services; and (2) the temporary use of a facility-based training and habilitation service site for the limited purpose of providing transportation to consumers receiving community-based day training and habilitation services from the license holder. The license holder must comply at all times with all applicable fire and safety codes under section 245A.04, subdivision 2a, and adequate supervision requirements under section 245B.055 for all persons receiving day training and habilitation services.

Subd. 3. **Residential service sites for more than four consumers; four-bed ICF's/MR.** Residential service sites licensed to serve more than four consumers and four-bed ICF's/MR must meet the fire protection provisions of either the Residential Board and Care Occupancies Chapter or the Health Care Occupancies Chapter of the Life Safety Code (LSC), National Fire Protection Association, 1985 edition, or its successors. Sites meeting the definition of a residential board and care occupancy for 16 or less beds must have the emergency evacuation capability of residents evaluated in accordance with Appendix F of the LSC or its successors, except for those sites that meet the LSC Health Care Occupancies Chapter or its successors.

Subd. 5. **Consumer health.** The license holder is responsible for meeting the health service needs assigned to the license holder in the individual service plan and for bringing health needs as discovered by the license holder promptly to the attention of the consumer, the consumer's legal representative, and the case manager. The license holder is required to maintain documentation on how the consumer's health needs will be met, including a description of procedures the license holder will follow for the consumer regarding medication monitoring and administration and seizure monitoring, if needed. The medication administration procedures are those procedures necessary to implement medication and treatment orders issued by appropriately licensed professionals, and must be established in consultation with a registered nurse, nurse practitioner, physician's assistant, or medical doctor.

Subd. 6. **First aid.** When the license holder is providing direct service and supervision to a consumer who requires a 24-hour plan of care and receives services at a site licensed under this chapter, the license holder must have available a staff person trained in first aid, and, if needed under section 245B.07, subdivision 6, paragraph (d), cardiopulmonary resuscitation from a qualified source, as determined by the commissioner.

Subd. 7. **Reporting incidents.** (a) The license holder must maintain information about and report incidents under section 245B.02, subdivision 10, clauses (1) to (7), to the consumer's legal representative, other licensed caregiver, if any, and case manager within 24 hours of the occurrence, or within 24 hours of receipt of the information unless the incident has been reported by another license holder. An incident under section 245B.02, subdivision 10, clause (8), must be reported as required under paragraph (c) unless the incident has been reported by another license holder.

(b) When the incident involves more than one consumer, the license holder must not disclose personally identifiable information about any other consumer when making the report to each consumer's legal representative, other licensed caregiver, if any, and case manager unless the license holder has the consent of a consumer or a consumer's legal representative.

(c) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the consumer's legal representative and case manager of the report unless there is reason to believe that the legal representative or case manager is involved in the suspected maltreatment. The information the license holder must disclose is the nature of the activity or occurrence reported, the agency that receives the report, and the telephone number of the Department of Human Services Licensing Division.

(d) Except as provided in paragraph (e), death or serious injury of the consumer must also be reported to the Department of Human Services Licensing Division and the ombudsman, as required under sections 245.91 and 245.94, subdivision 2a.

(e) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to

the Department of Health, Office of Health Facility Complaints, and the ombudsman, as required under sections 245.91 and 245.94, subdivision 2a.

245B.055 STAFFING FOR DAY TRAINING AND HABILITATION SERVICES.

Subdivision 1. **Scope.** This section applies only to license holders that provide day training and habilitation services.

Subd. 2. **Factors.** (a) The number of direct service staff members that a license holder must have on duty at a given time to meet the minimum staffing requirements established in this section varies according to:

(1) the number of persons who are enrolled and receiving direct services at that given time;

(2) the staff ratio requirement established under subdivision 3 for each of the persons who is present; and

(3) whether the conditions described in subdivision 8 exist and warrant additional staffing beyond the number determined to be needed under subdivision 7.

(b) The commissioner shall consider the factors in paragraph (a) in determining a license holder's compliance with the staffing requirements and shall further consider whether the staff ratio requirement established under subdivision 3 for each person receiving services accurately reflects the person's need for staff time.

Subd. 3. **Staff ratio requirement for each person receiving services.** The case manager, in consultation with the interdisciplinary team shall determine at least once each year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio assigned each person and the documentation of how the ratio was arrived at must be kept in each person's individual service plan. Documentation must include an assessment of the person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard assessment form required by the commissioner.

Subd. 4. **Person requiring staff ratio of one to four.** A person who has one or more of the following characteristics must be assigned a staff ratio requirement of one to four:

(1) on a daily basis the person requires total care and monitoring or constant hand-over-hand physical guidance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, or ambulating; or

(2) the person assaults others, is self-injurious, or manifests severe dysfunctional behaviors at a documented level of frequency, intensity, or duration requiring frequent daily ongoing intervention and monitoring as established in an approved behavior management program.

Subd. 5. **Person requiring staff ratio of one to eight.** A person who has all of the following characteristics must be assigned a staff ratio requirement of one to eight:

(1) the person does not meet the requirements in subdivision 4; and

(2) on a daily basis the person requires verbal prompts or spot checks and minimal or no physical assistance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, or ambulating.

Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio requirement of one to six.

Subd. 7. **Determining number of direct service staff required.** The minimum number of direct service staff members required at any one time to meet the combined staff ratio requirements of the persons present at that time can be determined by following the steps in clauses (1) through (4):

(1) assign each person in attendance the three-digit decimal below that corresponds to the staff ratio requirement assigned to that person. A staff ratio requirement of one to four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

(2) add all of the three-digit decimals (one three-digit decimal for every person in attendance) assigned in clause (1);

(3) when the sum in clause (2) falls between two whole numbers, round off the sum to the larger of the two whole numbers; and

(4) the larger of the two whole numbers in clause (3) equals the number of direct service staff members needed to meet the staff ratio requirements of the persons in attendance.

Subd. 8. **Conditions requiring additional direct service staff.** The license holder shall increase the number of direct service staff members present at any one time beyond the number arrived at in subdivision 4 if necessary when any one or combination of the following circumstances can be documented by the commissioner as existing:

(1) the health and safety needs of the persons receiving services cannot be met by the number of staff members available under the staffing pattern in effect even though the number has been accurately calculated under subdivision 7; or

(2) the behavior of a person presents an immediate danger and the person is not eligible for a special needs rate exception under Minnesota Rules, parts 9510.1020 to 9510.1140.

Subd. 9. **Supervision requirements.** At no time shall one direct service staff member be assigned responsibility for supervision and training of more than ten persons receiving supervision and training, except as otherwise stated in each person's risk management plan.

245B.06 SERVICE STANDARDS.

Subdivision 1. **Outcome-based services.** (a) The license holder must provide outcome-based services in response to the consumer's identified needs as specified in the individual service plan.

(b) Services must be based on the needs and preferences of the consumer and the consumer's personal goals and be consistent with the principles of least restrictive environment, self-determination, and consistent with:

(1) the recognition of each consumer's history, dignity, and cultural background;

(2) the affirmation and protection of each consumer's civil and legal rights;

(3) the provision of services and supports for each consumer which:

(i) promote community inclusion and self-sufficiency;

(ii) provide services in the least restrictive environment;

(iii) promote social relationships, natural supports, and participation in community life;

(iv) allow for a balance between safety and opportunities; and

(v) provide opportunities for the development and exercise of age-appropriate skills, decision making and choice, personal advocacy, and communication; and

(4) the provision of services and supports for families which address the needs of the consumer in the context of the family and support family self-sufficiency.

(c) The license holder must make available to the consumer opportunities to participate in the community, functional skill development, reduced dependency on care providers, and opportunities for development of decision-making skills. "Outcome" means the behavior, action, or status attained by the consumer that can be observed, measured, and can be determined reliable and valid. Outcomes are the equivalent of the long-range goals and short-term goals referenced in section 256B.092, and any rules promulgated under that section.

Subd. 2. **Risk management plan.** (a) The license holder must develop, document in writing, and implement a risk management plan that meets the requirements of this subdivision. License holders licensed under this chapter are exempt from sections 245A.65, subdivision 2, and 626.557, subdivision 14, if the requirements of this subdivision are met.

(b) The risk management plan must identify areas in which the consumer is vulnerable, based on an assessment, at a minimum, of the following areas:

(1) an adult consumer's susceptibility to physical, emotional, and sexual abuse as defined in section 626.5572, subdivision 2, and financial exploitation as defined in section 626.5572, subdivision 9; a minor consumer's susceptibility to sexual and physical abuse as defined in section 626.556, subdivision 2; and a consumer's susceptibility to self-abuse, regardless of age;

(2) the consumer's health needs, considering the consumer's physical disabilities; allergies; sensory impairments; seizures; diet; need for medications; and ability to obtain medical treatment;

(3) the consumer's safety needs, considering the consumer's ability to take reasonable safety precautions; community survival skills; water survival skills; ability to seek assistance or provide medical care; and access to toxic substances or dangerous items;

(4) environmental issues, considering the program's location in a particular neighborhood or community; the type of grounds and terrain surrounding the building; and the consumer's ability to respond to weather-related conditions, open locked doors, and remain alone in any environment; and

(5) the consumer's behavior, including behaviors that may increase the likelihood of physical aggression between consumers or sexual activity between consumers involving force or coercion, as defined under section 245B.02, subdivision 10, clauses (6) and (7).

(c) When assessing a consumer's vulnerability, the license holder must consider only the consumer's skills and abilities, independent of staffing patterns, supervision plans, the environment, or other situational elements.

(d) License holders jointly providing services to a consumer shall coordinate and use the resulting assessment of risk areas for the development of each license holder's risk management or the shared risk management plan. The license holder's plan must include the specific actions a staff person will take to protect the consumer and minimize risks for the identified vulnerability

areas. The specific actions must include the proactive measures being taken, training being provided, or a detailed description of actions a staff person will take when intervention is needed.

(e) Prior to or upon initiating services, a license holder must develop an initial risk management plan that is, at a minimum, verbally approved by the consumer or consumer's legal representative and case manager. The license holder must document the date the license holder receives the consumer's or consumer's legal representative's and case manager's verbal approval of the initial plan.

(f) As part of the meeting held within 45 days of initiating service, as required under section 245B.06, subdivision 4, the license holder must review the initial risk management plan for accuracy and revise the plan if necessary. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in this plan review. If the license holder revises the plan, or if the consumer or consumer's legal representative and case manager have not previously signed and dated the plan, the license holder must obtain dated signatures to document the plan's approval.

(g) After plan approval, the license holder must review the plan at least annually and update the plan based on the individual consumer's needs and changes to the environment. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in the ongoing plan development. The license holder shall obtain dated signatures from the consumer or consumer's legal representative and case manager to document completion of the annual review and approval of plan changes.

Subd. 3. **Assessments.** (a) The license holder shall assess and reassess the consumer within stated time lines and assessment areas specified in the individual service plan or as requested in writing by the case manager.

(b) For each area of assessment requested, the license holder must provide a written summary, analysis, and recommendations for use in the development of the individual service plan.

(c) All assessments must include information about the consumer that is descriptive of:

(1) the consumer's strengths and functional skills; and

(2) the level of support and supervision the consumer needs to achieve the outcomes in subdivision 1.

Subd. 4. **Supports and methods.** The license holder, in coordination with other service providers, shall meet with the consumer, the consumer's legal representative, case manager, and other members of the interdisciplinary team within 45 days of service initiation. Within ten working days after the meeting, the license holder shall develop and document in writing:

(1) the methods that will be used to support the individual or accomplish the outcomes in subdivision 1, including information about physical and social environments, the equipment and materials required, and techniques that are consistent with the consumer's communication mode and learning style specified as the license holder's responsibility in the individual service plan;

(2) the projected starting date for service supports and the criteria for identifying when the desired outcome has been achieved and when the service supports need to be reviewed; and

(3) the names of the staff, staff position, or contractors responsible for implementing each outcome.

Subd. 5. **Progress reviews.** The license holder must participate in progress review meetings following stated time lines established in the consumer's individual service plan or as requested in writing by the consumer, the consumer's legal representative, or the case manager, at a minimum of once a year. The license holder must summarize the progress toward achieving the desired outcomes and make recommendations in a written report sent to the consumer or the consumer's legal representative and case manager prior to the review meeting.

Subd. 6. **Reports.** The license holder shall provide written reports regarding the consumer's status as requested by the consumer, or the consumer's legal representative and case manager.

Subd. 7. **Staffing requirements.** The license holder must provide supervision to ensure the health, safety, and protection of rights of each consumer and to be able to implement each consumer's individual service plan. Day training and habilitation programs must meet the minimum staffing requirements as specified in sections 252.40 to 252.46 and rules promulgated under those sections.

Subd. 8. **Leaving the residence.** Each consumer requiring a 24-hour plan of care shall receive services during the day outside the residence unless otherwise specified in the individual's service plan. License holders, providing services to consumers living in a licensed site, shall ensure that they are prepared to care for consumers whenever they are at the residence during the day because of illness, work schedules, or other reasons.

Subd. 9. **Day training and habilitation service days.** Day training and habilitation services must meet a minimum of 195 available service days.

Subd. 10. **Prohibition.** Psychotropic medication and the use of aversive and deprivation procedures, as referenced in section 245.825 and rules promulgated under that section, cannot be used as a substitute for adequate staffing, as punishment, or for staff convenience.

245B.07 MANAGEMENT STANDARDS.

Subdivision 1. **Consumer data file.** The license holder must maintain the following information for each consumer:

(1) identifying information that includes date of birth, medications, legal representative, history, medical, and other individual-specific information, and names and telephone numbers of contacts;

(2) consumer health information, including individual medication administration and monitoring information;

(3) the consumer's individual service plan. When a consumer's case manager does not provide a current individual service plan, the license holder shall make a written request to the case manager to provide a copy of the individual service plan and inform the consumer or the consumer's legal representative of the right to an individual service plan and the right to appeal under section 256.045. In the event the case manager fails to provide an individual service plan after a written request from the license holder, the license holder shall not be sanctioned or penalized financially for not having a current individual service plan in the consumer's data file;

(4) copies of assessments, analyses, summaries, and recommendations;

(5) progress review reports;

(6) incidents involving the consumer;

(7) reports required under section 245B.05, subdivision 7;

(8) discharge summary, when applicable;

(9) record of other license holders serving the consumer that includes a contact person and telephone numbers, services being provided, services that require coordination between two license holders, and name of staff responsible for coordination;

(10) information about verbal aggression directed at the consumer by another consumer; and

(11) information about self-abuse.

Subd. 2. **Access to records.** The license holder must ensure that the following people have access to the information in subdivision 1:

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

(2) the consumer's case manager;

(3) staff providing direct services to the consumer unless the information is not relevant to carrying out the individual service plan; and

(4) the county adult foster care licensor, when services are also licensed as an adult foster home. Adult foster home means a licensed residence operated by an operator who, for financial gain or otherwise, provides 24-hour foster care to no more than four functionally impaired residents.

Subd. 3. **Retention of consumer's records.** The license holder must retain the records required for consumers for at least three years following termination of services.

Subd. 4. **Staff qualifications.** (a) The license holder must ensure that staff is competent through training, experience, and education to meet the consumer's needs and additional requirements as written in the individual service plan. Staff qualifications must be documented. Staff under 18 years of age may not perform overnight duties or administer medication.

(b) Delivery and evaluation of services provided by the license holder to a consumer must be coordinated by a designated person. The designated person or coordinator must minimally have a four-year degree in a field related to service provision, and one year work experience with consumers with developmental disabilities, a two-year degree in a field related to service provision, and two years of work experience with consumers with developmental disabilities, or a diploma in community-based developmental disability services from an accredited postsecondary institution and two years of work experience with consumers with developmental disabilities. The coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities designated in the individual service plan;

(2) instruction and assistance to staff implementing the individual service plan areas;

(3) evaluation of the effectiveness of service delivery, methodologies, and progress on consumer outcomes based on the condition set for objective change; and

(4) review of incident and emergency reports, identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences.

(c) The coordinator is responsible for taking the action necessary to facilitate the accomplishment of the outcomes for each consumer as specified in the consumer's individual service plan.

(d) The license holder must provide for adequate supervision of direct care staff to ensure implementation of the individual service plan.

Subd. 5. **Staff orientation.** (a) Within 60 days of hiring staff who provide direct service, the license holder must provide 30 hours of staff orientation. Direct care staff must complete 15 of the 30 hours orientation before providing any unsupervised direct service to a consumer. If the staff person has received orientation training from a license holder licensed under this chapter, or provides semi-independent living services only, the 15-hour requirement may be reduced to eight hours. The total orientation of 30 hours may be reduced to 15 hours if the staff person has previously received orientation training from a license holder licensed under this chapter.

(b) The 30 hours of orientation must combine supervised on-the-job training with review of and instruction on the following material:

(1) review of the consumer's service plans and risk management plan to achieve an understanding of the consumer as a unique individual and staff responsibilities related to implementation of those plans;

(2) review and instruction on implementation of the license holder's policies and procedures, including their location and access;

(3) staff responsibilities related to emergency procedures;

(4) explanation of specific job functions, including implementing objectives from the consumer's individual service plan;

(5) explanation of responsibilities related to section 245A.65; sections 626.556 and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults; and section 245.825, governing use of aversive and deprivation procedures;

(6) medication administration as it applies to the individual consumer, from a training curriculum developed by a health services professional described in section 245B.05, subdivision 5, and when the consumer meets the criteria of having overriding health care needs, then medication administration taught by a health services professional. Staff may administer medications only after they demonstrate the ability, as defined in the license holder's medication administration policy and procedures. Once a consumer with overriding health care needs is admitted, staff will be provided with remedial training as deemed necessary by the license holder and the health professional to meet the needs of that consumer.

For purposes of this section, overriding health care needs means a health care condition that affects the service options available to the consumer because the condition requires:

(i) specialized or intensive medical or nursing supervision; and

(ii) nonmedical service providers to adapt their services to accommodate the health and safety needs of the consumer;

(7) consumer rights and staff responsibilities related to protecting and ensuring the exercise of the consumer rights; and

(8) other topics necessary as determined by the consumer's individual service plan or other areas identified by the license holder.

(c) The license holder must document each employee's orientation received.

Subd. 6. **Staff training.** (a) A license holder providing semi-independent living services shall ensure that direct service staff annually complete hours of training equal to one percent of the number of hours the staff person worked. All other license holders shall ensure that direct service staff annually complete hours of training as follows:

(1) if the direct services staff have been employed for one to 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 40 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 30 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 20 training hours; or

(2) if the direct services staff have been employed for more than 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 20 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 15 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 12 training hours.

If direct service staff has received training from a license holder licensed under a program rule identified in this chapter or completed course work regarding disability-related issues from a postsecondary educational institute, that training may also count toward training requirements for other services and for other license holders.

(b) The license holder must document the training completed by each employee.

(c) Training shall address staff competencies necessary to address the consumer needs as identified in the consumer's individual service plan and ensure consumer health, safety, and protection of rights. Training may also include other areas identified by the license holder.

(d) For consumers requiring a 24-hour plan of care, the license holder shall provide training in cardiopulmonary resuscitation, from a qualified source determined by the commissioner, if the consumer's health needs as determined by the consumer's physician indicate trained staff would be necessary to the consumer.

Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide direct services to consumers receive the training and orientation necessary to fulfill their responsibilities.

Subd. 7a. **Subcontractors.** If the license holder uses a subcontractor to perform services licensed under this chapter on the license holder's behalf, the license holder must ensure that the subcontractor meets and maintains compliance with all requirements under this chapter that apply to the services to be provided.

Subd. 8. **Policies and procedures.** The license holder must develop and implement the policies and procedures in paragraphs (a) to (c).

(a) Policies and procedures that promote consumer health and safety by ensuring:

(1) consumer safety in emergency situations;

(2) consumer health through sanitary practices;

(3) safe transportation, when the license holder is responsible for transportation of consumers, with provisions for handling emergency situations;

(4) a system of record keeping for both individuals and the organization, for review of incidents and emergencies, and corrective action if needed;

(5) a plan for responding to all incidents, as defined in section 245B.02, subdivision 10, and reporting all incidents required to be reported under section 245B.05, subdivision 7;

(6) safe medication administration as identified in section 245B.05, subdivision 5, incorporating an observed skill assessment to ensure that staff demonstrate the ability to administer medications consistent with the license holder's policy and procedures;

(7) psychotropic medication monitoring when the consumer is prescribed a psychotropic medication, including the use of the psychotropic medication use checklist. If the responsibility for implementing the psychotropic medication use checklist has not been assigned in the individual service plan and the consumer lives in a licensed site, the residential license holder shall be designated; and

(8) criteria for admission or service initiation developed by the license holder.

(b) Policies and procedures that protect consumer rights and privacy by ensuring:

(1) consumer data privacy, in compliance with the Minnesota Data Practices Act, chapter 13; and

(2) that complaint procedures provide consumers with a simple process to bring grievances and consumers receive a response to the grievance within a reasonable time period. The license holder must provide a copy of the program's grievance procedure and time lines for addressing grievances. The program's grievance procedure must permit consumers served by the program and the authorized representatives to bring a grievance to the highest level of authority in the program.

(c) Policies and procedures that promote continuity and quality of consumer supports by ensuring:

(1) continuity of care and service coordination, including provisions for service termination, temporary service suspension, and efforts made by the license holder to coordinate services with other vendors who also provide support to the consumer. The policy must include the following requirements:

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

(ii) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective;

(iii) the license holder must provide information requested by the consumer or consumer's legal representative or case manager when services are temporarily suspended or upon notice of termination;

(iv) use of temporary service suspension procedures are restricted to situations in which the consumer's behavior causes immediate and serious danger to the health and safety of the individual or others;

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

(vi) during the period of temporary service suspension, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the individual and others; and

(2) quality services measured through a program evaluation process including regular evaluations of consumer satisfaction and sharing the results of the evaluations with the consumers and legal representatives.

Subd. 9. **Availability of current written policies and procedures.** The license holder shall:

(1) review and update, as needed, the written policies and procedures in this chapter;

(2) inform consumers or the consumer's legal representatives of the written policies and procedures in this chapter upon service initiation. Copies of policies and procedures affecting a consumer's rights under section 245D.04 must be provided upon service initiation. Copies of all other policies and procedures must be available to consumers or the consumer's legal representatives, case managers, the county where services are located, and the commissioner upon request;

(3) provide all consumers or the consumers' legal representatives and case managers a copy of the revised policies and procedures and explanation of the revisions that affect consumers' service-related or protection-related rights under section 245B.04 and maltreatment reporting policies and procedures. Unless there is reasonable cause, the license holder must provide this notice at least 30 days before implementing the revised policy and procedure. The license holder must document the reason for not providing the notice at least 30 days before implementing the revisions;

(4) annually notify all consumers or the consumers' legal representatives and case managers of any revised policies and procedures under this chapter, other than those in clause (3). Upon request, the license holder must provide the consumer or consumer's legal representative and case manager copies of the revised policies and procedures;

(5) before implementing revisions to policies and procedures under this chapter, inform all employees of the revisions and provide training on implementation of the revised policies and procedures; and

(6) document and maintain relevant information related to the policies and procedures in this chapter.

Subd. 10. **Consumer funds.** (a) The license holder must ensure that consumers retain the use and availability of personal funds or property unless restrictions are justified in the consumer's individual service plan.

(b) The license holder must ensure separation of consumer funds from funds of the license holder, the program, or program staff.

(c) Whenever the license holder assists a consumer with the safekeeping of funds or other property, the license holder must have written authorization to do so by the consumer or the consumer's legal representative, and the case manager. In addition, the license holder must:

(1) document receipt and disbursement of the consumer's funds or the property;

(2) annually survey, document, and implement the preferences of the consumer, consumer's legal representative, and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of consumer funds or other property; and

(3) return to the consumer upon the consumer's request, funds and property in the license holder's possession subject to restrictions in the consumer's individual service plan, as soon as possible, but no later than three working days after the date of the request.

(d) License holders and program staff must not:

(1) borrow money from a consumer;

(2) purchase personal items from a consumer;

(3) sell merchandise or personal services to a consumer;

(4) require a consumer to purchase items for which the license holder is eligible for reimbursement;

(5) use consumer funds in a manner that would violate section 256B.04, or any rules promulgated under that section; or

(6) accept powers-of-attorney from a person receiving services from the license holder for any purpose, and may not accept an appointment as guardian or conservator of a person receiving services from the license holder. This does not apply to license holders that are Minnesota counties or other units of government.

Subd. 11. **Travel time to and from a day training and habilitation site.** Except in unusual circumstances, the license holder must not transport a consumer receiving services for longer than 90 minutes per one-way trip. Nothing in this subdivision relieves the provider of the obligation to provide the number of program hours as identified in the individualized service plan.

Subd. 12. **Separate license required for separate sites.** The license holder shall apply for separate licenses for each day training and habilitation service site owned or leased by the license holder at which persons receiving services and the provider's employees who provide training and habilitation services are present for a cumulative total of more than 30 days within any 12-month period, and for each residential service site. Notwithstanding this subdivision, a separate license is not required for:

(1) a day training and habilitation service site used only for the limited purpose of providing transportation to consumers receiving community-based day training and habilitation services from a license holder;

(2) a day training and habilitation program that is in a separate building that is adjacent to the central operation of the day training and habilitation program; or

(3) a satellite day training and habilitation program. For purposes of this clause, a satellite day training and habilitation program is a program that is affiliated with the central operations of an existing day training and habilitation program and is in a separate nonadjacent building in the same county as the central operation day training and habilitation program.

Subd. 13. **Variance.** The commissioner may grant a variance to any of the requirements in sections 245B.02 to 245B.07 except section 245B.07, subdivision 8(1)(vii), or provisions governing data practices and information rights of consumers if the conditions in section 245A.04, subdivision 9 are met. Upon the request of the license holder, the commissioner shall continue variances from the standards in this chapter previously granted under Minnesota Rules that are repealed as a result of this chapter. The commissioner may approve variances for a license holder on a program, geographic, or organizational basis.

245B.08 COMPLIANCE STRATEGIES.

Subdivision 1. **Alternative methods of determining compliance.** (a) In addition to methods specified in chapters 245A and 245C, the commissioner may use alternative methods and new regulatory strategies to determine compliance with this section. The commissioner may use sampling techniques to ensure compliance with this section. Notwithstanding section 245A.09, subdivision 7, paragraph (e), the commissioner may also extend periods of licensure, not to exceed five years, for license holders who have demonstrated substantial and consistent compliance with sections 245B.02 to 245B.07 and have consistently maintained the health and safety of consumers and have demonstrated by alternative methods in paragraph (b) that they meet or exceed the requirements of this section. For purposes of this section, "substantial and consistent compliance" means that during the current licensing period:

(1) the license holder's license has not been made conditional, suspended, or revoked;

(2) there have been no substantiated allegations of maltreatment against the license holder;

(3) there have been no program deficiencies that have been identified that would jeopardize the health or safety of consumers being served; and

(4) the license holder is in substantial compliance with the other requirements of chapters 245A and 245C and other applicable laws and rules.

(b) To determine the length of a license, the commissioner shall consider:

(1) information from affected consumers, and the license holder's responsiveness to consumers' concerns and recommendations;

(2) self assessments and peer reviews of the standards of this section, corrective actions taken by the license holder, and sharing the results of the inspections with consumers, the consumers' families, and others, as requested;

(3) length of accreditation by an independent accreditation body, if applicable;

(4) information from the county where the license holder is located; and

(5) information from the license holder demonstrating performance that meets or exceeds the minimum standards of this chapter.

(c) The commissioner may reduce the length of the license if the license holder fails to meet the criteria in paragraph (a) and the conditions specified in paragraph (b).

Subd. 2. **Additional measures.** The commissioner may require the license holder to implement additional measures on a time-limited basis to ensure the health and safety of consumers when the health and safety of consumers has been determined to be at risk as determined by substantiated incidents of maltreatment under sections 626.556 and 626.557. The license holder may request reconsideration of the actions taken by the commissioner under this subdivision according to section 245A.06.

Subd. 3. **Sanctions available.** Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend or revoke a license or issue a fine at any time under section 245A.07; make correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06; or deny an application for license under section 245A.05.

Subd. 4. **Efficient application.** The commissioner shall establish application procedures for license holders licensed under this chapter to reduce the need to submit duplicative material.

Subd. 5. **Information.** The commissioner shall make information available to consumers and interested others regarding the licensing status of a license holder.

Subd. 6. **Implementation.** The commissioner shall seek advice from parties affected by the implementation of this chapter.

Subd. 7. **Deem status.** The commissioner may exempt a license holder from duplicative standards if the license holder is already licensed under chapter 245A.

245D.08 RECORD REQUIREMENTS.

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

Subd. 2. **Service recipient record.** (a) The license holder must:

(1) maintain a record of current services provided to each person on the premises where the services are provided or coordinated; and

(2) protect service recipient records against loss, tampering, or unauthorized disclosure in compliance with sections 13.01 to 13.10 and 13.46.

(b) The license holder must maintain the following information for each person:

(1) identifying information, including the person's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of the person's legal representative, if any, an emergency contact, the case manager, and family members or others as identified by the person or case manager;

(3) service information, including service initiation information, verification of the person's eligibility for services, and documentation verifying that services have been provided as identified in the service plan according to paragraph (a);

(4) health information, including medical history and allergies, and when the license holder is assigned responsibility for meeting the person's health needs according to section 245D.05:

(i) current orders for medication, treatments, or medical equipment;

(ii) medication administration procedures;

(iii) a medication administration record documenting the implementation of the medication administration procedures, including any agreements for administration of injectable medications by the license holder; and

(iv) a medical appointment schedule;

(5) the person's current service plan or that portion of the plan assigned to the license holder. When a person's case manager does not provide a current service plan, the license holder must make a written request to the case manager to provide a copy of the service plan and inform the person of the right to a current service plan and the right to appeal under section 256.045;

(6) a record of other service providers serving the person when the person's service plan identifies the need for coordination between the service providers that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to the service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3; and

(12) discharge summary, including service termination notice and related documentation, when applicable.

Subd. 3. **Access to service recipient records.** The license holder must ensure that the following people have access to the information in subdivision 1 in accordance with applicable state and federal law, regulation, or rule:

(1) the person, the person's legal representative, and anyone properly authorized by the person;

(2) the person's case manager;

(3) staff providing services to the person unless the information is not relevant to carrying out the service plan; and

(4) the county adult foster care licensor, when services are also licensed as adult foster care.

Subd. 4. **Personnel records.** The license holder must maintain a personnel record of each employee, direct service volunteer, and subcontractor to document and verify staff qualifications, orientation, and training. For the purposes of this subdivision, the terms "staff" and "staff person" mean paid employee, direct service volunteer, or subcontractor. The personnel record must include:

(1) the staff person's date of hire, completed application, a position description signed by the staff person, documentation that the staff person meets the position requirements as determined by the license holder, the date of first supervised direct contact with a person served by the program, and the date of first unsupervised direct contact with a person served by the program;

(2) documentation of staff qualifications, orientation, training, and performance evaluations as required under section 245D.09, subdivisions 3, 4, and 5, including the date the training was completed, the number of hours per subject area, and the name and qualifications of the trainer or instructor; and

(3) a completed background study as required under chapter 245C.

256.82 PAYMENTS BY STATE.

Subd. 4. **Rules.** The commissioner shall adopt rules to implement subdivision 3. In developing rules, the commissioner shall take into consideration any existing difficulty of care payment rates so that, to the extent possible, no child for whom a difficulty of care rate is currently established will be adversely affected.

256B.055 ELIGIBILITY CATEGORIES.

Subd. 3. **AFDC families.** Until March 31, 1998, medical assistance may be paid for a person who is eligible for or receiving, or who would be eligible for, except for excess income or assets, public assistance under the aid to families with dependent children program in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193.

Subd. 5. **Pregnant women; dependent unborn child.** Medical assistance may be paid for a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, who meets the other eligibility criteria of this section and who would be categorically eligible for assistance under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, if the child had been born and was living with the woman. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

Subd. 10b. **Children.** This subdivision supersedes subdivision 10 as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Medical assistance may be paid for a child less than two years of age with countable family income as established for infants under section 256B.057, subdivision 1.

256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

Subd. 5b. **Individuals with low income.** Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 1c. **No asset test for pregnant women.** Beginning September 30, 1998, eligibility for medical assistance for a pregnant woman must be determined without regard to asset standards established in section 256B.056, subdivision 3.

Subd. 2. **Children.** (a) Except as specified in subdivision 1b, effective October 1, 2003, a child one through 18 years of age in a family whose countable income is no greater than 150 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance.

(b) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

(1) the lead agency must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner. Effective no sooner than on or after July 1, 2012, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the lead agency.

Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility;

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota; and

(3) a person, 21 years of age or older, who satisfies the following criteria, as specified in Code of Federal Regulations, title 42, section 483.106(b)(2):

(i) the person is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital;

(ii) the person requires nursing facility services for the same condition for which care was provided in the hospital; and

(iii) the attending physician has certified before the nursing facility admission that the person is likely to receive less than 30 days of nursing facility services.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.
Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

(e) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in subdivision 1a. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Certified assessors shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The lead agency screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

256B.0917 SENIORS' AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS.

Subdivision 1. **Purpose, mission, goals, and objectives.** (a) The purpose of implementing seniors' agenda for independent living (SAIL) projects under this section is to demonstrate a new cooperative strategy for the long-term care system in the state of Minnesota.

The projects are part of the initial plan for a 20-year strategy. The mission of the 20-year strategy is to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and human resources. The goals for the 20-year strategy are to:

(1) achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care;

(4) maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly persons served in institutional settings; and

(5) build a community-based approach and community commitment to delivering long-term care services for elderly persons in their homes.

(b) The objective for the fiscal years 1994 and 1995 biennial plan is to continue at least four but not more than six projects in anticipation of a statewide program. These projects will continue the process of implementing:

(1) a coordinated planning and administrative process;

(2) a refocused function of the preadmission screening program;

(3) the development of additional home, community, and residential alternatives to nursing homes;

(4) a program to support the informal caregivers for elderly persons;

(5) programs to strengthen the use of volunteers; and

(6) programs to support the building of community commitment to provide long-term care for elderly persons.

The services offered through these projects are available to those who have their own funds to pay for services, as well as to persons who are eligible for medical assistance and to persons who are 180-day eligible clients to the extent authorized in this section.

Subd. 2. **Design of SAIL projects; local long-term care coordinating team.** (a) The commissioner of human services shall contract with SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost-effectiveness of a local long-term care strategy that is consistent with the state's long-term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.

(b) To be selected for the project, a county board or boards must establish a long-term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, a representative of local nursing home providers, a representative of local home care providers, and the area agencies on aging in a geographic area which is responsible for:

(1) developing a local long-term care strategy consistent with state goals and objectives;

(2) submitting an application to be selected as a project;

(3) coordinating planning for funds to provide services to elderly persons, including funds received under title III of the Older Americans Act, title XX of the Social Security Act and the Local Public Health Act; and

(4) ensuring efficient services provision and nonduplication of funding.

(c) The board or boards shall designate a public agency to serve as the lead agency. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long-term care coordinating team must semiannually evaluate the progress of the local long-term care strategy in meeting state measures of performance and results as established in the contract.

(d) Each member of the local coordinating team must indicate its endorsement of the local strategy. The local long-term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order to develop and offer a variety of cost-effective services to the elderly and their caregivers.

(e) The board or boards shall apply to be selected as a project. If the project is selected, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(f) Projects shall be selected according to the following conditions.

No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long-term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

Subd. 3. **Local long-term care strategy.** The local long-term care strategy must list performance outcomes and indicators which meet the state's objectives. The local strategy must provide for:

(1) accessible information, assessment, and preadmission screening activities as described in subdivision 4;

(2) an increase in numbers of alternative care clients served under section 256B.0913, including those who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload; and

(3) the development of additional services such as adult family foster care homes; family adult day care; assisted living projects and congregate housing service projects in apartment buildings; expanded home care services for evenings and weekends; expanded volunteer services; and caregiver support and respite care projects.

The county or groups of counties selected for the projects shall be required to comply with federal regulations, alternative care funding policies in section 256B.0913, and the federal waiver programs' policies in section 256B.0915. The requirements for preadmission screening are defined in section 256B.0911, subdivisions 1 to 6. Requirements for an access, screening, and assessment function are defined in subdivision 4. Requirements for the service development and service provision are defined in subdivision 5.

Subd. 4. **Information, screening, and assessment function.** (a) The projects selected by and under contract with the commissioner shall establish an accessible information, screening, and assessment function for persons who need assistance and information regarding long-term care. This accessible information, screening, and assessment activity shall include information and referral, early intervention, follow-up contacts, telephone screening, home visits, assessments, preadmission screening, and relocation case management for the frail elderly and their caregivers in the area served by the county or counties. The purpose is to ensure that information and help is provided to elderly persons and their families in a timely fashion, when they are making decisions about long-term care. These functions may be split among various agencies, but must be coordinated by the local long-term care coordinating team.

(b) Accessible information, screening, and assessment functions shall be reimbursed as follows:

(1) The screenings of all persons entering nursing homes shall be reimbursed as defined in section 256B.0911, subdivision 6; and

(2) Additional state administrative funds shall be available for the access, screening, and assessment activities that are not reimbursed under clause (1). This amount shall not exceed the amount authorized in the guidelines and in instructions for the application and must be within the amount appropriated for this activity.

(c) Any information and referral functions funded by other sources, such as title III of the Older Americans Act and title XX of the Social Security Act, shall be considered by the local long-term care coordinating team in establishing this function to avoid duplication and to ensure access to information for persons needing help and information regarding long-term care.

(d) The lead agency or the agencies under contract with the lead agency which are responsible for the accessible information, screening, and assessment function must complete the forms and reports required by the commissioner as specified in the contract.

Subd. 5. **Service development and delivery.** (a) In addition to the access, screening, and assessment activity, each local strategy may include provisions for the following:

(1) the addition of a full-time staff person who is responsible to develop the following services and recruit providers as established in the contract:

(i) additional adult family foster care homes;

(ii) family adult day care providers as defined in section 256B.0919, subdivision 2;

(iii) an assisted living program in an apartment;

(iv) a congregate housing service project in a subsidized housing project; and

(v) the expansion of evening and weekend coverage of home care services as deemed necessary by the local strategic plan;

(2) small incentive grants to new adult family care providers for renovations needed to meet licensure requirements;

(3) a plan to divert new applicants to nursing homes and to relocate a targeted population from nursing homes, using the individual's own resources or the funding available for services;

(4) one or more caregiver support and respite care projects, as described in subdivision 6; and

(5) one or more living-at-home/block nurse projects, as described in subdivisions 7 to 10.

(b) The expansion of alternative care clients under paragraph (a) shall be accomplished with the funds provided under section 256B.0913, and includes the allocation of targeted funds. The funding for all participating counties must be coordinated by the local long-term care coordinating team and must be part of the local long-term care strategy. Alternative care funds may be transferred from one SAIL county to another within a designated SAIL project area during a fiscal year as authorized by the local long-term care coordinating team and approved by the commissioner. The base allocation used for a future year shall reflect the final transfer. Each county retains responsibility for reimbursement as defined in section 256B.0913, subdivision 12. All other requirements for the alternative care program must be met unless an exception is provided in this section. The commissioner may establish by contract a reimbursement mechanism for alternative care that does not require invoice processing through the Medical Assistance Management Information System (MMIS). The commissioner and local agencies must assure that the same client and reimbursement data is obtained as is available under MMIS.

(c) The administration of these components is the responsibility of the agencies selected by the local coordinating team and under contract with the local lead agency. However, administrative funds for paragraph (a), clauses (2) to (4), and grant funds for paragraph (a), clause (5), shall be granted to the local lead agency. The funding available for each component is based on the plan submitted and the amount negotiated in the contract.

Subd. 7. **Contract.** (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.

Subd. 8. **Living-at-home/block nurse program grant.** (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to 33 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals;

(3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed $80,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Subd. 9. **State technical assistance center.** The organization under contract shall be the state technical assistance center to provide orientation and technical assistance, and to coordinate the living-at-home/block nurse programs established. The state resource center shall:

(1) provide communities with criteria in planning and designing their living-at-home/block nurse programs;

(2) provide general orientation and technical assistance to communities who desire to establish living-at-home/block nurse programs;

(3) provide ongoing analysis and data collection of existing and newly established living-at-home/block nurse programs and provide data to the organization performing the independent assessment; and

(4) serve as the living-at-home/block nurse programs' liaison to the legislature and other state agencies.

Subd. 10. **Implementation plan.** The organization under contract shall develop a plan that specifies a strategy for implementing living-at-home/block nurse programs statewide. The plan must also analyze the data collected by the state technical assistance center and describe the effectiveness of services provided by living-at-home/block nurse programs, including the program's impact on acute care costs. The organization shall report to the commissioner of human services and to the legislature by January 1, 1993.

Subd. 11. **SAIL evaluation and expansion.** The commissioner shall evaluate the success of the SAIL projects against the objective stated in subdivision 1, paragraph (b), and recommend to the legislature the continuation or expansion of the long-term care strategy by February 15, 1995.

Subd. 12. **Public awareness campaign.** The commissioner, with assistance from the commissioner of health and with the advice of the long-term care planning committee, shall contract for a public awareness campaign to educate the general public, seniors, consumers, caregivers, and professionals about the aging process, the long-term care system, and alternatives available including alternative care and residential alternatives. Particular emphasis will be given

to informing consumers on how to access the alternatives and obtain information on the long-term care system. The commissioner shall pursue the development of new names for preadmission screening, alternative care, foster care, and other services as deemed necessary for the public awareness campaign.

Subd. 14. **Essential community supports grants.** (a) The purpose of the essential community supports grant program is to provide targeted services to persons 65 years and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Within the limits of the appropriation and not to exceed $400 per person per month, funding must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) would otherwise be financially eligible for the alternative care program under section 256B.0913, subdivision 4;

(4) has received a community assessment under section 256B.0911, subdivision 3a or 3b, and does not require the level of care provided in a nursing facility;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, subdivision 3a or 3b, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) caregiver support;

(ii) homemaker;

(iii) chore; or

(iv) a personal emergency response device or system.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination as part of their community support plan.

(d) A person who has been determined to be eligible for an essential community support grant must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for an essential community support grant.

(e) The commissioner shall allocate grants to counties and tribes under contract with the department based upon the historic use of the medical assistance elderly waiver and alternative care grant programs and other criteria as determined by the commissioner.

256B.092 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

(1) providers of residential support services must own or control the residential site;

(2) the residential site must not be the primary residence of the license holder;

(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;

(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's coordinated service and support plan; and

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR DISABLED.

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care

waiver service, supported employment, prevocational service, and structured day service under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through the following methods:

(1) for independent living skills services, supported employment, prevocational service, and structured day service through one of the methods in paragraphs (c) and (d); and

(2) for foster care waiver services through the method in paragraph (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the brain injury, community alternatives for disabled persons, or community alternative care home and community-based waivers.

(d) The commissioner shall certify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;

(iii) a minimum of five hours of related training annually; and

(iv) when applicable:

(A) safe medication administration;

(B) proper handling of consumer funds; and

(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.

(e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:

(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;

(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and

(3) safe medication management and administration.

The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.

(f) The commissioner shall seek federal waiver approval for Medicaid reimbursement of family adult day services under all disability waivers. After the waiver is granted, the commissioner shall include family adult day services in the common services menu that is currently under development.

Subd. 22. **Residential support services.** For the purposes of this section, the provisions of section 256B.092, subdivision 11, are controlling.

256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.

Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least 115 percent of the federal poverty guidelines at the time of the adjustment. The adjustment to the disregard shall be based on a household size of three, and the resulting earned

income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented whenever a Supplemental Nutrition Assistance Program adjustment is reflected in the food portion of the MFIP transitional standard as required under subdivision 5a.

256L.01 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this chapter, the following terms shall have the meanings given them.

Subd. 1a. **Child.** "Child" means an individual under 21 years of age, including the unborn child of a pregnant woman, an emancipated minor, and an emancipated minor's spouse.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Eligible providers.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subd. 3a. **Family with children.** (a) "Family with children" means:

(1) parents and their children residing in the same household; or

(2) grandparents, foster parents, relative caretakers as defined in the medical assistance program, or legal guardians; and their wards who are children residing in the same household.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility.

Subd. 5. **Income.** (a) "Income" has the meaning given for earned and unearned income for families and children in the medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 1996. The definition does not include medical assistance income methodologies and deeming requirements. The earned income of full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security income are not excluded income.

(b) For purposes of this subdivision, and unless otherwise specified in this section, the commissioner shall use reasonable methods to calculate gross earned and unearned income including, but not limited to, projecting income based on income received within the past 30 days, the last 90 days, or the last 12 months.

256L.02 PROGRAM ADMINISTRATION.

Subdivision 1. **Purpose.** The MinnesotaCare program is established to promote access to appropriate health care services to assure healthy children and adults.

Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all eligible providers. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services. A toll-free telephone number must be used to provide information about medical programs and to promote access to the covered services.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the

adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

256L.03 COVERED HEALTH SERVICES.

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

Subd. 1a. **Pregnant women and children; MinnesotaCare health care reform waiver.** Beginning January 1, 1999, children and pregnant women are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Pregnant women and children are exempt from the provisions of subdivision 5, regarding co-payments. Pregnant women and children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Subd. 1b. **Pregnant women; eligibility for full medical assistance services.** A pregnant woman enrolled in MinnesotaCare is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date of conception. Co-payments totaling $30 or more, paid after the date of conception, shall be refunded.

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the Department of Human Services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6660. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of $10,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Subd. 3a. **Interpreter services.** Covered services include sign and spoken language interpreter services that assist an enrollee in obtaining covered health care services.

Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic services: medically necessary exams, manual manipulation of the spine, and x-rays.

Subd. 4. **Coordination with medical assistance.** The commissioner shall coordinate the provision of hospital inpatient services under the MinnesotaCare program with enrollee eligibility under the medical assistance spenddown.

Subd. 5. **Cost-sharing.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(5) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

(6) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

(h) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible

under paragraph (a), clause (6). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; and county-based purchasing entities under section 256B.692.

256L.031 HEALTHY MINNESOTA CONTRIBUTION PROGRAM.

Subdivision 1. **Defined contributions to enrollees.** (a) Beginning July 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income equal to or greater than 200 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration, continue to apply to enrollees obtaining coverage under this section.

Subd. 2. **Use of defined contribution; health plan requirements.** (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3, or as provided in section 256L.031, subdivision 6.

(b) An enrollee must select a health plan within four calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) Coverage purchased under this section must:

(1) include mental health and chemical dependency treatment services; and

(2) comply with the coverage limitations specified in section 256L.03, subdivision 1, paragraph (b).

Subd. 3. **Determination of defined contribution amount.** (a) The commissioner shall determine the defined contribution sliding scale using the base contribution specified in this paragraph for the specified age ranges. The commissioner shall use a sliding scale for defined contributions that provides:

(1) persons with household incomes equal to 200 percent of the federal poverty guidelines with a defined contribution of 93 percent of the base contribution;

(2) persons with household incomes equal to 250 percent of the federal poverty guidelines with a defined contribution of 80 percent of the base contribution; and

(3) persons with household incomes in evenly spaced increments between the percentages of the federal poverty guideline or income level specified in clauses (1) and (2) with a base contribution that is a percentage interpolated from the defined contribution percentages specified in clauses (1) and (2).

19-29	$125
30-34	$135
35-39	$140
40-44	$175
45-49	$215
50-54	$295

55-59	$345
60+	$360

(b) The commissioner shall multiply the defined contribution amounts developed under paragraph (a) by 1.20 for enrollees who purchase coverage through the Minnesota Comprehensive Health Association.

Subd. 4. **Administration by commissioner.** (a) The commissioner shall administer the defined contributions. The commissioner shall:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage may not reenroll until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning July 1, 2012, MinnesotaCare enrollees eligible for coverage through a health plan offered by the Minnesota Comprehensive Health Association may enroll in MCHA in accordance with section 62E.14. Any difference between the revenue and actual covered losses to MCHA related to the implementation of this section are appropriated annually to the commissioner of human services from the health care access fund and shall be paid to MCHA.

Subd. 7. **Federal approval.** The commissioner shall seek federal financial participation for the adult enrollees eligible under this section.

256L.04 ELIGIBLE PERSONS.

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Parents are not eligible for MinnesotaCare if their gross income exceeds $57,500.

(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision 8, are exempt from the eligibility requirements of this subdivision.

Subd. 1a. **Social Security number required.** (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number.

(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.

(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision.

(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.

Subd. 1b. **Children with family income greater than 275 percent of federal poverty guidelines.** Children with family income greater than 275 percent of federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

Subd. 2. **Third-party liability, paternity, and other medical support.** (a) To be eligible for MinnesotaCare, individuals and families must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.

Subd. 2a. **Applications for other benefits.** To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days of notification.

Subd. 7. **Single adults and households with no children.** (a) The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines.

(b) Effective July 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 250 percent of the federal poverty guidelines.

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program.

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009.

Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals who receive supplemental security income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not cooperate with medical assistance within the 60-day enrollment period shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

(c) Beginning January 1, 2000, counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications to also be applications for medical assistance. Applicants who are potentially eligible for medical assistance, except for those described in paragraph (a), may choose to enroll in either MinnesotaCare or medical assistance.

(d) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Subd. 9. **General assistance medical care.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month. Eligibility for MinnesotaCare cannot be replaced by eligibility for general assistance medical care, and eligibility for general assistance medical care cannot be replaced by eligibility for MinnesotaCare.

Subd. 10. **Citizenship requirements.** Eligibility for MinnesotaCare is limited to citizens or nationals of the United States, qualified noncitizens, and other persons residing lawfully in the United States as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens and nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8,

section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

Subd. 10a. **Sponsor's income and resources deemed available; documentation.** (a) When determining eligibility for any federal or state benefits under sections 256L.01 to 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of support as defined under United States Code, title 8, section 1183a, shall be deemed to include their sponsors' income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules. To be eligible for the program, noncitizens must provide documentation of their immigration status.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, sponsor deeming does not apply to pregnant women and children who are qualified noncitizens, as described in section 256B.06, subdivision 4, paragraph (b).

Subd. 12. **Persons in detention.** Beginning January 1, 1999, an applicant residing in a correctional or detention facility is not eligible for MinnesotaCare. An enrollee residing in a correctional or detention facility is not eligible at renewal of eligibility under section 256L.05, subdivision 3a.

Subd. 13. **Families with relative caretakers, foster parents, or legal guardians.** Beginning January 1, 1999, in families that include a relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount.

256L.05 APPLICATION PROCEDURES.

Subdivision 1. **Application assistance and information availability.** (a) Applications and application assistance must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies.

(b) Application assistance must be available for applicants choosing to file an online application.

Subd. 1a. **Person authorized to apply on applicant's behalf.** Beginning January 1, 1999, a family member who is age 18 or over or who is an authorized representative, as defined in the medical assistance program, may apply on an applicant's behalf.

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

Subd. 2. **Commissioner's duties.** The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the

date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(e) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (d), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.

(f) The effective date of coverage for children eligible under section 256L.07, subdivision 8, is the first day of the month following the date of termination from foster care or release from a juvenile residential correctional facility.

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For children enrolled in MinnesotaCare under section 256L.07, subdivision 8, the first period of renewal begins the month the enrollee turns 21 years of age.

Subd. 3b. **Reapplication.** Beginning January 1, 1999, families and individuals must reapply after a lapse in coverage of one calendar month or more and must meet all eligibility criteria.

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. General assistance medical care recipients may qualify for retroactive coverage under this subdivision at six-month renewal.

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the Department of Human Services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare.

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c).

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare who identify themselves as veterans are referred to a county veterans service

officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

256L.06 PREMIUM ADMINISTRATION.

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 200 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance.

Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit. This subdivision does not apply to children with family gross incomes that are equal to or less than 200 percent of federal poverty guidelines.

(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled. Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health coverage for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 200 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Coverage purchased as provided under section 256L.031, subdivision 2, medical assistance, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance within one month of application must meet the provisions of this subdivision and subdivision 2.

(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.

Subd. 4. **Families with children in need of chemical dependency treatment.** Premiums for families with children when a parent has been determined to be in need of chemical dependency treatment pursuant to an assessment conducted by the county under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, who are eligible for MinnesotaCare under section 256L.04, subdivision 1, may be paid by the county of residence of the person in need of treatment for one year from the date the family is determined to be eligible or if the family is currently enrolled in MinnesotaCare from the date the person is determined to be in need of chemical dependency treatment. Upon renewal, the family is responsible for any premiums owed under section 256L.15. If the family is not currently enrolled in MinnesotaCare, the local county human services agency shall determine whether the family appears to meet the eligibility requirements and shall assist the family in applying for the MinnesotaCare program.

Subd. 5. **Voluntary disenrollment for members of military.** Notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military and their families, who choose to voluntarily disenroll from the program when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Those individuals and families shall be considered to have good cause for voluntary termination

under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18 shall apply to individuals and families enrolled under this subdivision upon 12-month renewal.

Subd. 8. **Automatic eligibility for certain children.** Any child who was residing in foster care or a juvenile residential correctional facility on the child's 18th birthday is automatically deemed eligible for MinnesotaCare upon termination or release until the child reaches the age of 21, and is exempt from the requirements of this section and section 256L.15. To be enrolled under this section, a child must complete an initial application for MinnesotaCare. The commissioner shall contact individuals enrolled under this section annually to ensure the individual continues to reside in the state and is interested in continuing MinnesotaCare coverage.

Subd. 9. **Firefighters; volunteer ambulance attendants.** (a) For purposes of this subdivision, "qualified individual" means:

(1) a volunteer firefighter with a department as defined in section 299N.01, subdivision 2, who has passed the probationary period; and

(2) a volunteer ambulance attendant as defined in section 144E.001, subdivision 15.

(b) A qualified individual who documents to the satisfaction of the commissioner status as a qualified individual by completing and submitting a one-page form developed by the commissioner is eligible for MinnesotaCare without meeting other eligibility requirements of this chapter, but must pay premiums equal to the average expected capitation rate for adults with no children paid under section 256L.12. Individuals eligible under this subdivision shall receive coverage for the benefit set provided to adults with no children.

256L.09 RESIDENCY.

Subdivision 1. **Findings and purpose.** The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the general assistance medical care program, the medical assistance program, and public and private charity care programs.

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, pregnant women, individuals, and families with children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval.

Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

(b) To be eligible as a permanent resident, an applicant must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address, through the use of evidence of residence described in section 256D.02, subdivision 12a, paragraph (b), clause (2);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

(c) A person who is temporarily absent from the state does not lose eligibility for MinnesotaCare. "Temporarily absent from the state" means the person is out of the state for a temporary purpose and intends to return when the purpose of the absence has been accomplished. A person is not temporarily absent from the state if another state has determined that the person

is a resident for any purpose. If temporarily absent from the state, the person must follow the requirements of the health plan in which the person is enrolled to receive services.

Subd. 5. **Persons excluded as permanent residents.** An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

Subd. 6. **12-month preexisting exclusion.** If the 180-day requirement in subdivision 4, paragraph (b), clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month preexisting condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

Subd. 7. **Effect of a court determination.** If any paragraph, sentence, clause, or phrase of this section is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the section. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this section, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

256L.10 APPEALS.

If the commissioner suspends, reduces, or terminates eligibility for the MinnesotaCare program, or services provided under the MinnesotaCare program, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A MinnesotaCare program applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

256L.11 PROVIDER PAYMENT.

Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6.

(b) Effective for services provided on or after July 1, 2009, total payments for basic care services shall be reduced by three percent, in accordance with section 256B.766. Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(c) Effective for services provided on or after July 1, 2009, payment rates for physician and professional services shall be reduced as described under section 256B.76, subdivision 1, paragraph (c). Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under section 256L.03, subdivision 3, shall be paid for as provided in subdivisions 4 to 6.

Subd. 4. **Definition of medical assistance rate for inpatient hospital services.** The "medical assistance rate," as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive Minnesota family investment program assistance.

Subd. 5. **Enrollees younger than 18.** Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, through August 31, 2011, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 50 percent above the payment rate that would otherwise be paid to the provider. Effective for dental services provided on or after September 1, 2011, the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

256L.12 MANAGED CARE.

Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

Subd. 2. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. **Limitation of choice.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **Exemptions to limitations on choice.** All contracts between the Department of Human Services and prepaid health plans to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance will remain in the same managed care plan if the managed care plan has a contract for that population. MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all co-payments in section 256L.03, subdivision 5, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the Department of Human Services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee co-payments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's

enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Subd. 9b. **Rate setting; ratable reduction.** In addition to the reduction in subdivision 9a, the total payment made to managed care plans under the MinnesotaCare program shall be reduced for services provided on or after January 1, 2006, to reflect a 6.0 percent reduction in reimbursement for inpatient hospital services.

Subd. 10. **Childhood immunization.** Each managed care plan contracting with the Department of Human Services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

Subd. 11. **Coverage at Indian health service facilities.** For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian health service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Act, Public Law 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

256L.15 PREMIUMS.

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the

first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

(d) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

Subd. 1a. **Payment options.** The commissioner may offer the following payment options to an enrollee:

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

(5) payment by wage withholding with the consent of the employer and the employee; or

(6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the $10 fee under section 270A.07, subdivision 1.

Subd. 1b. **Payments nonrefundable.** Only MinnesotaCare premiums paid for future months of coverage for which a health plan capitation fee has not been paid may be refunded.

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums. For purposes of paragraph (d), "minimum" means a monthly premium of $4.

(d) The following premium scale is established for individuals and families with gross family incomes of 275 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	$4 or 1.1% of family income, whichever is greater
55-81%	1.6%

82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-275%	7.2%

256L.17 ASSET REQUIREMENT FOR MINNESOTACARE.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply.

(a) "Asset" means cash and other personal property, as well as any real property, that a family or individual owns which has monetary value.

(b) "Homestead" means the home that is owned by, and is the usual residence of, the family or individual, together with the surrounding property which is not separated from the home by intervening property owned by others. Public rights-of-way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. "Usual residence" includes the home from which the family or individual is temporarily absent due to illness, employment, or education, or because the home is temporarily not habitable due to casualty or natural disaster.

(c) "Net asset" means the asset's fair market value minus any encumbrances including, but not limited to, liens and mortgages.

Subd. 2. **Limit on total assets.** (a) Effective July 1, 2002, or upon federal approval, whichever is later, in order to be eligible for the MinnesotaCare program, a household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets.

(b) For purposes of this subdivision, assets are determined according to section 256B.056, subdivision 3c, except that workers' compensation settlements received due to a work-related injury shall not be considered.

(c) State-funded MinnesotaCare is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify assets. Enrollees who become eligible for federally funded medical assistance shall be terminated from state-funded MinnesotaCare and transferred to medical assistance.

Subd. 3. **Documentation.** (a) The commissioner of human services shall require individuals and families, at the time of application or renewal, to indicate on a form developed by the commissioner whether they satisfy the MinnesotaCare asset requirement.

(b) The commissioner may require individuals and families to provide any information the commissioner determines necessary to verify compliance with the asset requirement, if the commissioner determines that there is reason to believe that an individual or family has assets that exceed the program limit.

Subd. 4. **Penalties.** Individuals or families who are found to have knowingly misreported the amount of their assets as described in this section shall be subject to the penalties in section 256.98. The commissioner shall present recommendations on additional penalties to the 1998 legislature.

Subd. 5. **Exemption.** This section does not apply to pregnant women or children. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

256L.18 PENALTIES.

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

(1) benefits under the MinnesotaCare program to which the person is not entitled; or

(2) benefits under the MinnesotaCare program greater than that to which the person is reasonably entitled;

shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided under that section.

256L.22 DEFINITION; CHILDREN'S HEALTH PROGRAM.

For purposes of sections 256L.22 to 256L.28, "children's health program" means the medical assistance and MinnesotaCare programs to the extent medical assistance and MinnesotaCare provide health coverage to children.

256L.24 HEALTH CARE ELIGIBILITY FOR CHILDREN.

Subdivision 1. **Applicability.** This section applies to children who are enrolled in a children's health program.

Subd. 2. **Application procedure.** The commissioner shall develop an application form for children's health programs for children that is easily understandable and does not exceed four pages in length. The provisions of section 256L.05, subdivision 1, apply.

Subd. 3. **Premiums.** Children enrolled in MinnesotaCare shall pay premiums as provided in section 256L.15.

Subd. 4. **Eligibility renewal.** The commissioner shall require children enrolled in MinnesotaCare to renew eligibility every 12 months.

256L.26 ASSISTANCE TO APPLICANTS.

The commissioner shall assist children in choosing a managed care organization to receive services under a children's health program, by:

(1) establishing a Web site to provide information about managed care organizations and to allow online enrollment;

(2) making applications and information on managed care organizations available to applicants and enrollees according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services; and

(3) making benefit educators available to assist applicants in choosing a managed care organization.

256L.28 FEDERAL APPROVAL.

The commissioner shall seek all federal waivers and approvals necessary to implement sections 256L.22 to 256L.28, including, but not limited to, waivers and approvals necessary to:

(1) coordinate medical assistance and MinnesotaCare coverage for children; and

(2) maximize receipt of the federal medical assistance match for covered children, by increasing income standards through the use of more liberal income methodologies as provided under United States Code, title 42, sections 1396a and 1396u-1.

260C.441 COST, PAYMENT.

In addition to the usual care and services given by public and private agencies, the necessary cost incurred by the commissioner of human services in providing care for such child shall be paid by the county committing such child which, subject to uniform rules established by the commissioner of human services, may receive a reimbursement not exceeding one-half of such costs from funds made available for this purpose by the legislature during the period beginning July 1, 1985, and ending December 31, 1985. Beginning January 1, 1986, the necessary cost incurred by the commissioner of human services in providing care for the child must be paid by the county committing the child. Where such child is eligible to receive a grant of Minnesota family investment program or supplemental security income for the aged, blind, and disabled, or a foster care maintenance payment under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, the child's needs shall be met through these programs.

485.14 VITAL STATISTICS, RECORDS RECEIVED FOR PRESERVATION.

The court administrators of the district court may, at their option as county registrars of vital statistics, receive for preservation records or certificates of live birth, death or stillbirth from town clerks, statutory city clerks, city agents of a board of health as authorized under section 145A.04 of cities which do not maintain local registration of vital statistics under section 144.214, or other local officers, who may have lawful custody and possession thereof in their respective counties. The court administrators taking possession of such records and certificates shall with regard to them be subject to all applicable provisions of sections 144.211 to 144.227.

3400.0130 CHILD CARE PROVIDER RATES.

Subp. 8. [Repealed, L 2011 1Sp9 art 3 s 35]

4668.0002 APPLICABILITY, AUTHORITY, AND SCOPE.

This chapter implements the licensing of home care providers under Minnesota Statutes, sections 144A.43 to 144A.47, under the authority of Minnesota Statutes, sections 144A.45, subdivision 1, and 144A.4605. Unless otherwise provided, all licensed home care providers must meet the requirements of this chapter. Provisions that apply only to specified classes of licensees are identified by those provisions. The commissioner may delegate any authority or responsibility to an agent of the department. This chapter must be read together with Minnesota Statutes, sections 144A.43 to 144A.47.

4668.0003 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 4668.0002 to 4668.0870, the terms in subparts 2 to 45 have the meanings given them.

Subp. 2. **Ambulatory.** "Ambulatory" means the ability to move about and transfer between locations without the assistance of another person, either with or without the assistance of a walking device or wheel chair.

Subp. 2a. **Assistance with self-administration of medication.** "Assistance with self-administration of medication" means performing a task to enable a client to self-administer medication, including:

A. bringing the medication to the client;

B. opening a container containing medications set up by a nurse, physician, or pharmacist;

C. emptying the contents from the container into the client's hand;

D. providing liquids or nutrition to accompany medication that a client is self-administering; or

E. reporting information to a nurse regarding concerns about a client's self-administration of medication.

Subp. 2b. **Class F home care provider.** "Class F home care provider" has the meaning given in Minnesota Statutes, section 144A.4605, subdivision 1.

Subp. 2c. **Assisted living home care service.** "Assisted living home care service" means a nursing service, delegated nursing service, other service performed by an unlicensed person, or central storage of medications provided solely for a resident of a housing with services establishment registered under Minnesota Statutes, chapter 144D.

Subp. 3. **Assisted living services.** "Assisted living services," as provided under a class E home care license, means individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. In this subpart, "individualized" means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illnesses, disabilities, or physical conditions.

Subp. 4. **Business.** "Business" means an individual or other legal entity that provides services to persons in their homes.

Subp. 5. **Client.** "Client" means a person to whom a home care provider provides home care services.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 7. **Contract.** "Contract" means a legally binding agreement, whether in writing or not.

Subp. 8. **Department.** "Department" means the Minnesota Department of Health.

Subp. 9. **Home care aide tasks.** "Home care aide tasks" means those services specified in part 4668.0110, subpart 1.

Subp. 10. **Home care provider or provider.** "Home care provider" or "provider" has the meaning given to home care provider by Minnesota Statutes, section 144A.43, subdivision 4.

Subp. 11. **Home care service.** "Home care service" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3.

Subp. 12. **Home health aide tasks.** "Home health aide tasks" means those tasks allowed in part 4668.0100, subpart 1.

Subp. 13. **Home management services.** "Home management services" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3, clause (8).

Subp. 14. **Home management tasks.** "Home management tasks" means all home management services that are not home health aide or home care aide tasks.

Subp. 15. [Repealed, 28 SR 1639]

Subp. 16. **Hospital.** "Hospital" means a facility licensed as a hospital under chapter 4640 and Minnesota Statutes, sections 144.50 to 144.56.

Subp. 17. **Inpatient facility.** "Inpatient facility" means a hospital or nursing home.

Subp. 17a. **Legend drug.** "Legend drug" has the meaning given in Minnesota Statutes, section 151.01, subdivision 17.

Subp. 18. **Licensee.** "Licensee" means a home care provider that is licensed under parts 4668.0002 to 4668.0870 and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 19. **Licensed practical nurse.** "Licensed practical nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 8.

Subp. 20. **Managerial official.** "Managerial official" means a director, officer, trustee, or employee of a provider, however designated, who has the authority to establish or control business policy.

Subp. 21. **Medical social work or medical social services.** "Medical social work" or "medical social services" means social work related to the medical, health, or supportive care of clients.

Subp. 21a. **Medication administration.** "Medication administration" means performing a task to ensure a client takes a medication, and includes the following tasks, performed in the following order:

A. checking the client's medication record;

B. preparing the medication for administration;

C. administering the medication to the client;

D. documenting after administration, or the reason for not administering the medication as ordered; and

E. reporting information to a nurse regarding concerns about the medication or the client's refusal to take the medication.

Subp. 21b. **Medication reminder.** "Medication reminder" means providing a verbal or visual reminder to a client to take medication.

Subp. 22. **Nurse.** "Nurse" means a registered nurse or licensed practical nurse.

Subp. 23. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, sections 144A.01 to 144A.16.

Subp. 24. **Nutritional services.** "Nutritional services" means the services provided by a dietitian, including evaluation of a client's nutritional status and recommendation for changes in nutritional care; planning, organizing, and coordinating nutritional parts of other health services; adapting a medically ordered diet to the needs and understanding of the client; and translating the recommendations for nutritional care into appropriate food selection and food preparation guidelines.

Subp. 25. **Occupational therapist.** "Occupational therapist" means a person who performs occupational therapy.

Subp. 26. **Occupational therapy.** "Occupational therapy" means services designed to assist a client, who has functional disabilities related to developmental, restorative, or health needs, to adapt the client's environment and skills to aid in the performance of daily living tasks.

Subp. 26a. **Oral hygiene.** "Oral hygiene" means care of teeth, gums, and oral prosthetic devices.

Subp. 26b. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription," and as a result, may be sold without a prescription.

Subp. 27. **Owner.** "Owner" means a:

A. proprietor;

B. general partner;

C. limited partner who has five percent or more of equity interest in a limited partnership;

D. person who owns or controls voting stock in a corporation in an amount equal to or greater than five percent of the shares issued and outstanding; or

E. corporation that owns an equity interest in a licensee or applicant for a license.

Subp. 28. **Paraprofessional.** "Paraprofessional" means a person who performs home health aide, home care aide, or home management tasks.

Subp. 28a. **Pharmacist.** "Pharmacist" means a person currently licensed under Minnesota Statutes, chapter 151.

Subp. 29. **Physical therapist.** "Physical therapist" has the meaning given by Minnesota Statutes, section 148.65, subdivision 2.

Subp. 30. **Physical therapy.** "Physical therapy" has the meaning given by Minnesota Statutes, section 148.65, subdivision 1.

Subp. 31. **Physician.** "Physician" means a person licensed under Minnesota Statutes, chapter 147.

Subp. 32. **Prescriber.** "Prescriber" means a person who is authorized by law to prescribe legend drugs.

Subp. 33. **Registered nurse.** "Registered nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 20.

Subp. 34. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine.

Subp. 35. **Residential center.** "Residential center" means a building or complex of contiguous or adjacent buildings in which clients rent or own distinct living units.

Subp. 36. **Respiratory therapist.** "Respiratory therapist" means a person who performs respiratory therapy.

Subp. 37. **Respiratory therapy.** "Respiratory therapy" means therapeutic services provided under medical orders for the assessment, treatment, management, diagnostic evaluation, and care of clients with deficiencies, abnormalities, and diseases of the cardiopulmonary system.

Subp. 38. **Responsible person.** "Responsible person" means a person who, because of the client's incapacity, makes decisions about the client's care on behalf of the client. A responsible person may be a guardian, conservator, attorney-in-fact, family member, or other agent of the client. Nothing in this chapter expands or diminishes the rights of persons to act on behalf of clients under other law.

Subp. 39. **Social work.** "Social work" has the meaning of "social work practice" as defined by Minnesota Statutes, section 148B.18, subdivision 11.

Subp. 40. **Speech therapy.** "Speech therapy" means diagnostic, screening, preventive, or corrective services for clients with speech, hearing, and language disorders.

Subp. 41. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. Surveys include investigations of complaints.

Subp. 42. **Surveyor.** "Surveyor" means a representative of the department authorized by the commissioner to conduct surveys of licensees.

Subp. 43. **Therapist.** "Therapist" means a respiratory therapist, physical therapist, occupational therapist, speech therapist, or provider of nutritional services.

Subp. 44. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or the United States, and includes any instrumentality of a unit of government.

Subp. 44a. **Unlicensed person.** "Unlicensed person" means a person who is employed by the licensee and who is not a nurse. Unlicensed person does not include nonemployee family members, nonemployee significant others, and nonemployee responsible persons.

Subp. 45. **Verbal.** "Verbal" means oral and not in writing.

4668.0005 PROFESSIONAL LICENSES.

Nothing in this chapter limits or expands the rights of health care professionals to provide services within the scope of their licenses or registrations, as provided by Minnesota law.

4668.0008 SERVICES INCLUDED IN AND EXCLUDED FROM LICENSURE.

Subpart 1. **Purpose.** This part implements Minnesota Statutes, section 144A.43, and establishes a process for determining what businesses are subject to licensure under this chapter.

This part must be read together with Minnesota Statutes, section 144A.43. A business that is not required to be licensed under this chapter may obtain a license for the purpose of excluding individual contractors under subpart 6 or for other lawful purposes.

Subp. 2. **Determination of direct services.** As defined in Minnesota Statutes, section 144A.43, subdivision 4, a home care provider is a business that provides at least one home care service directly. A service that is provided directly means a service provided to a client by the provider or employees of the provider, and not by contract with an independent contractor. The administration of a contract for home care services is not in itself a direct service. Factors that shall be considered in determining whether a business provides home care services directly include whether the business:

A. has the right to control and does control the types of services provided;

B. has the right to control and does control when and how the services are provided;

C. establishes the charges;

D. collects fees from the clients or receives payment from third party payers on the clients' behalf;

E. pays compensation on an hourly, weekly, or similar time basis;

F. treats the individuals as employees for purposes of payroll taxes and workers' compensation insurance; and

G. holds itself out as a provider of services or acts in a manner that leads clients or potential clients reasonably to believe that it is a provider of services.

None of the factors listed in items A to G is solely determinative.

Subp. 3. **Contract services.** If a licensee contracts for a home care service with a business that is not subject to licensure under this chapter, it must require, in the contract, that the business comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Coordination of providers of home care services.** The coordination of home care services is not itself a home care service. Coordination of home care services means one or more of the following:

A. Determination whether a client needs home care services, what services are needed, and whether existing services need to continue or be modified.

B. Referral of clients to home care providers.

C. Administration of payments for home care services.

Subp. 5. **Determination of regularly engaged.** As used in Minnesota Statutes, section 144A.43, subdivision 4, "regularly engaged" means providing, or offering to provide, home care services as a regular part of a provider's business. The following factors shall be considered by the commissioner in determining whether a person is regularly engaged in providing home care services:

A. whether the person markets services specifically to individuals whose illnesses, disabilities, or physical conditions create needs for the services;

B. whether the services are designed and intended specifically to assist the individuals;

C. whether the individuals constitute a substantial part of the person's clientele; and

D. whether the home care services are other than occasional or incidental to the provision of services that are not home care services.

None of the factors listed in items A to D is solely determinative.

Subp. 6. **Exclusion for a paraprofessional not regularly engaged in delivering home care services.** For purposes of subpart 5, an individual who performs home care aide tasks or home management tasks for no more than 14 hours each calendar week to no more than one client, is not regularly engaged in the delivery of home care services, and is not subject to licensure under this chapter.

Subp. 7. **Exclusion of individual contractors.** An individual who is not an employee of a licensed provider need not be licensed under this chapter, if the person:

A. only provides services as an independent contractor with one or more licensed providers;

B. provides no services under direct agreements with clients; and

C. is contractually bound to perform services in compliance with the contracting providers' policies and service agreements.

Individuals excluded from licensure under this subpart must comply with the same requirements of this chapter as employees of the contracting licensee.

Subp. 8. **Governmental providers.** Except as otherwise provided in this chapter or in law, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

Subp. 9. **Exclusion of certain instructional and incidental services.** A business is not subject to Minnesota Statutes, sections 144A.43 to 144A.47, and is not required to be licensed under this chapter if the business only provides services that are primarily instructional and not medical services or health-related support services.

Subp. 10. **Temporary staffing agencies.** A business that provides staff to home care providers, such as temporary employment agencies, is not required to be licensed under this chapter if the business:

A. only provides staff under contract to licensed or exempt providers;

B. provides no services under direct agreements with clients; and

C. is contractually bound to perform services under the contracting providers' direction and supervision.

Subp. 11. **Status of temporary staff.** For purposes of this chapter, staff of businesses excluded from licensure under subpart 10 shall be treated as if they are employees of the contracting licensee.

Subp. 12. **Medical equipment provider.** A provider of medical supplies and equipment is subject to this chapter only if:

A. the provider provides a home care service;

B. the provider makes more than one visit to a client's residence to provide the home care service; and

C. the supplies or equipment are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber.

In this subpart, home care service does not include maintenance of supplies or equipment or instruction in their use.

4668.0012 LICENSURE.

Subpart 1. **License issued.** If a provider complies with the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall issue to the provider a certificate of licensure that will contain:

A. the provider's name and address;

B. the class of license as provided in subpart 3;

C. the beginning and expiration dates; and

D. a unique license number.

Subp. 2. **Multiple units.** Multiple units of a provider must share the same management that supervises and administers services provided by all units. Multiple units of a provider must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services with the main office because of distinct organizational structures.

Subp. 3. **Classes of licenses.** In issuing a license under this part, the commissioner shall assign a license classification according to items A and B. A provider performing only home management tasks must be registered according to Minnesota Statutes, section 144A.461, and need not obtain a home care license.

A. A provider must apply for one of the classes of the home care license listed in subitems (1) to (5).

(1) Class A, or professional home care agency license. Under this license, a provider may provide all home care services in a place of residence, including a residential center, at least one of which is nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, medical social services, home health aide tasks, or the provision of medical supplies and equipment when accompanied by the provision of a home care service.

(2) Class B, or paraprofessional agency license. Under this license, a provider may perform home care aide tasks and home management tasks, as provided by parts 4668.0110 and 4668.0120.

(3) Class C, or individual paraprofessional license. Under this license, a provider may perform home health aide, home care aide, and home management tasks.

(4) Class E, or assisted living programs license. Under this license, a provider may only provide assisted living services to residents of a residential center.

(5) Class F home care provider license. Under this license, a provider may provide assisted living home care services solely for residents of one or more registered housing with services establishments, as provided by Minnesota Statutes, section 144A.4605.

B. If a provider meets the requirements of more than one license class, the commissioner shall issue to the provider a separate license for each applicable class of home care licensure.

Subp. 4. **Applicability of rules to classes.**

A. A class A licensee must comply with parts 4668.0002 to 4668.0180, and 4668.0218 to 4668.0240, except that one certified for Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with the requirements listed in part 4668.0180, subpart 10.

B. A class B licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0190, and 4668.0218 to 4668.0240.

C. A class C licensee must comply with parts 4668.0002 to 4668.0035, 4668.0050 to 4668.0065, 4668.0075 to 4668.0170, 4668.0200, and 4668.0218 to 4668.0240.

D. A class E licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0215, and 4668.0218 to 4668.0240.

E. A class F home care provider licensee must comply with parts 4668.0002 to 4668.0050, 4668.0065, 4668.0070, 4668.0170, 4668.0218 to 4668.0240, and 4668.0800to 4668.0870.

Subp. 5. **New license.** A license shall be issued to an applicant that is not currently licensed if the applicant completes the application, pays the fee in full, and complies with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. A license is effective for one year after the date the license is issued.

Subp. 6. **License application.** To apply for a license under this chapter, an applicant must follow the procedures in items A and B.

A. An applicant for a license under this chapter must provide the following information on forms provided by the commissioner:

(1) the applicant's name and address, including the name of the county in which the applicant resides or has its principal place of business;

(2) address and telephone number of the principal administrative office;

(3) address and telephone number of each branch office, if any;

(4) names and addresses of all owners and managerial officials;

(5) documentation of compliance with the background study requirements of Minnesota Statutes, section 144A.46, subdivision 5, for all persons involved in the management, operation, or control of a provider;

(6) evidence of workers' compensation coverage, as required by Minnesota Statutes, sections 176.181 and 176.182;

(7) in the case of class C applicants, proof that the applicant is not contagious with tuberculosis, as required by part 4668.0065, subparts 1 and 2;

(8) in the case of class C applicants, proof that the applicant has met any applicable training and supervision requirements for paraprofessionals, as provided by parts 4668.0100 and 4668.0110; and

(9) a list of those home care services listed in Minnesota Statutes, section 144A.43, subdivision 3, or 144A.4605, that will be made available to clients.

B. An application on behalf of a corporation, association, or unit of government must be signed by an officer or managing agent.

Subp. 7. **Agent.** Each application for a home care provider license or for renewal of a home care provider license shall designate one or more owners, managerial officials, or employees, as an agent:

A. who is authorized to transact business with the commissioner of health on all matters provided for in this chapter and Minnesota Statutes, sections 144A.43 to 144A.47; and

B. upon whom all notices and orders shall be served, and who is authorized to accept service of notices and orders on behalf of the licensee, in proceedings under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

The designation of one or more persons under this subpart shall not affect the legal responsibility of any other owner or managerial official under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 8. **Notification of changes in information.** The licensee shall notify the commissioner in writing within ten working days after any change in the information required to be provided by subparts 6 and 7, except for the information required by subpart 6, item A, subitem (4), which will be required at the time of license renewal, and except for services reported under subpart 6, item A, subitem (9), that are discontinued for less than 90 days.

Subp. 9. **Application processing.** The commissioner shall process an application in the manner provided by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (b). No application shall be processed without payment of the license fee in full, in the amount provided by subpart 18.

Subp. 10. **Prelicensing survey.** Before granting a license, the commissioner may investigate the applicant for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 11. **Denial of license.** A license shall be denied if:

A. the applicant; an owner of the applicant, individually or as an owner of another home care provider; or another home care provider of which an owner of the applicant also was or is an owner; has ever been issued a correction order for failing to assist its clients, in violation of part 4668.0050, subpart 2, upon the licensee's decision to cease doing business as a home care provider;

B. the applicant is not in compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

C. the applicant is disqualified under Minnesota Statutes, sections 144.057and 245A.04;

D. the applicant or an owner or managerial official has been unsuccessful in having a disqualification under Minnesota Statutes, section 144.057 or 245A.04, set aside; or

E. the commissioner determines that an owner or managerial official, as an owner or managerial official of another licensee, was substantially responsible for the other licensee's failure to substantially comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 12. **Change of classification.** A licensee may change to a different class of license under subpart 3, by submitting a new application under subpart 6 and meeting all applicable requirements of this chapter. An application under this subpart shall be accompanied by the fee provided by subpart 18.

Subp. 13. **License renewals.** Except as provided in subpart 14 or 15, a license will be renewed for a period of one year if the licensee satisfies items A to C. The licensee must:

A. submit an application for renewal on forms provided by the commissioner at least 30 days before expiration of the license;

B. submit the renewal fee, in the amount provided by subpart 18; and

C. comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 14. **Conditional license.** If a licensee is not in full compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, at the time of expiration of its license, and the violations do not warrant denial of renewal of the license, the commissioner shall issue a license for a limited period conditioned on the licensee achieving full compliance within the term of the license or the term of any correction orders.

Subp. 15. **Suspension, revocation, or denial of renewal of license.** The commissioner may deny renewal of a license, or may suspend, revoke, or make conditional a license, if the licensee, or an owner or managerial official of the licensee:

A. is in violation, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47;

B. permits, aids, or abets the commission of any illegal act in the provision of home care;

C. performs any act detrimental to the welfare of a client;

D. obtained the license by fraud or misrepresentation;

E. knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

F. denies representatives of the commissioner access to any part of the provider, its books, records, or files, or employees;

G. interferes with or impedes a representative of the commissioner in contacting the provider's clients;

H. interferes with or impedes a representative of the commissioner in the enforcement of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

I. destroys or makes unavailable any records or other evidence relating to the licensee's compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

J. refuses to initiate a background study under Minnesota Statutes, section 144.057 or 245A.04; or

K. has failed to timely pay any fines assessed under part 4668.0230 or 4668.0800, subpart 6.

Subp. 16. **Transfers prohibited; changes in ownership.** A license issued under this part may not be transferred to another party. Before changing ownership, a prospective provider must apply for a new license under this part. A change of ownership means a transfer of operational control to a different business entity, and includes:

A. transfer of the business to a different or new corporation;

B. in the case of a partnership, the dissolution or termination of the partnership under Minnesota Statutes, chapter 323A, with the business continuing by a successor partnership or other entity;

C. relinquishment of control of the provider by the licensee to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

D. transfer of the business by a sole proprietor to another party or entity; or

E. in the case of a privately held corporation, the change in ownership or control of 50 percent or more of the outstanding voting stock.

Subp. 17. **Display of license.** The original license must be displayed in the provider's principal business office and copies must be displayed in all other offices. The licensee must provide a copy of the license to any person who requests it.

Subp. 18. **Fees.** Each application for a license must include payment in full of the fee according to the schedule in chapter 4669.

4668.0016 WAIVERS AND VARIANCES.

Subpart 1. **Definitions.** For purposes of this part:

A. "waiver" means an exemption from compliance with a requirement of this chapter; and

B. "variance" means a specified alternative to a requirement of this chapter.

Subp. 2. **Criteria for waiver or variance.** Upon application of a licensee, the commissioner shall waive or vary any provision of this chapter, except for those provisions relating to criminal disqualification, part 4668.0020, and to the home care bill of rights, part 4668.0030, if the commissioner finds that:

A. the waiver or variance is necessary because of the unavailability of services or resources in the provider's geographic area; or

B. enforcement of a requirement would result in unreasonable hardship on the licensee; and

C. the waiver or variance will not adversely affect the health, safety, or welfare of any client.

Subp. 3. **Experimental variance.** A variance may be granted to allow a provider to offer home care services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the clients, and is likely to improve the services provided.

Subp. 4. **Conditions.** The commissioner may impose conditions on the granting of a waiver or variance that the commissioner considers necessary.

Subp. 5. **Duration and renewal.** The commissioner may limit the duration of any waiver or variance, and may renew a limited waiver or variance.

Subp. 6. **Applications.** An application for waiver or variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following:

A. the rule from which the waiver or variance is requested;

B. the time period for which the waiver or variance is requested;

C. if the request is for a variance, the specific alternative action that the licensee proposes;

D. the reasons for the request; and

E. justification that subpart 2 or 3 will be satisfied.

The commissioner may require additional information from the licensee before acting on the request.

Subp. 7. **Grants and denials.** The commissioner shall grant or deny each request for waiver or variance in writing. Notice of a denial shall contain the reasons for the denial. The terms of a requested variance may be modified upon agreement between the commissioner and a licensee.

Subp. 8. **Violation of variances.** A failure to comply with the terms of a variance shall be deemed to be a violation of this chapter.

Subp. 9. **Revocation or denial of renewal.** The commissioner shall revoke or deny renewal of a waiver or variance if:

A. it is determined that the waiver or variance is adversely affecting the health, safety, or welfare of the licensee's clients;

B. the licensee has failed to comply with the terms of the variance;

C. the licensee notifies the commissioner in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or

D. the revocation or denial is required by a change in law.

Subp. 10. **Hearings.** A denial of a waiver or variance may be contested by requesting a hearing as provided by part 4668.0017. The licensee bears the burden of proving that the denial of a waiver or variance was in error.

4668.0017 HEARINGS.

Subpart 1. **Hearing rights.** An applicant for a license or a licensee that has been assessed a fine under part 4668.0230 or 4668.0800, subpart 6, that has had a waiver or variance denied or revoked under part 4668.0016, or that has a right to a hearing under Minnesota Statutes, section 144A.46, subdivision 3, may request a hearing to contest that action or decision according to the rights and procedures provided by Minnesota Statutes, chapter 14, and this part.

Subp. 2. **Request for hearing.** A request for a hearing shall be in writing and shall:

A. be mailed or delivered to the commissioner or the commissioner's designee;

B. contain a brief and plain statement describing every matter or issue contested; and

C. contain a brief and plain statement of any new matter that the licensee believes constitutes a defense or mitigating factor.

Subp. 3. **Informal conference.** At any time, the licensee and the commissioner may hold an informal conference to exchange information, clarify issues, or resolve any or all issues.

4668.0019 ADVERTISING.

Licensees shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this part, advertising includes any means of communicating to potential clients the availability, nature, or terms of home care services.

4668.0030 HOME CARE BILL OF RIGHTS.

Subpart 1. **Scope and enforcement against those exempt from licensure.** All home care providers, including those exempt from licensure under Minnesota Statutes, section 144A.46, subdivision 2, must comply with this part and the home care bill of rights, as provided by Minnesota Statutes, section 144A.44. The commissioner shall enforce this part and the home care bill of rights against providers exempt from licensure in the same manner as against licensees.

Subp. 2. **Notification of client.** The provider shall give a written copy of the home care bill of rights, as required by Minnesota Statutes, section 144A.44, to each client or each client's responsible person.

Subp. 3. **Time of notice.** The provider shall deliver the bill of rights at the time that the provider and the client or the client's responsible person agree to a service agreement, or before services are initiated, whichever is earlier.

Subp. 4. **Content of notice.** In addition to the text of the bill of rights in Minnesota Statutes, section 144A.44, subdivision 1, the written notice to the client must include the following:

A. a statement, printed prominently in capital letters, that is substantially the same as the following:

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR OLDER MINNESOTANS.

B. the telephone number, mailing address, and street address, of the Office of Health Facility Complaints;

C. the telephone number and address of the office of the ombudsman for older Minnesotans; and

D. the licensee's name, address, telephone number, and name or title of the person to whom problems or complaints may be directed.

The information required by items B and C shall be provided by the commissioner to licensees upon issuance of licenses and whenever changes are made.

Subp. 5. **Acknowledgment of receipt.** The provider shall obtain written acknowledgment of the client's receipt of the bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's responsible person.

Subp. 6. **Documentation.** The licensee shall retain in the client's record documentation of compliance with this part.

Subp. 7. **Prohibition against waivers.** The licensee may not request nor obtain from clients any waiver of any of the rights enumerated in Minnesota Statutes, section 144A.44, subdivision 1. Any waiver obtained in violation of this subpart is void.

4668.0035 HANDLING OF CLIENTS' FINANCES AND PROPERTY.

Subpart 1. **Powers-of-attorney.** A licensee may not accept powers-of-attorney from clients for any purpose, and may not accept appointments as guardians or conservators of clients, unless the licensee maintains a clear organizational separation between the home care service and the program that accepts guardianship or conservatorship appointments. This subpart does not apply to licensees that are Minnesota counties or other units of government.

Subp. 2. **Handling clients' finances.** A licensee may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A licensee must provide a client with receipts for all transactions and purchases paid with the clients' funds. When receipts are not available, the transaction or purchase must be documented. A licensee must maintain records of all such transactions.

Subp. 3. **Security of clients' property.** A licensee may not borrow a client's property, nor in any way convert a client's property to the licensee's possession, except in payment of a fee at the fair market value of the property.

Subp. 4. **Gifts and donations.** Nothing in this part precludes a licensee or its staff from accepting bona fide gifts of minimal value, or precludes the acceptance of donations or bequests made to a licensee that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

4668.0040 COMPLAINT PROCEDURE.

Subpart 1. **Complaint procedure.** A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

Subp. 2. **Informing clients.** The system required by subpart 1 must provide written notice to each client that includes:

A. the client's right to complain to the licensee about the services received;

B. the name or title of the person or persons to contact with complaints;

C. the method of submitting a complaint to the licensee;

D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and

E. a statement that the provider will in no way retaliate because of a complaint.

Subp. 3. **Prohibition against retaliation.** A licensee must not take any action that negatively affects a client in retaliation for a complaint made by the client.

Subp. 4. **Scope.** This part applies to all licensees except class C licensees.

4668.0050 ACCEPTANCE, RETENTION, DISCONTINUATION OF SERVICES, AND DISCHARGE OF CLIENTS.

Subpart 1. **Acceptance of clients.** No licensee may accept a person as a client unless the licensee has staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement, under part 4668.0140 for class A, B, and C licensees, or the service plan, under part 4668.0815, for class F home care provider licensees.

Subp. 2. **Assistance upon discontinuance of services.** If the licensee discontinues a home care service to a client for any reason and the client continues to need the home care service, the licensee shall provide to the client a list of home care providers that provide similar services in the client's geographic area.

This subpart does not apply to a licensee that discontinues a service to a client because of the client's failure to pay for the service.

4668.0060 ADMINISTRATION.

Subpart 1. **Services by contract.** The licensee may contract for services to be provided to its clients. Personnel providing services under contract must meet the same requirements required by this chapter of personnel employed by the licensee.

Subp. 2. **Responsibility of licensee for contractors.** A violation of this chapter by a contractor of the licensee will be considered to be a violation by the licensee.

Subp. 3. **Fulfillment of services.** The licensee shall provide all services required by the client's service agreement, required by part 4668.0140.

Subp. 4. **Scheduled appointments for nonessential services.** If a licensee, contractor, or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee shall:

A. follow the procedure, if any, established in the service agreement;

B. provide a replacement person; or

C. notify the client that the appointment will not be kept, and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 5. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time, and the licensee, contractor, or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee shall make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 6. **Availability of contact person.** Every class A or class B licensee that provides home health aide or home care aide tasks, must have a contact person available for consultation whenever a paraprofessional is performing home health aide or home care aide tasks for a client. The contact person must be available to the paraprofessional in person, by telephone, or by other means.

4668.0065 INFECTION CONTROL.

Subpart 1. **Tuberculosis screening.** No person who is contagious with tuberculosis may provide services that require direct contact with clients. All individual licensees and employees and contractors of licensees must document the following before providing services that require direct contact with clients:

A. the person must provide documentation of having received a negative reaction to a Mantoux test administered within the 12 months before working in a position involving direct client contact, and no later than every 24 months after the most recent Mantoux test; or

B. if the person has had a positive reaction to a Mantoux test upon employment or within the two years before working in a position involving direct client contact, or has a positive reaction to a Mantoux test in repeat testing during the course of employment, the person must provide:

(1) documentation of a negative chest x-ray administered within the three months before working in a position involving direct client contact; or

(2) documentation of a negative chest x-ray administered each 12 months, for two years after the positive reaction to a Mantoux test or documentation of completing or currently taking a course of tuberculosis preventative therapy; or

C. if the person has had a positive reaction to a Mantoux test more than two years before working in a position involving direct client contact, the person must provide documentation of

a negative chest x-ray taken within the previous 12 months or documentation of completing or currently taking a course of tuberculosis preventative therapy.

In this subpart, "Mantoux test" means a Mantoux tuberculin skin test.

Subp. 2. **Exposure to tuberculosis.** In addition to the requirements of subpart 1, a person who has been exposed to active tuberculosis must document a negative result of a Mantoux test or chest x-ray administered no earlier than ten weeks and no later than 14 weeks after the exposure.

Subp. 3. **Infection control in-service training.** For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

A. hand washing techniques;

B. the need for and use of protective gloves, gowns, and masks;

C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;

D. disinfecting reusable equipment; and

E. disinfecting environmental surfaces.

4668.0070 PERSONNEL RECORDS.

Subpart 1. **Scope.** This part applies to all licensees except class C licensees.

Subp. 2. **Personnel records.** The licensee must maintain a record of each employee, of each individual contractor excluded under part 4668.0008, subpart 7, and of other individual contractors. The record must include the following information:

A. evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this chapter, statute, or other rules;

B. records of training required by this chapter; and

C. evidence of licensure under this chapter, if required.

Subp. 3. **Job descriptions.** The licensee shall maintain current job descriptions, including qualifications, responsibilities, and identification of supervisors, if any, for each job classification.

Subp. 4. **Retention of personnel records.** Each personnel record must be retained for at least three years after an employee or contractor ceases to be employed by the licensee.

4668.0075 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** Every individual applicant for a license, and every person who provides direct care, supervision of direct care, or management of services for a licensee, shall complete an orientation to home care requirements before providing home care services to clients. This orientation may be incorporated into the training required of paraprofessionals under part 4668.0130. This orientation need only be completed once.

Subp. 2. **Content.** The orientation required by subpart 1 must contain the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

B. handling of emergencies and use of emergency services;

C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

D. home care bill of rights;

E. handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints; and

F. services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by the licensee or may be obtained from other sources. The commissioner shall provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** Each licensee shall retain evidence that each person required under subpart 1, has completed the orientation training required by this part.

Subp. 5. **Transferability.** Licensees may accept from another provider written verification that a person has completed the orientation.

4668.0080 QUALIFICATIONS OF PROFESSIONAL PERSONNEL.

Subpart 1. **Occupational therapy.** A person who provides occupational therapy as a licensee or as an employee or contractor of a licensee must:

A. have earned a baccalaureate degree from an occupational therapy program accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association;

B. be registered as an occupational therapist by the American Occupational Therapy Certification Board; or

C. meet the standards established for registration by the American Occupational Therapy Certification Board, in effect on June 1, 1990.

Subp. 2. **Speech therapy.** A person who provides speech therapy as a licensee or as an employee or contractor of a licensee must be registered with the department as a speech- language pathologist, under parts 4750.0010 to 4750.0700.

Subp. 3. **Respiratory therapy.** A person who provides respiratory therapy as a licensee or as an employee or contractor of a licensee must have completed a respiratory care program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation and the Joint Review Committee for Respiratory Therapy Education or by an accrediting agency approved by the commissioner.

Subp. 4. **Dietitians.** A person who provides nutritional services as a licensee or as an employee or contractor of a licensee, must have a baccalaureate degree in nutrition or a comparable program, including at least six months of supervised experience, or be registered by the Commission on Dietetic Registration of the American Dietetic Association.

Subp. 5. **Physical therapy.** A person who provides physical therapy as an employee or contractor of a licensee must be registered as a physical therapist with the Board of Medical Practice under Minnesota Statutes, sections 148.65 to 148.78.

4668.0100 HOME HEALTH AIDE TASKS.

Subpart 1. **Home health aide tasks.** For a class A or C licensee, a registered nurse may delegate medical or nursing services as tasks or a therapist may assign therapy services as tasks only to a person who satisfies the requirements of subpart 5. These delegated or assigned tasks, as set forth in this part, include home care aide tasks as set forth in part 4668.0110. Class A licensees providing home care aide tasks must satisfy the training and supervision requirements of this part, and not part 4668.0110. These tasks include:

A. administration of medications, as provided by subpart 2;

B. performing routine delegated medical or nursing or assigned therapy procedures, as provided by subpart 4, except items C to H;

C. assisting with body positioning or transfers of clients who are not ambulatory;

D. feeding of clients who, because of their condition, are at risk of choking;

E. assistance with bowel and bladder control, devices, and training programs;

F. assistance with therapeutic or passive range of motion exercises;

G. providing skin care, including full or partial bathing and foot soaks; and

H. during episodes of serious disease or acute illness, providing services performed for a client or to assist a client to maintain the hygiene of the client's body and immediate environment, to satisfy nutritional needs, and to assist with the client's mobility, including movement, change of location, and positioning, and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Administration of medications.** A person who satisfies the requirements of subpart 5 may administer medications, whether oral, suppository, eye drops, ear drops, inhalant, topical, or administered through a gastrostomy tube, if:

A. the medications are regularly scheduled;

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration;

C. prior to the administration, the person is instructed by a registered nurse in the procedures to administer the medications to each client;

D. a registered nurse specifies, in writing, and documents in the clients' records, the procedures to administer the medications; and

E. prior to the administration, the person demonstrates to a registered nurse the person's ability to competently follow the procedure.

For purposes of this subpart, "pro re nata medication," commonly called p.r.n. medication, means a medication that is ordered to be administered to or taken by a client as necessary.

Subp. 3. **Limitations on administering medications.** A person who administers medications under subpart 2 may not inject medications into veins, muscle, or skin.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of subpart 5 may perform delegated medical or nursing and assigned therapy procedures, if:

A. prior to performing the procedures, the person is instructed by a registered nurse or therapist, respectively, in the proper methods to perform the procedures with respect to each client;

B. a registered nurse or therapist, respectively, specifies, in writing, specific instructions for performing the procedures for each client;

C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person's ability to competently follow the procedures; and

D. the procedures for each client are documented in the clients' records.

Subp. 5. **Qualifications for persons who perform home health aide tasks.** A person may only offer or perform home health aide tasks, or be employed to perform home health aide tasks, if the person has:

A. successfully completed the training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction substantially equivalent to that required by item A;

D. satisfied the requirements of Medicare for training or competency of home health aides, as provided by Code of Federal Regulations, title 42, section 484.36;

E. satisfied subitems (1) and (2):

(1) meets the requirements of title XVIII of the Social Security Act for nursing assistants in nursing facilities certified for participation in the Medicare program, or has successfully completed a nursing assistant training program approved by the state; and

(2) has had at least 20 hours of supervised practical training or experience performing home health aide tasks in a home setting under the supervision of a registered nurse, or completes the supervised practical training or experience within one month after beginning work performing home health aide tasks, except that a class C licensee must have completed this supervised training or experience before a license will be issued; or

F. before April 19, 1993, completed a training course of at least 60 hours for home health aides that had been approved by the department.

Subp. 6. **In-service training and demonstration of competence.** For each person who performs home health aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

C. If a person has not performed home health aide tasks for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence in the skills listed in part 4668.0130, subpart 3, item A, subitem (1).

Subp. 7. **Documentation.** Class A licensees shall verify that persons employed or contracted by the licensees to perform home health aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home health aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 8. **Initiation of home health aide tasks.** Prior to the initiation of home health aide tasks, a registered nurse or therapist shall orient each person who is to perform home health aide tasks to each client and to the tasks to be performed.

Subp. 9. **Periodic supervision of home health aide tasks.** After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

A. within 14 days after initiation of home health aide tasks; and

B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4; or

C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4.

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse at least every other visit, and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

4668.0110 HOME CARE AIDE TASKS.

Subpart 1. **Home care aide tasks.** For a class B or C licensee, only a person who satisfies the requirements of subpart 2 or part 4668.0100, subpart 5, may perform the following services for clients:

A. preparing modified diets, such as diabetic or low sodium diets;

B. reminding clients to take regularly scheduled medications or perform exercises;

C. household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

D. household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

E. assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the client is ambulatory, and if the client has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Qualifications for persons who perform home care aide tasks.** No person may offer or perform home care aide tasks, or be employed to perform home care aide tasks, unless the person has:

A. successfully completed training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction comparable to that required by item A; or

D. satisfied the requirements of part 4668.0100.

Subp. 3. **Documentation.** Class B licensees shall verify that the persons employed or contracted by the licensees to perform home care aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home care aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 4. **In-service training.** For each person who performs home care aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home care aide tasks must complete at least six hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

Subp. 5. [Repealed, L 2009 c 174 art 2 s 12]

Subp. 6. **Class E visits.** A class E licensee must visit the client and observe the provision of home care services every 60 days after initiation of home care aide tasks to verify that the work is being performed adequately and to identify problems.

4668.0120 HOME MANAGEMENT TASKS.

Subpart 1. **Home management tasks.** Any person may perform services that are not listed in part 4668.0100, subpart 1, or part 4668.0110, subpart 1, including housekeeping, meal preparation, and shopping.

Subp. 2. **Training of persons who perform home management tasks.** Except for the orientation training required by Minnesota Statutes, section 144A.461, no training is required of persons who perform home management tasks.

4668.0130 TRAINING AND COMPETENCY EVALUATION FOR PERSONS WHO PERFORM HOME HEALTH AIDE AND HOME CARE AIDE TASKS.

Subpart 1. **Scope of training course and instructor.** The training required by part 4668.0100, subpart 5, and by part 4668.0110, subpart 2, must:

A. include the topics and course requirements specified in subpart 2 and use a curriculum approved by the commissioner;

B. be taught by a registered nurse with experience or training in home care, except that specific topics required by subpart 2 may be taught by another instructor in conjunction with the registered nurse; and

C. include a competency evaluation required by subpart 3.

Subp. 2. **Curriculum.** The training required in part 4668.0100, subpart 5 for home health aide tasks must contain the topics described in items A to N, and must contain no less than 75 hours of classroom and laboratory instruction. The training required in part 4668.0110, subpart 2 for home care aide tasks, must contain the topics described in items A to G, and must contain no less than 24 hours of classroom and laboratory instruction. The required topics are:

A. those topics required in the orientation training required by part 4668.0075;

B. observation, reporting, and documentation of client status and of the care or services provided;

C. basic infection control;

D. maintenance of a clean, safe, and healthy environment;

E. medication reminders;

F. appropriate and safe techniques in personal hygiene and grooming, including bathing and skin care, the care of teeth, gums, and oral prosthetic devices, and assisting with toileting;

G. adequate nutrition and fluid intake including basic meal preparation and special diets;

H. communication skills;

I. reading and recording temperature, pulse, and respiration;

J. basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional;

K. recognition of and handling emergencies;

L. physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family;

M. safe transfer techniques and ambulation; and

N. range of motion and positioning.

Subp. 3. **Competency evaluation.** The competency evaluation tests must be approved by the commissioner.

A. To qualify to perform home health aide tasks, the person must pass the following:

(1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E, F, I, M, and N; and

(2) a written, oral, or practical test of the topics listed in subpart 2, items A to D, G, H, and J to L.

B. To qualify to perform home care aide tasks, the person must pass the competency evaluation for home health aide tasks, or the following:

(1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E and F; and

(2) a written, oral, or practical test of the topics in subpart 2, items A to D and G.

Subp. 4. **Evidence of qualifications.** A licensee that provides the training and the competency evaluation required by this part shall provide each person who completes the training or passes the competency evaluation with written certification of satisfying this part.

4668.0140 SERVICE AGREEMENTS.

Subpart 1. **Service agreements.** No later than the second visit to a client, a licensee shall enter into a written service agreement with the client or the client's responsible person. Any modifications of the service agreement must be in writing and agreed to by the client or the client's responsible person.

Subp. 2. **Contents of service agreement.** The service agreement required by subpart 1 must include:

A. a description of the services to be provided, and their frequency;

B. identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required, if any;

D. fees for services;

E. a plan for contingency action that includes:

(1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;

(3) who to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the licensee to contact a responsible person of the client, if any; and

(5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.

Class C licensees need not comply with items B and C and this item, subitems (2) and (5). Subitems (3) and (5) are not required for clients receiving only home management services.

4668.0150 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to medications and treatments that are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber to be administered by the licensee.

Subp. 2. **Medication and treatment orders.** Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Subp. 3. **Authorizations.** All orders for medications and treatments must be dated and signed by the prescriber, except as provided by subpart 5.

Subp. 4. **Content of orders.** All orders for medications must contain the name of the drug, dosage, and directions for use.

Subp. 5. **Verbal orders.** Upon receiving an order verbally from a prescriber, the nurse or therapist shall:

A. record and sign the order; and

B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 6. **Renewal of orders.** All orders must be renewed at least every three months.

4668.0160 CLIENT RECORDS.

Subpart 1. **Maintenance of client record.** The licensee shall maintain a record for each client.

Subp. 2. **Security.** The licensee shall establish written procedures to control use and removal of client records from the provider's offices and for security in client residences and to establish criteria for release of information. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 3. **Retention.** A client's record must be retained for at least five years following discharge. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider, other health care practitioner or provider, or is admitted to an inpatient facility, the licensee, upon request of

the client, shall send a copy or summary of the client's record to the new provider or facility or to the client.

Subp. 5. **Form of entries.** All entries in the client record must be:

A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or

B. recorded in an electronic media in a secure manner.

Subp. 6. **Content of client record.** The client record must contain:

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

(5) dates of the beginning and end of services; and

(6) names, addresses, and telephone numbers of any responsible persons;

B. a service agreement as required by part 4668.0140;

C. medication and treatment orders, if any;

D. notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact;

E. names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

F. a summary following the termination of services, which includes the reason for the initiation and termination of services, and the client's condition at the termination of services.

Class C licensees need only include the information required by items A, B, and E. Class E licensees need only include the information required by items A, B, D, and E.

Subp. 7. **Confidentiality.** The licensee shall not disclose to any other person any personal, financial, medical, or other information about the client, except:

A. as may be required by law;

B. to staff, contractors of the licensee, another home care provider, other health care practitioner or provider, or inpatient facility who require information in order to provide services to the client, but only such information that is necessary to the provision of services;

C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; and

D. representatives of the commissioner authorized to survey or investigate home care providers.

4668.0170 REQUEST BY CLIENT FOR DISCONTINUATION OF LIFE SUSTAINING TREATMENT.

Subpart 1. **Action by person receiving request.** If a client, family member, or other caregiver of the client requests that an employee or other agent of the licensee discontinue a life sustaining treatment, the employee or other agent of the licensee receiving the request:

A. shall take no action to discontinue the treatment; and

B. shall promptly inform the person's supervisor or other representative of the licensee of the client's request.

Subp. 2. **Action by licensee.** Upon being informed of a request for termination of treatment, the licensee shall promptly:

A. inform the client that the request will be made known to the physician who ordered the client's treatment; and

B. inform the physician of the client's request.

Subp. 3. **Right to maintain treatment.** This part does not require the licensee to discontinue treatment, except as may be required by law or court order.

Subp. 4. **Rights of clients.** This part does not diminish the rights of clients to control their treatments or terminate their relationships with providers.

Subp. 5. **Health care declarations.** This part shall be construed in a manner consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by clients under that act.

4668.0180 CLASS A PROVIDER, PROFESSIONAL HOME CARE AGENCY.

Subpart 1. **Scope.** This part applies only to a professional home care agency with a class A license under part 4668.0012, subpart 3.

Subp. 2. **Required services.** The licensee shall provide at least one of the following home care services directly:

A. professional nursing;

B. physical therapy;

C. speech therapy;

D. respiratory therapy;

E. occupational therapy;

F. nutritional services;

G. medical social services;

H. home health aide tasks; or

I. provision of medical supplies and equipment when accompanied by the provision of a home care service.

Subp. 3. **Scope of services.** The licensee may provide all home care services, except that the licensee may provide a hospice program only if licensed as a hospice program under part 4664.0010, as provided by Minnesota Statutes, section 144A.753, subdivision 1.

Subp. 4. **Medical social services.** If provided, medical social services must be provided in compliance with Minnesota Statutes, sections 148B.18 to 148B.28.

Subp. 5. **Nursing services.** If provided, nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 6. **Physical therapy.** If provided, physical therapy must be provided according to Minnesota Statutes, sections 148.65 to 148.78.

Subp. 7. **Other services.** Other services not addressed in this chapter may be provided.

Subp. 8. **Referrals.** If a licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee shall:

A. inform the client of the possible need;

B. determine the client's preferences with respect to obtaining the service; and

C. if the client desires the service, inform the client about available providers or referral services.

Subp. 9. **Quality assurance.** The licensee shall establish and implement a quality assurance plan, described in writing, in which the licensee must:

A. monitor and evaluate two or more selected components of its services at least once every 12 months; and

B. document the collection and analysis of data and the action taken as a result.

Subp. 10. **Equivalent requirements for certified providers.** A class A licensee that is certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with this part, or with the following items, if the Medicare certification is based on compliance with the federal conditions of participation, and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services:

A. part 4668.0040;

B. part 4668.0050;

C. part 4668.0060, subparts 1, 2, 3, and 6;

D. part 4668.0070, subparts 2 and 3;

E. part 4668.0080, subparts 1 and 2;

F. part 4668.0100, subparts 1 and 4 to 9;

G. part 4668.0110;

H. part 4668.0130;

I. part 4668.0140, subparts 1 and 2, items A to D;

J. part 4668.0150;

K. part 4668.0160;

L. part 4668.0180, subparts 1 to 9.

4668.0190 CLASS B PROVIDER, PARAPROFESSIONAL AGENCY.

A paraprofessional agency with a class B license under part 4668.0012, subpart 3, may perform home care aide tasks and home management tasks.

4668.0200 CLASS C PROVIDER, INDIVIDUAL PARAPROFESSIONALS.

Subpart 1. **Scope.** This part applies only to a paraprofessional with a class C license under part 4668.0012, subpart 3.

Subp. 2. **Services.** The licensee may perform:

A. home health aide tasks;

B. home care aide tasks; and

C. home management tasks.

Subp. 3. **Training.** The licensee who performs home health aide tasks or home care aide tasks must meet the requirements of part 4668.0130 before a license will be issued.

Subp. 4. **Record of supervision.** The licensee who performs home health aide tasks must maintain a record of the supervision required by part 4668.0100, subpart 9.

Subp. 5. **Records.** The licensee must maintain a written record of the services provided at each visit to clients.

Subp. 6. **Notice of clientele.** Upon request of the commissioner, class C licensees shall provide the name, address, and telephone numbers of all or specified clients and the clients' responsible persons.

4668.0218 INFORMATION AND REFERRAL SERVICES.

The commissioner shall request from licensees information necessary to establish and maintain information and referral services required by Minnesota Statutes, section 144A.47, and licensees shall provide the requested information. This information may be required to be provided together with the licensing information required by part 4668.0012, or may be required to be provided separately.

4668.0220 SURVEYS AND INVESTIGATIONS.

Subpart 1. **Surveys.** Except as provided in subpart 3 or 10, the commissioner may survey each applicant or licensee before issuing a new license or renewing an existing license. An applicant for a license that is certified and surveyed by the Minnesota Department of Health for Medicare or medical assistance shall be surveyed at the time of its next certification survey. Applicants and licensees shall provide any and all information requested by the surveyor or investigator that is within the scope of licensure.

Subp. 2. **Coordination of surveys.** If feasible, the commissioner shall survey licensees to determine compliance with this chapter at the same time as surveys for certification for Medicare and medical assistance if Medicare certification is based on compliance with the federal conditions of participation and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services.

Subp. 3. **Biennial surveys.** A licensee that has been licensed for at least two consecutive years and that has been in substantial compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, and has had no serious violations in that period, may be surveyed every second license term rather than during each license term.

Subp. 4. **Complaint investigations.** Upon receiving information that a licensee may be violating or may have violated a requirement of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall investigate the complaint.

Subp. 5. **Scheduling surveys.** Surveys and investigations shall be conducted without advance notice to licensees. Surveyors may contact licensees on the day of a survey to arrange for someone to be available at the survey site. The contact does not constitute advance notice.

Subp. 6. **Contacting and visiting clients.** Surveyors may contact or visit a licensee's clients without notice to the licensee. Licensees shall provide a list of current and past clients

and responsible persons with addresses and telephone numbers upon request of a surveyor. Before visiting a client, a surveyor shall obtain the client's or responsible person's permission by telephone, by mail, or in person. Surveyors shall inform all clients and responsible persons of their right to decline permission for a visit.

Subp. 7. **Information from clients.** The commissioner may solicit information from clients by telephone, mail, or other means.

Subp. 8. **Client information.** Upon the commissioner's request, licensees shall provide to the commissioner information identifying some or all of its clients and any other information about the licensee's services to the clients.

Subp. 9. **Sampling of clientele.** The commissioner may conduct a written survey of all or a sampling of home care clients to determine their satisfaction with the services provided.

Subp. 10. **Surveys of class C licensees.** The commissioner may survey class C licensees by telephoning, visiting, or writing to the licensees' clients. Office visits may be conducted, but are not required.

4668.0230 FINES FOR UNCORRECTED VIOLATIONS.

Subpart 1. **Authority.** The fines provided under this part are under the authority of Minnesota Statutes, sections 144.653, subdivision 6, and 144A.45, subdivision 2, clause (4).

Subp. 2. **Fines for license classes.** Class A and class B licensees shall be assessed fines at 100 percent of the amounts provided in subpart 3. Class C licensees shall be assessed fines at 25 percent of the amounts provided in subpart 3.

Subp. 3. **Schedule of fines for violations of statutory provisions.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective provision that was violated in Minnesota Statutes:

A. section 144A.44, subdivision 1, clause (1), $250;

B. section 144A.44, subdivision 1, clause (2), $250;

C. section 144A.44, subdivision 1, clause (3), $50;

D. section 144A.44, subdivision 1, clause (4), $350;

E. section 144A.44, subdivision 1, clause (5), $250;

F. section 144A.44, subdivision 1, clause (6), $250;

G. section 144A.44, subdivision 1, clause (7), $50;

H. section 144A.44, subdivision 1, clause (8), $250;

I. section 144A.44, subdivision 1, clause (9), $250;

J. section 144A.44, subdivision 1, clause (10), $250;

K. section 144A.44, subdivision 1, clause (11), $350;

L. section 144A.44, subdivision 1, clause (12), $250;

M. section 144A.44, subdivision 1, clause (13), $500;

N. section 144A.44, subdivision 1, clause (14), $250;

O. section 144A.44, subdivision 1, clause (15), $350;

P. section 144A.44, subdivision 1, clause (16), $250;

Q. section 144A.44, subdivision 1, clause (17), $500; and

R. section 144A.44, subdivision 2, $250.

Subp. 4. **Schedule of fines for violations of Vulnerable Adults Act.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 626.557, the following fines shall be assessed:

A. subdivision 3, $250;

B. subdivision 3a, $100;

C. subdivision 4, $250;

D. subdivision 9, $250; and

E. subdivision 17, $250.

Subp. 5. **Schedule of fines for violations of rules.** For each violation of a rule provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective rule that was violated:

A. part 4668.0008, subpart 3, $300;

B. for providing false information required by part 4668.0012, subpart 6, $500;

C. part 4668.0012, subpart 8, $100;

D. part 4668.0012, subpart 17, $50;

E. a variance, under part 4668.0016, subpart 8, the fine shall be the amount of the fine established for the rule that was varied;

F. part 4668.0019, $250;

G. part 4668.0030, subpart 2, $250;

H. part 4668.0030, subpart 3, $50;

I. part 4668.0030, subpart 4, $50;

J. part 4668.0030, subpart 5, $50;

K. part 4668.0030, subpart 6, $50;

L. part 4668.0030, subpart 7, $250;

M. part 4668.0035, subpart 1, $250;

N. part 4668.0035, subpart 2, $100;

O. part 4668.0035, subpart 3, $100;

P. part 4668.0040, subpart 1, $250;

Q. part 4668.0040, subpart 2, $50;

R. part 4668.0040, subpart 3, $250;

S. part 4668.0050, subpart 1, $350;

T. part 4668.0050, subpart 2, $100;

U. part 4668.0060, subpart 1, $50;

V. part 4668.0060, subpart 3, $350;

W. part 4668.0060, subpart 4, $350;

X. part 4668.0060, subpart 5, $500;

Y. part 4668.0060, subpart 6, $300;

Z. part 4668.0065, subpart 1, $500;

AA. part 4668.0065, subpart 2, $500;

BB. part 4668.0065, subpart 3, $300;

CC. part 4668.0070, subpart 2, $50;

DD. part 4668.0070, subpart 3, $50;

EE. part 4668.0070, subpart 4, $50;

FF. part 4668.0075, subpart 1, $300;

GG. part 4668.0075, subpart 2, $100;

HH. part 4668.0075, subpart 4, $50;

II. part 4668.0080, subpart 1, $300;

JJ. part 4668.0080, subpart 2, $300;

KK. part 4668.0080, subpart 3, $300;

LL. part 4668.0080, subpart 4, $300;

MM. part 4668.0080, subpart 5, $300;

NN. part 4668.0100, subpart 1, $350;

OO. part 4668.0100, subpart 2, $350;

PP. part 4668.0100, subpart 3, $500;

QQ. part 4668.0100, subpart 4, $350;

RR. part 4668.0100, subpart 5, $300;

SS. part 4668.0100, subpart 6, $300;

TT. part 4668.0100, subpart 7, $50;

UU. part 4668.0100, subpart 8, $350;

VV. part 4668.0100, subpart 9, $350;

WW. part 4668.0110, subpart 1, $350;

XX. part 4668.0110, subpart 2, $300;

YY. part 4668.0110, subpart 3, $50;

ZZ. part 4668.0110, subpart 4, $300;

AAA. part 4668.0110, subpart 5, $350;

BBB. part 4668.0110, subpart 6, $350;

CCC. part 4668.0120, subpart 2, $50;

DDD. part 4668.0130, subpart 1, $300;

EEE. part 4668.0130, subpart 2, $300;

FFF. part 4668.0130, subpart 3, $300;

GGG. part 4668.0130, subpart 4, $50;

HHH. part 4668.0140, subpart 1, $250;

III. part 4668.0140, subpart 2, $50;

JJJ. part 4668.0150, subpart 2, $350;

KKK. part 4668.0150, subpart 3, $350;

LLL. part 4668.0150, subpart 4, $350;

MMM. part 4668.0150, subpart 5, $350;

NNN. part 4668.0150, subpart 6, $350;

OOO. part 4668.0160, subpart 1, $100;

PPP. part 4668.0160, subpart 2, $100;

QQQ. part 4668.0160, subpart 3, $50;

RRR. part 4668.0160, subpart 4, $100;

SSS. part 4668.0160, subpart 5, $50;

TTT. part 4668.0160, subpart 6, $100;

UUU. part 4668.0160, subpart 7, $350;

VVV. part 4668.0170, subpart 1, $500;

WWW. part 4668.0170, subpart 2, $500;

XXX. part 4668.0180, subpart 3, $500;

YYY. part 4668.0180, subpart 4, $300;

ZZZ. part 4668.0180, subpart 5, $300;

AAAA. part 4668.0180, subpart 6, $300;

BBBB. part 4668.0180, subpart 8, $200;

CCCC. part 4668.0180, subpart 9, $100;

DDDD. part 4668.0190, $500;

EEEE. part 4668.0200, subpart 2, $500;

FFFF. part 4668.0200, subpart 4, $100;

GGGG. part 4668.0200, subpart 5, $50;

HHHH. part 4668.0200, subpart 6, $500;

IIII. part 4668.0220, subpart 6, $500; and

JJJJ. part 4668.0220, subpart 8, $500.

4668.0240 FAILURE TO CORRECT DEFICIENCY AFTER FINE HAS BEEN IMPOSED.

If, upon subsequent reinspection after a fine has been imposed under part 4668.0230, the deficiency has still not been corrected, another fine shall be assessed. This fine shall be double the amount of the previous fine.

4668.0800 CLASS F HOME CARE PROVIDER.

Subpart 1. **Scope of license.** A class F home care provider licensee may provide nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications, solely for residents of one or more housing with services establishments registered under Minnesota Statutes, chapter 144D.

Subp. 2. **Required services.** A class F home care provider licensee must provide at least one of the following assisted living home care services directly:

A. professional nursing services;

B. delegated nursing services;

C. non-nursing services performed by unlicensed personnel; or

D. central storage of medications.

Subp. 3. **Fulfillment of services.** A class F home care provider licensee must provide all services required by a client's service plan under part 4668.0815.

Subp. 4. **Referrals.** If a class F home care provider licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee must:

A. inform the client of the possible need;

B. determine the client's preferences with respect to obtaining the service; and

C. if the client desires the service, inform the client about available providers or referral services.

Subp. 5. **Availability of contact person.** A class F home care provider licensee must have a contact person available for consultation whenever an unlicensed person employed by the licensee is performing assisted living home care services for a client. The contact person must be available to unlicensed personnel in person, by telephone, or by other means of direct communication.

Subp. 6. **Violations of rules.** For each violation of parts 4668.0800 to 4668.0870subject to a fine under Minnesota Statutes, section 144.653, subdivisions 5 to 8, a fine shall be assessed according to the schedules established in parts 4668.0800 to 4668.0870.

Subp. 7. **Failure to correct deficiency.** If, upon subsequent reinspection after a fine has been imposed under subpart 6, the deficiency has still not been corrected, another fine must be assessed. This fine must be double the amount of the previous fine.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 3, $350;

B. subpart 4, $200; and

C. subpart 5, $300.

4668.0805 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.

Subp. 2. **Content.** The orientation required under subpart 1 must contain the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

B. handling emergencies and using emergency services;

C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

D. the home care bill of rights, Minnesota Statutes, section 144A.44;

E. handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and

F. the services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by a class F home care provider licensee or may be obtained from other sources. The commissioner must provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** A class F home care provider licensee must retain evidence that each person has completed the orientation training required under this part.

Subp. 5. **Transferability.** A class F home care provider licensee may accept written verification from another provider that a person has completed the orientation required under this part.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, $300;

B. subpart 2, $100; and

C. subpart 4, $50.

4668.0810 CLIENT RECORDS.

Subpart 1. **Maintenance of client record.** A class F home care provider licensee must maintain a record for each client at the housing with services establishment where the services are provided. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 2. **Security.** A class F home care provider licensee must establish and implement written procedures for security of client records, including:

A. the use of client records;

B. the removal of client records from the establishment; and

C. the criteria for release of client information.

Subp. 3. **Retention.** A class F home care provider licensee must retain a client's record for at least five years following the client's discharge or discontinuation of services. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider or other health care practitioner or provider or is admitted to an inpatient facility, a class F home care provider licensee, upon request of the client, must send a copy or summary of the client's record to the new provider or facility or to the client.

Subp. 5. **Form of entries.** Except as required by subpart 6, items F and G, documentation of a class F home care service must be created and signed by the staff person providing the service no later than the end of the work period. The documentation must be entered into the client record no later than two weeks after the end of the day service was provided. All entries in the client record must be:

A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or

B. recorded in an electronic media in a manner that ensures the confidentiality and security of the electronic information, according to current standards of practice in health information management, and that allows for a printed copy to be created.

Subp. 6. **Content of client record.** The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

(5) dates of the beginning and end of services;

(6) names, addresses, and telephone numbers of any responsible persons;

(7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

(9) the client's advance directive, if any;

B. an evaluation and service plan as required under part 4668.0815;

C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;

D. medication and treatment orders, if any;

E. the client's current tuberculosis infection status, if known;

F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;

G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;

H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;

I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

Subp. 7. **Confidentiality.** A Class F home care provider licensee must not disclose to any other person any personal, financial, medical, or other information about the client, except:

A. as may be required by law;

B. to staff, another home care provider, a health care practitioner or provider, or an inpatient facility that requires information to provide services to the client, but only the information that is necessary to provide services;

C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; or

D. to representatives of the commissioner authorized to survey or investigate home care providers.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, $100;

B. subpart 2, $100;

C. subpart 3, $50;

D. subpart 4, $100;

E. subpart 5, $50;

F. subpart 6, $100; and

G. subpart 7, $350.

4668.0815 EVALUATION AND SERVICE PLAN.

Subpart 1. **Evaluation; documentation.** No later than two weeks after the initiation of assisted living home care services to a client, a registered nurse must complete an individualized evaluation of the client's needs and must establish, with the client or the client's responsible person, a suitable and up-to-date service plan for providing assisted living home care services in accordance with accepted standards of practice for professional nursing. The service plan must be in writing and include a signature or other authentication by the class F home care provider licensee and by the client or the client's responsible person documenting agreement on the services to be provided.

Subp. 2. **Reevaluation.** A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

Subp. 3. **Modifications.** A modification of the service plan must be in writing and agreed to by the client or the client's responsible person before the modification is initiated. A modification must be authenticated by the client or the client's responsible person and must be entered into the client's record no later than two weeks after the modification is initiated.

Subp. 4. **Contents of service plan.** The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the class F home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the class F home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

Subp. 5. **Scheduled appointments for nonessential services.** If a class F home care provider licensee or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee must:

A. follow the procedure established in the service plan;

B. provide a replacement person; or

C. notify the client that the appointment will not be kept and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 6. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time and the class F home care provider licensee or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee must make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 7. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, $250;

B. subpart 2, $250;

C. subpart 3, $250;

D. subpart 4, $50;

E. subpart 5, $350; and

F. subpart 6, $500.

4668.0820 NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services.

Subp. 2. **Compliance with Minnesota Nurse Practice Act.** Nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285, and rules adopted thereunder.

4668.0825 DELEGATED NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services delegated to unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** Before initiating delegated nursing services for a client, a registered nurse must conduct a nursing assessment of the client's functional status and need for nursing services and must develop a service plan for providing the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for delegated nursing services must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Nursing services delegated to unlicensed personnel.** A registered nurse may delegate the nursing services specified in items A to I only to a person who satisfies the requirements of part 4668.0835 and possesses the knowledge and skills consistent with the complexity of the nursing task being delegated, only in accordance with Minnesota Statutes, sections 148.171 to 148.285. Nursing services that may be delegated are:

A. performing assistance with self-administration of medication and medication administration according to part 4668.0855;

B. performing routine delegated medical or nursing procedures, as provided under subpart 4;

C. assisting with body positioning or transfer of a client;

D. feeding a client who, because of the client's condition, is at risk of choking;

E. assisting with bowel and bladder control, devices, and training programs;

F. assisting with therapeutic or passive range of motion exercises;

G. providing skin care, including full or partial bathing and foot soaks;

H. during episodes of serious disease or acute illness, providing the following services or assisting a client to:

(1) maintain the hygiene of the client's body and immediate environment;

(2) satisfy nutritional needs;

(3) assist with the client's mobility, including movement, change of location, and positioning;

(4) bathe;

(5) maintain oral hygiene;

(6) dress;

(7) care for hair;

(8) use the toilet;

(9) change bedding;

(10) perform basic housekeeping; and

(11) prepare meals; and

I. providing central storage of medications, according to part 4668.0865.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 5. **Information to determine delegation.** The licensee must establish and implement policies to communicate up-to-date information to the registered nurse regarding the current available unlicensed personnel and their training and qualifications, so the registered nurse has sufficient information to determine the appropriateness of delegating tasks in individual situations.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $250;

B. subpart 3, $350;

C. subpart 4, $350; and

D. subpart 5, $350.

4668.0830 OTHER SERVICES PERFORMED BY UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides other services performed by unlicensed personnel.

Subp. 2. **Other services.** A person who satisfies the requirements of part 4668.0835may perform services in the registered housing with services establishment including:

A. preparing modified diets, including diabetic or low sodium diets;

B. providing medication reminders;

C. performing household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

D. performing household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease;

E. assisting with dressing, oral hygiene, hair care, grooming, and bathing; and

F. performing home management tasks.

Subp. 3. **Schedule of fines.** A fine of $350 shall be assessed for a violation of subpart 2.

4668.0835 QUALIFICATIONS FOR UNLICENSED PERSONNEL WHO PERFORM ASSISTED LIVING HOME CARE SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Qualifications.** An unlicensed person may offer to perform, or be employed to perform nursing services delegated to unlicensed personnel as provided under part 4668.0825, other services performed by unlicensed personnel as provided under part 4668.0830, or central storage of medications as provided under part 4668.0865, only if the person has:

A. successfully completed the training and passed the competency evaluation according to part 4668.0840, subpart 2;

B. successfully completed the training under part 4668.0840, subpart 3, and passed a competency evaluation according to part 4668.0840, subpart 4; or

C. satisfied the requirements of part 4668.0100, subpart 5.

Subp. 3. **In-service training and demonstration of competency.** For each unlicensed person who performs assisted living home care services, a class F home care provider licensee must comply with items A to C.

A. For each 12 months of employment, a person who performs assisted living home care services must complete at least eight hours of in-service training in topics relevant to the provision of home care services, including training in infection control required under part 4668.0065, subpart 3, obtained from the licensee or another source.

B. If a person has not performed assisted living home care services for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence according to part 4668.0840, subpart 4, item C.

C. A licensee must retain documentation of satisfying this part and must provide documentation to a person who completes the in-service training.

Subp. 4. **Documentation.**

A. An unlicensed person who performs assisted living home care services must provide documentation to the employing licensee of satisfying this part.

B. A class F home care provider licensee must verify that unlicensed persons employed by the licensee to perform assisted living home care services have satisfied the requirements of this part, and must retain documentation in the personnel records.

Subp. 5. **Initiation of services by unlicensed personnel.** Before initiating delegated nursing services by unlicensed personnel, a registered nurse must orient each person who is to perform assisted living home care services to each client and to the assisted living home care services to be performed. Based on the professional judgment of the registered nurse and on the individual needs of the client, the orientation may occur onsite, verbally, or in writing.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $300;

B. subpart 3, $300;

C. subpart 4, $50; and

D. subpart 5, $350.

4668.0840 TRAINING AND COMPETENCY EVALUATION FOR UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Scope of training course and instructor.** The training required under part 4668.0835, subpart 2, must:

A. include each assisted living home care service offered to clients that the unlicensed person will perform, taught by a registered nurse with experience or training in the subject being taught;

B. include the core training requirements specified in subpart 3;

C. include the competency evaluation required under subpart 4; and

D. use a curriculum that meets the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 3. **Core training of unlicensed personnel.**

A. An unlicensed person performing assisted living home care services must successfully complete training or demonstrate competency in the topics described in subitems (1) to (12). The required topics are:

(1) an overview of this chapter and Minnesota Statutes, sections 144A.43to 144A.47;

(2) recognizing and handling emergencies and using emergency services;

(3) reporting maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

(4) the home care bill of rights, Minnesota Statutes, section 144A.44;

(5) handling clients' complaints and reporting complaints to the Office of Health Facility Complaints;

(6) the services of the ombudsman for older Minnesotans;

(7) communication skills;

(8) observing, reporting, and documenting client status and the care or services provided;

(9) basic infection control;

(10) maintaining a clean, safe, and healthy environment;

(11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and

(12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

B. The core training of unlicensed personnel must be taught by a registered nurse with experience or training in home care, except that item A, subitems (1) to (7), may be taught by another instructor under the direction of the registered nurse.

C. The core training curriculum must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Competency evaluation.**

A. The competency evaluation tests required under part 4668.0835, subpart 2, items A and B, must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

B. A registered nurse must complete and document each competency evaluation.

C. To qualify to perform assisted living home care services, a person must demonstrate competency by successfully completing:

(1) a written, oral, or practical test of the topics in subpart 3; and

(2) a written, oral, or practical test of all assisted living home care provider services that the person will perform.

Subp. 5. **Evidence of qualifications.** A class F home care provider licensee that provides the training and the competency evaluation required by this part must provide each person who successfully completes the training or passes the competency evaluation with written verification of satisfying this part.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $300;

B. subpart 3, $300;

C. subpart 4, $300; and

D. subpart 5, $50.

4668.0845 PERIODIC SUPERVISION OF UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Services that require supervision by a registered nurse.**

A. After the orientation required under part 4668.0835, subpart 5, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who perform assisted living home care services that require supervision by

a registered nurse at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. Supervision or monitoring must be provided no less often than the following schedule:

(1) within 14 days after initiation of assisted living home care services that require supervision by a registered nurse; and

(2) at least every 62 days thereafter, or more frequently if indicated by a nursing assessment and the client's individualized service plan.

B. If the unlicensed person is monitored by a licensed practical nurse, the client must be supervised by a registered nurse at the housing with services establishment at least every other visit and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 3. **Services that do not require supervision by a registered nurse.** After the orientation required under part 4668.0835, subpart 5, unlicensed persons who perform services listed under part 4668.0830, subpart 2, or other assisted living home care services that do not require supervision by a registered nurse must be supervised at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. The service plan developed under part 4668.0815 must address the frequency of the supervision of each service and the appropriate person to perform the supervision.

Subp. 4. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350; and

B. subpart 3, $300.

4668.0855 MEDICATION ADMINISTRATION AND ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides medication administration or assistance with self-administration of medication by unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845, and must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Delegation by a registered nurse.** A registered nurse may delegate medication administration or assistance with self-administration of medication only to a person who satisfies the requirements of part 4668.0835, subpart 2, and possesses the knowledge and skills consistent with the complexity of medication administration or assistance with self-administration of medication, only in accordance with Minnesota Statutes, sections 148.171 to 148.285.

Subp. 4. **Training for assistance with self-administration of medication or medication administration.** Before the registered nurse delegates the task of assistance with self-administration of medication or the task of medication administration, a registered nurse must instruct the unlicensed person on the following:

A. the complete procedure for checking a client's medication record;

B. preparation of the medication for administration;

C. administration of the medication to the client;

D. assistance with self-administration of medication;

E. documentation, after assistance with self-administration of medication or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with self-administration of medication or medication administration as ordered, and the signature of the nurse or authorized person who assisted or administered and observed the same; and

F. the type of information regarding assistance with self-administration of medication and medication administration reportable to a nurse.

Subp. 5. **Administration of medications.** A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

A. the medications are regularly scheduled; and

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration.

Subp. 6. **Limitations on administering medications.** A person who administers medications under subpart 3 may not draw up injectables. Medication administered by injection under subpart 5 is limited to insulin.

Subp. 7. **Performance of routine procedures.** A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's records; and

E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 8. **Documentation.** A class F home care provider licensee must retain documentation in the personnel records of the unlicensed personnel who have satisfied the training requirements of this part.

Subp. 9. **Medication records.** The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350;

B. subpart 3, $350;

C. subpart 4, $300;

D. subpart 5, $350;

E. subpart 6, $500;

F. subpart 7, $350;

G. subpart 8, $50; and

H. subpart 9, $300.

4668.0860 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee when an authorized prescriber orders a medication or treatment to be administered by the licensee.

Subp. 2. **Prescriber's order required.** There must be a written prescriber's order for a drug for which a class F home care provider licensee provides assistance with self-administration of medication or medication administration, including an over-the-counter drug.

Subp. 3. **Medication and treatment orders.** A medication or treatment must be administered by a nurse qualified to implement the order or by an unlicensed person under the direction of a nurse and the supervision of a registered nurse, according to part 4668.0845.

Subp. 4. **Authorizations.** An order for medication or treatment must be dated and signed by the prescriber, except as provided by subparts 6 and 7, and must be current and consistent with the nursing assessment required under part 4668.0855, subpart 2.

Subp. 5. **Content of medication orders.** An order for medication must contain the name of the drug, dosage indication, and directions for use.

Subp. 6. **Verbal orders.** Upon receiving an order verbally from a prescriber, a nurse must:

A. record and sign the order; and

B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 7. **Electronically transmitted orders.**

A. An order received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.291to 144.298 and 144A.44.

B. An order received by telephone, facsimile machine, or other electronic means must be communicated to the supervising registered nurse within one hour of receipt.

C. An order received by electronic means, not including facsimile machine, must be immediately recorded or placed in the client's record by a nurse and must be countersigned by the prescriber within 62 days.

D. An order received by facsimile machine must have been signed by the prescriber and must be immediately recorded or a durable copy placed in the client's record by a person authorized by the class F home care provider licensee.

Subp. 8. **Implementation of order.** When an order is received, the class F home care provider licensee or an employee of the licensee must take action to implement the order within 24 hours of receipt of the order.

Subp. 9. **Renewal of orders.** A medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350;

B. subpart 3, $350;

C. subpart 4, $350;

D. subpart 5, $350;

E. subpart 6, $350;

F. subpart 7, item A, $250;

G. subpart 7, item B, $300;

H. subpart 7, item C, $300;

I. subpart 7, item D, $300;

J. subpart 8, $500 per day; and

K. subpart 9, $100.

4668.0865 CENTRAL STORAGE OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Nursing assessment and service plan.** For a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of a client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Control of medications.**

A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

B. The system must contain at least the following provisions:

(1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;

(2) a description of how the distribution and storage of medications will be handled, including a description of suitable storage facilities;

(3) the procedures for recording medications that clients are taking;

(4) the procedures for storage of legend and over-the-counter drugs;

(5) a method of refrigeration of biological medications; and

(6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.

Subp. 4. **Over-the-counter drugs.** An over-the-counter drug may be retained in general stock supply and must be kept in the original labeled container.

Subp. 5. **Legend drugs.** A legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of a time-dated drug, directions for use, client's name, prescriber's name, date of issue, and the name and address of the licensed pharmacy that issued the medications.

Subp. 6. **Medication samples.** A sample of medication provided to a client by an authorized prescriber may be used by that client, and must be kept in its original container bearing the original label with legible directions for use. If assistance with self-administration of medication or medication administration is provided by the class F home care provider licensee, a client's plan of care must address the use of a medication sample.

Subp. 7. **Prohibitions.** No legend drug supply for one client may be used or saved for the use of another client.

Subp. 8. **Storage of drugs.** A class F home care provider licensee providing central storage of medications must store all drugs in locked compartments under proper temperature controls and permit only authorized nursing personnel to have access to keys.

Subp. 9. **Storage of Schedule II drugs.** A class F home care provider licensee providing central storage of medications must provide separately locked compartments, permanently affixed to the physical plant or medication cart, for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350;

B. subpart 3, $300;

C. subpart 4, $300;

D. subpart 5, $300;

E. subpart 6, $300;

F. subpart 7, $300;

G. subpart 8, $300; and

H. subpart 9, $300.

4668.0870 DISPOSITION OF MEDICATIONS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Drugs given to discharged clients.** Current medications belonging to a client must be given to the client, or the client's responsible person, when the client is discharged or moves from the housing with services establishment. A class F home care provider licensee must document in the client's record to whom the medications were given.

Subp. 3. **Disposition of medications.**

A. Unused portions of a controlled substance remaining in a housing with services establishment after death or discharge of the client for whom the controlled substance was prescribed, or any controlled substance discontinued permanently, must be disposed of by contacting the Minnesota Board of Pharmacy, which shall furnish the necessary instructions and forms, a copy of which shall be kept on file by the class F home care provider licensee for two years.

B. Unused portions of a legend drug remaining in a housing with services establishment after the death or discharge of the client for whom the legend drug was prescribed, or any legend drug permanently discontinued, must be destroyed by the class F home care provider licensee or a designee of the licensee, in the presence of a pharmacist or nurse who shall witness the destruction. A notation of the destruction listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded in the client's record.

Subp. 4. **Loss or spillage.** When a loss or spillage of a Schedule II drug occurs, an explanatory notation must be made in the client's record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill.

Subp. 5. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $300;

B. subpart 3, $300; and

C. subpart 4, $300.

4669.0001 AUTHORITY.

This chapter establishes fees for the licensing of home care providers, as required by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (c), and part 4668.0012, subpart 18.

4669.0010 DEFINITIONS.

Subpart 1. **Applicant.** "Applicant" means a provider of home care services that applies for a new license or renewal license under chapter 4668.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Health.

Subp. 3. **Provider.** "Provider" means a home care provider required to be licensed under Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Revenues.** "Revenues" means all money or the value of property or services received by a registrant and derived from the provision of home care services, including fees for services, grants, bequests, gifts, donations, appropriations of public money, and earned interest or dividends.

4669.0020 LICENSE FEE.

An applicant for a new license or renewal license under chapter 4668 shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the formula in part 4669.0050.

4669.0030 PROCEDURE FOR PAYING LICENSE FEE.

Subpart 1. **Payment of fee.** An applicant shall submit the fee required by part 4669.0050 to the commissioner together with the application for the license.

Subp. 2. **Verification of revenues.** Under a circumstance listed in item A or B, the commissioner shall require each applicant to verify its revenues by providing a copy of an income tax return; informational tax return, such as an Internal Revenue Service form 1065 partnership return or form 990 tax-exempt organization return; Medicare cost report; certified financial statement; or other documentation that verifies the accuracy of the revenues derived from the provision of home care services for the reporting period on which the fee is based if either:

A. the commissioner has received information that a revenue report may be inaccurate; or

B. the provider has been randomly selected for compliance verification.

4669.0040 FEE LIMITATION.

A provider is subject to one license fee, regardless of the number of distinct programs through which home care services are provided unless the provider operates under multiple units as set forth in part 4668.0012, subpart 2. The fee shall be based on the total revenue of all home care services.

4669.0050 FEE SCHEDULE.

Subpart 1. **Fees for classes A and B.** The amount of the fee for class A and class B providers shall be determined according to the following schedule:

A. for revenues greater than $1,500,000, $4,000;

B. for revenues greater than $1,275,000 and no more than $1,500,000, $3,500;

C. for revenues greater than $1,100,000 and no more than $1,275,000, $3,000;

D. for revenues greater than $950,000 and no more than $1,100,000, $2,500;

E. for revenues greater than $850,000 and no more than $950,000, $2,250;

F. for revenues greater than $750,000 and no more than $850,000, $2,000;

G. for revenues greater than $650,000 and no more than $750,000, $1,750;

H. for revenues greater than $550,000 and no more than $650,000, $1,500;

I. for revenues greater than $450,000 and no more than $550,000, $1,250;

J. for revenues greater than $350,000 and no more than $450,000, $1,000;

K. for revenues greater than $250,000 and no more than $350,000, $750;

L. for revenues greater than $100,000 and no more than $250,000, $500;

M. for revenues greater than $25,000 and no more than $100,000, $250; and

N. for revenues no more than $25,000, $100.

Subp. 2. **Fees for class C.** The amount of the fee for class C providers shall be as follows:

A. for revenues greater than $1,000, $50; and

B. for revenues no more than $1,000, $20.

Subp. 3. **Fees for class E.** The amount of the fee for class E providers is $500.

Subp. 4. **Fees for medical equipment vendors.** Regardless of the class under which it is licensed, a provider whose principal business is medical supplies and equipment shall pay an annual fee of $500.

9502.0355 CAREGIVER QUALIFICATIONS.

Subp. 4. **Day care insurance coverage.** A provider shall have:

A. a certificate of insurance for the residence for general liability coverage for bodily injury in the amount of at least $100,000 per person and $250,000 per occurrence; or

B. if the provider has liability coverage of lesser limits or no liability coverage, the provider shall give a written notice of the level of liability coverage to parents of all children in care prior to admission or when there is a change in the amount of insurance coverage; and

C. the provider shall maintain copies of the notice, signed by the parents to indicate they have read and understood it, in the provider's records on the residence as specified in part 9502.0405.

9560.0650 MAINTENANCE STANDARDS.

Subpart 1. **Payments.** The local agency shall make payments based on the following maintenance standards:

Age	Monthly Maintenance Standard	Initial Clothing
0-11	$212 ($244 effective January 1984)	up to $146 (up to $168 effective January 1984)
12-14	$293	up to $288
15-18	$320	up to $348

The initial clothing allowance shall be available based on the child's needs during the first 60 days of the initial placement. The state agency shall annually review and revise the maintenance standard based on "USDA Estimates of the Cost of Raising a Child," issued by the United States Department of Agriculture, Agricultural Resources Service, Publication 1411 (October, 1982).

9560.0650 MAINTENANCE STANDARDS.

Subp. 3. **Agency contract care.** When foster care is provided for a child by a provider licensed under parts 9545.0010 to 9545.0260 through contract with a public or private agency, foster care maintenance payments and difficulty of care payments shall be determined according

to the rate schedules in subpart 1 and parts 9560.0653 to 9560.0655. If the local agency is contracting for administrative or social services costs, the payments to the contracting agency shall be in addition to the rates established in subpart 1 and parts 9560.0653 to 9560.0655.

9560.0650 MAINTENANCE STANDARDS.

Subp. 6. **Reassessment.** The agency shall reassess a child:

A. at the end of 12 months;

B. at the request of a foster parent;

C. when a child is placed in a different facility; or

D. if a child's level of need changes.

9560.0651 DIFFICULTY OF CARE ASSESSMENTS AND PAYMENTS.

Parts 9560.0652 to 9560.0656 provide criteria for assessing the difficulty of care and the payment rate for a child in foster care.

9560.0655 DIFFICULTY OF CARE PAYMENT RATE.

Subpart 1. **Payment rate.** Except as provided by subpart 2, the local agency shall make payments to the foster care provider at the rate of $3.70 per month for each point assessed under part 9560.0654.

Subp. 2. **Existing placements.** In a placement for which a difficulty of care payment was established and was being made prior to January 1, 1989, and the payment is greater than the payment which would be made under subpart 1, the local agency shall continue to pay the greater amount until the child's difficulty of care changes or the placement terminates.

Subp. 3. **Annual revision of payment rate.** By November 1 of each year following January 1, 1989, the commissioner shall review and revise the difficulty of care payment rate in subpart 1 based on USDA Estimates of the Cost of Raising a Child, published by the United States Department of Agriculture, Agricultural Resources Service, Publication 1411. The revision shall be the average percentage by which costs increase for the age ranges represented in the USDA Estimates of the Cost of Raising a Child. The USDA Estimates of the Cost of Raising a Child is subject to annual revision.