

State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 1233

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

The bill was read for the first time and referred to the Committee on Rules and Legislative Administration

03/11/2013 Adoption of Report: Pass and re-referred to the Committee on Health and Human Services Finance

04/15/2013 Adoption of Report: Pass as Amended and re-referred to the Committee on Ways and Means

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

A bill for an act

1.1 relating to state government; establishing the health and human services budget;
 1.2 modifying provisions related to health care, continuing care, human services
 1.3 licensing, chemical and mental health, managed care organizations, waiver
 1.4 provider standards, home care, and the Department of Health; redesigning
 1.5 home and community-based services; establishing payment methodologies
 1.6 for home and community-based services; adjusting nursing and ICF/DD
 1.7 facility rates; setting and modifying fees; modifying autism coverage; making
 1.8 technical changes; requiring studies; requiring reports; appropriating money;
 1.9 amending Minnesota Statutes 2012, sections 16A.724, subdivisions 2, 3; 16C.10,
 1.10 subdivision 5; 16C.155, subdivision 1; 62A.65, subdivision 2, by adding a
 1.11 subdivision; 62J.692, subdivision 4; 62Q.19, subdivision 1; 103I.005, by
 1.12 adding a subdivision; 103I.521; 119B.13, subdivision 7; 144.051, by adding
 1.13 subdivisions; 144.0724, subdivisions 4, 6; 144.123, subdivision 1; 144.125,
 1.14 subdivision 1; 144.966, subdivisions 2, 3a; 144.98, subdivisions 3, 5, by
 1.15 adding subdivisions; 144.99, subdivision 4; 144A.351; 144A.43; 144A.44;
 1.16 144A.45; 144A.53, subdivision 2; 144D.01, subdivision 4; 145.986; 145C.01,
 1.17 subdivision 7; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5,
 1.18 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding
 1.19 subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;
 1.20 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions 1,
 1.21 2, 4; 149A.74; 149A.91, subdivision 9; 149A.93, subdivisions 3, 6; 149A.94;
 1.22 149A.96, subdivision 9; 174.30, subdivision 1; 214.40, subdivision 1; 243.166,
 1.23 subdivisions 4b, 7; 245.4661, subdivisions 5, 6; 245.4682, subdivision 2;
 1.24 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04,
 1.25 subdivision 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08,
 1.26 subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435;
 1.27 245A.144; 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5;
 1.28 245A.50; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245D.02;
 1.29 245D.03; 245D.04; 245D.05; 245D.06; 245D.07; 245D.09; 245D.10; 246.18,
 1.30 subdivision 8, by adding a subdivision; 246.54; 254B.04, subdivision 1; 254B.13;
 1.31 256.01, subdivisions 2, 24, 34, by adding subdivisions; 256.9657, subdivisions 2,
 1.32 3a; 256.9685, subdivision 2; 256.969, subdivisions 3a, 29; 256.975, subdivision
 1.33 7, by adding subdivisions; 256.9754, subdivision 5, by adding subdivisions;
 1.34 256B.02, by adding subdivisions; 256B.021, by adding subdivisions; 256B.04,
 1.35 subdivisions 18, 21, by adding a subdivision; 256B.055, subdivisions 3a, 6,
 1.36 10, 14, 15, by adding a subdivision; 256B.056, subdivisions 1, 1c, 3, 4, as
 1.37 amended, 5c, 10, by adding a subdivision; 256B.057, subdivisions 1, 8, 10,
 1.38 by adding a subdivision; 256B.06, subdivision 4; 256B.0623, subdivision 2;
 1.39

2.1 256B.0625, subdivisions 9, 13e, 19c, 31, 39, 48, 58, by adding subdivisions;
 2.2 256B.0631, subdivision 1; 256B.064, subdivisions 1a, 1b, 2; 256B.0659,
 2.3 subdivision 21; 256B.0755, subdivision 3; 256B.0756; 256B.0911, subdivisions
 2.4 1, 1a, 3a, 4d, 6, 7, by adding a subdivision; 256B.0913, subdivision 4, by
 2.5 adding a subdivision; 256B.0915, subdivisions 3a, 5, by adding a subdivision;
 2.6 256B.0916, by adding a subdivision; 256B.0917, subdivisions 6, 13, by
 2.7 adding subdivisions; 256B.092, subdivisions 11, 12, by adding subdivisions;
 2.8 256B.0946; 256B.095; 256B.0951, subdivisions 1, 4; 256B.0952, subdivisions 1,
 2.9 5; 256B.097, subdivisions 1, 3; 256B.431, subdivision 44; 256B.434, subdivision
 2.10 4, by adding a subdivision; 256B.437, subdivision 6; 256B.439, subdivisions
 2.11 1, 2, 3, 4, by adding a subdivision; 256B.441, subdivisions 13, 53; 256B.49,
 2.12 subdivisions 11a, 12, 14, 15, by adding subdivisions; 256B.4912, subdivisions
 2.13 1, 2, 3, 7, by adding subdivisions; 256B.4913, subdivisions 5, 6, by adding a
 2.14 subdivision; 256B.492; 256B.493, subdivision 2; 256B.5011, subdivision 2;
 2.15 256B.5012, by adding subdivisions; 256B.69, subdivisions 5c, 31, by adding a
 2.16 subdivision; 256B.694; 256B.76, subdivisions 2, 4, by adding a subdivision;
 2.17 256B.761; 256B.764; 256B.766; 256I.04, subdivision 3; 256I.05, subdivision
 2.18 1e, by adding a subdivision; 256J.35; 256K.45; 256L.01, subdivisions 3a, 5, by
 2.19 adding subdivisions; 256L.02, subdivision 2, by adding subdivisions; 256L.03,
 2.20 subdivisions 1, 1a, 3, 5, 6, by adding a subdivision; 256L.04, subdivisions 1, 7, 8,
 2.21 10, by adding subdivisions; 256L.05, subdivisions 1, 2, 3; 256L.06, subdivision
 2.22 3; 256L.07, subdivisions 1, 2, 3; 256L.09, subdivision 2; 256L.11, subdivision 6;
 2.23 256L.15, subdivisions 1, 2; 257.0755, subdivision 1; 260B.007, subdivisions 6,
 2.24 16; 260C.007, subdivisions 6, 31; 471.59, subdivision 1; 626.556, subdivisions 2,
 2.25 3, 10d; 626.557, subdivisions 4, 9, 9a, 9e; 626.5572, subdivision 13; Laws 1998,
 2.26 chapter 407, article 6, section 116; Laws 2011, First Special Session chapter
 2.27 9, article 1, section 3; article 2, section 27; article 10, section 3, subdivision
 2.28 3, as amended; proposing coding for new law in Minnesota Statutes, chapters
 2.29 62A; 62D; 144; 144A; 145; 149A; 214; 245; 245A; 245D; 254B; 256; 256B;
 2.30 256L; repealing Minnesota Statutes 2012, sections 103I.005, subdivision 20;
 2.31 144.123, subdivision 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision
 2.32 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6;
 2.33 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a;
 2.34 149A.53, subdivision 9; 245A.655; 245B.01; 245B.02; 245B.03; 245B.031;
 2.35 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, 7; 245B.055; 245B.06; 245B.07;
 2.36 245B.08; 245D.08; 256B.055, subdivisions 3, 5, 10b; 256B.056, subdivision 5b;
 2.37 256B.057, subdivisions 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917,
 2.38 subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.096, subdivisions 1, 2, 3, 4;
 2.39 256B.14, subdivision 3a; 256B.49, subdivision 16a; 256B.4913, subdivisions 1,
 2.40 2, 3, 4; 256B.5012, subdivision 13; 256J.24, subdivision 6; 256K.45, subdivision
 2.41 2; 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, 10a;
 2.42 256L.05, subdivision 3b; 256L.07, subdivisions 5, 8, 9; 256L.11, subdivision 5;
 2.43 256L.12; 256L.17, subdivisions 1, 2, 3, 4, 5; 485.14; 609.093; Laws 2011, First
 2.44 Special Session chapter 9, article 7, section 54, as amended; Minnesota Rules,
 2.45 parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016;
 2.46 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040; 4668.0050;
 2.47 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
 2.48 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160;
 2.49 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220;
 2.50 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810; 4668.0815;
 2.51 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840; 4668.0845;
 2.52 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010;
 2.53 4669.0020; 4669.0030; 4669.0040; 4669.0050.

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

3.1 **ARTICLE 1**

3.2 **AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH**
 3.3 **CARE FOR MORE MINNESOTANS**

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

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

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

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

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

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

3.33 (b) A person not entitled to services under paragraph (a), but with family income
 3.34 that is less than 215 percent of the federal poverty guidelines for the applicable family

4.1 size, shall be eligible to receive chemical dependency fund services within the limit
4.2 of funds appropriated for this group for the fiscal year. If notified by the state agency
4.3 of limited funds, a county must give preferential treatment to persons with dependent
4.4 children who are in need of chemical dependency treatment pursuant to an assessment
4.5 under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision
4.6 6, or 260C.212. A county may spend money from its own sources to serve persons under
4.7 this paragraph. State money appropriated for this paragraph must be placed in a separate
4.8 account established for this purpose.

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

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

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

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

4.29 (2) Medicaid funding; and

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

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

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

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

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

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

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

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

5.16 (e) The commissioner shall report progress on implementing this subdivision to the
5.17 chairs and ranking minority members of the legislative committees with jurisdiction over
5.18 health and human services policy and finance by December 1, 2014.

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

5.21 Sec. 4. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
5.22 to read:

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

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

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

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

5.31 (1) medical assistance under this chapter;

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

- 6.1 (3) MinnesotaCare as defined in chapter 256L; and
6.2 (4) a Basic Health Plan as defined in section 1331 of the Affordable Care Act.

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

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

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

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

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

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

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

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

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

6.27 Sec. 8. Minnesota Statutes 2012, section 256B.055, subdivision 6, is amended to read:

6.28 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid
6.29 for a pregnant woman who ~~has written verification of a positive pregnancy test from a~~
6.30 ~~physician or licensed registered nurse, who~~ meets the other eligibility criteria of this
6.31 section and whose unborn child would be eligible as a needy child under subdivision 10 if
6.32 born and living with the woman. In accordance with Code of Federal Regulations, title

7.1 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless
7.2 the agency has information that is not reasonably compatible with such attestation. For
7.3 purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

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

7.5 Sec. 9. Minnesota Statutes 2012, section 256B.055, subdivision 10, is amended to read:

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

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

7.13 Sec. 10. Minnesota Statutes 2012, section 256B.055, subdivision 15, is amended to read:

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

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

7.17 (2) not pregnant;

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

7.20 (4) ~~not an adult in a family with children as defined in section 256L.01, subdivision~~
7.21 ~~3a; and~~ not otherwise eligible under subdivision 7 as a person who meets the categorical
7.22 eligibility requirements of the supplemental security income program;

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

7.26 ~~(5)~~ (6) not described in another subdivision of this section.

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

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

7.30 Subd. 17. **Adults who were in foster care at the age of 18.** Medical assistance may
7.31 be paid for a person under 26 years of age who was in foster care under the commissioner's
7.32 responsibility on the date of attaining 18 years of age, and who was enrolled in medical

8.1 assistance under the state plan or a waiver of the plan while in foster care, in accordance
8.2 with section 2004 of the Affordable Care Act.

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

8.4 Sec. 12. Minnesota Statutes 2012, section 256B.056, subdivision 1, is amended to read:

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

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

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

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

8.13 (2) For applications processed within one calendar month prior to July 1, 2003,
8.14 eligibility shall be determined by applying the income standards and methodologies in
8.15 effect prior to July 1, 2003, for any months in the six-month budget period before July
8.16 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any
8.17 months in the six-month budget period on or after that date. The income standards for
8.18 each month shall be added together and compared to the applicant's total countable income
8.19 for the six-month budget period to determine eligibility.

8.20 (3) For children ages one through 18 ~~whose eligibility is determined under section~~
8.21 ~~256B.057, subdivision 2,~~ the following deductions shall be applied to income counted
8.22 toward the child's eligibility as allowed under the state's AFDC plan in effect as of July
8.23 16, 1996: \$90 work expense, dependent care, and child support paid under court order.
8.24 This clause is effective October 1, 2003.

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

8.31 (c) If the four-month disregard in paragraph (b) has been applied to the wage
8.32 earner's income for four months, the disregard shall not be applied again until the wage

9.1 earner's income has not been considered in determining medical assistance eligibility for
9.2 12 consecutive months.

9.3 (d) The commissioner shall adjust the income standards under this section each July
9.4 1 by the annual update of the federal poverty guidelines following publication by the
9.5 United States Department of Health and Human Services except that the income standards
9.6 shall not go below those in effect on July 1, 2009.

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

9.10 Sec. 14. Minnesota Statutes 2012, section 256B.056, subdivision 3, is amended to read:

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

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

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

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

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

9.32 (5) for a person who no longer qualifies as an employed person with a disability due
9.33 to loss of earnings, assets allowed while eligible for medical assistance under section
9.34 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month

10.1 of ineligibility as an employed person with a disability, to the extent that the person's total
10.2 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

10.3 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
10.4 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
10.5 before the person's 65th birthday, the assets owned by the person and the person's spouse
10.6 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
10.7 when determining eligibility for medical assistance under section 256B.055, subdivision
10.8 7. The income of a spouse of a person enrolled in medical assistance under section
10.9 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
10.10 65th birthday must be disregarded when determining eligibility for medical assistance
10.11 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
10.12 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
10.13 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
10.14 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65; and

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

10.19 ~~(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision~~
10.20 ~~15.~~

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

10.22 Sec. 15. Minnesota Statutes 2012, section 256B.056, subdivision 4, as amended by
10.23 Laws 2013, chapter 1, section 5, is amended to read:

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

10.29 (b) To be eligible for medical assistance, families and children may have an income
10.30 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,
10.31 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,
10.32 1996, shall be increased by three percent.

10.33 (c) Effective January 1, 2014, to be eligible for medical assistance, under section
10.34 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
10.35 percent of the federal poverty guidelines for the household size.

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

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

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

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

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

11.23 Sec. 16. Minnesota Statutes 2012, section 256B.056, subdivision 5c, is amended to read:

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

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

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

11.32 Sec. 17. Minnesota Statutes 2012, section 256B.056, is amended by adding a
 11.33 subdivision to read:

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

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

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

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

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

12.18 Sec. 18. Minnesota Statutes 2012, section 256B.056, subdivision 10, is amended to read:

12.19 **Subd. 10. Eligibility verification.** (a) The commissioner shall require women who
12.20 are applying for the continuation of medical assistance coverage following the end of the
12.21 60-day postpartum period to update their income and asset information and to submit
12.22 any required income or asset verification.

12.23 (b) The commissioner shall determine the eligibility of private-sector health care
12.24 coverage for infants less than one year of age eligible under section 256B.055, subdivision
12.25 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage
12.26 if this is determined to be cost-effective.

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

12.29 (d) The commissioner shall utilize information obtained through the electronic
12.30 service established by the secretary of the United States Department of Health and Human
12.31 Services and other available electronic data sources in Code of Federal Regulations, title
12.32 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner
12.33 shall establish standards to define when information obtained electronically is reasonably
12.34 compatible with information provided by applicants and enrollees, including use of

13.1 self-attestation, to accomplish real-time eligibility determinations and maintain program
13.2 integrity.

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

13.4 Sec. 19. Minnesota Statutes 2012, section 256B.057, subdivision 1, is amended to read:

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

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

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

13.24 (2) ~~For applications processed within one calendar month prior to July 1, 2003,~~
13.25 ~~eligibility shall be determined by applying the income standards and methodologies in~~
13.26 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July 1,~~
13.27 ~~2003, and the income standards and methodologies in effect on the expiration date for any~~
13.28 ~~months in the six-month budget period on or after July 1, 2003. The income standards~~
13.29 ~~for each month shall be added together and compared to the applicant's total countable~~
13.30 ~~income for the six-month budget period to determine eligibility.~~

13.31 (3) ~~An amount equal to the amount of earned income exceeding 275 percent of~~
13.32 ~~the federal poverty guideline, up to a maximum of the amount by which the combined~~
13.33 ~~total of 185 percent of the federal poverty guideline plus the earned income disregards~~
13.34 ~~and deductions allowed under the state's AFDC plan as of July 16, 1996, as required~~
13.35 ~~by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public~~

14.1 ~~Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for~~
14.2 ~~pregnant women and infants less than one year of age.~~

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

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

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

14.9 Sec. 20. Minnesota Statutes 2012, section 256B.057, subdivision 8, is amended to read:

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

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

14.16 Sec. 21. Minnesota Statutes 2012, section 256B.057, subdivision 10, is amended to read:

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

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

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

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

14.27 (4) is under age 65;

14.28 (5) is not otherwise eligible for medical assistance under United States Code, title
14.29 42, section 1396a(a)(10)(A)(i); and

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

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

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

15.7 Sec. 22. Minnesota Statutes 2012, section 256B.057, is amended by adding a
15.8 subdivision to read:

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

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

15.16 Sec. 23. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

16.10 (c) All qualified noncitizens who were residing in the United States before August
16.11 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
16.12 medical assistance with federal financial participation.

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

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

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

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

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

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

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

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

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

17.5 (g) For purposes of this subdivision, the term "emergency medical condition" means
17.6 a medical condition that meets the requirements of United States Code, title 42, section
17.7 1396b(v).

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

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

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

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

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

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

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

17.22 (iii) services for routine prenatal care;

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

17.25 (v) elective surgery;

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

17.28 (vii) preventative health care and family planning services;

17.29 (viii) dialysis;

17.30 (ix) chemotherapy or therapeutic radiation services;

17.31 (x) rehabilitation services;

17.32 (xi) physical, occupational, or speech therapy;

17.33 (xii) transportation services;

17.34 (xiii) case management;

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

17.36 (xv) dental services;

- 18.1 (xvi) hospice care;
- 18.2 (xvii) audiology services and hearing aids;
- 18.3 (xviii) podiatry services;
- 18.4 (xix) chiropractic services;
- 18.5 (xx) immunizations;
- 18.6 (xxi) vision services and eyeglasses;
- 18.7 (xxii) waiver services;
- 18.8 (xxiii) individualized education programs; or
- 18.9 (xxiv) chemical dependency treatment.

18.10 (i) ~~Beginning July 1, 2009, Pregnant noncitizens who are undocumented,~~
18.11 ~~nonimmigrants, or lawfully present in the United States as defined in Code of Federal~~
18.12 ~~Regulations, title 8, section 103.12, ineligible for federally funded medical assistance~~
18.13 are not covered by a group health plan or health insurance coverage according to Code
18.14 of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility
18.15 requirements of this chapter, are eligible for medical assistance through the period of
18.16 pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal
18.17 funds are available under title XXI of the Social Security Act, and the state children's
18.18 health insurance program.

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

18.25 (k) Noncitizens who are lawfully present in the United States as defined in Code
18.26 of Federal Regulations, title 8, section 103.12, who are not children or pregnant women
18.27 as defined in paragraph (d), and who otherwise meet the eligibility requirements of this
18.28 chapter, are eligible for medical assistance without federal financial participation. These
18.29 individuals must cooperate with the United States Citizenship and Immigration Services to
18.30 pursue any applicable immigration status, including citizenship, that would qualify them
18.31 for medical assistance with federal financial participation.

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

18.33 Sec. 24. Minnesota Statutes 2012, section 256B.0755, subdivision 3, is amended to read:

18.34 Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility
18.35 for the quality of care based on standards established under subdivision 1, paragraph (b),

19.1 clause (10), and the cost of care or utilization of services provided to its enrollees under
 19.2 subdivision 1, paragraph (b), clause (1).

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

19.7 (c) A health care delivery system must demonstrate how its services will be
 19.8 coordinated with other services affecting its attributed patients' health, quality of care,
 19.9 and cost of care that are provided by other providers and county agencies in the local
 19.10 service area. The health care delivery system must: (1) document how other providers
 19.11 and counties, including county-based purchasing plans, will provide services to persons
 19.12 attributed to the health care delivery system; (2) document how other providers and
 19.13 counties, including county-based purchasing plans, participated in developing the
 19.14 application; (3) provide verification that other providers and counties, including
 19.15 county-based purchasing plans, support the project and are willing to participate; and (4)
 19.16 document how it will address applicable local needs, priorities, and public health goals.

19.17 **EFFECTIVE DATE.** This section applies to health care delivery system contracts
 19.18 entered into or renewed on or after July 1, 2013.

19.19 Sec. 25. Minnesota Statutes 2012, section 256B.694, is amended to read:

19.20 **256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE**
 19.21 **CONTRACT.**

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

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

19.31 Sec. 26. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
 19.32 to read:

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

20.5 Sec. 27. Minnesota Statutes 2012, section 256L.01, subdivision 3a, is amended to read:

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

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

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

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

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

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

20.19 Subd. 4b. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace"
20.20 means the Minnesota Insurance Marketplace as defined in Minnesota Statutes, section
20.21 62V.02.

20.22 Sec. 29. Minnesota Statutes 2012, section 256L.01, subdivision 5, is amended to read:

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

20.31 ~~(b) For purposes of this subdivision, and unless otherwise specified in this section,~~
20.32 ~~the commissioner shall use reasonable methods to calculate gross earned and unearned~~

21.1 ~~income including, but not limited to, projecting income based on income received within~~
21.2 ~~the past 30 days, the last 90 days, or the last 12 months.~~

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

21.6 Sec. 30. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
21.7 to read:

21.8 Subd. 8. **Participating entity.** "Participating entity" means a health carrier as
21.9 defined in section 62A.011, subdivision 2; a county-based purchasing plan established
21.10 under section 256B.692; an accountable care organization or other entity operating a
21.11 health care delivery systems demonstration project authorized under section 256B.0755;
21.12 an entity operating a county integrated health care delivery network pilot project
21.13 authorized under section 256B.0756; or a network of health care providers established to
21.14 offer services under MinnesotaCare.

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

21.16 Sec. 31. Minnesota Statutes 2012, section 256L.02, subdivision 2, is amended to read:

21.17 Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the
21.18 state administration of this plan. The plan shall be used to provide covered health services
21.19 for eligible persons. Payment for these services shall be made to all ~~eligible providers~~
21.20 ~~participating entities under contract with the commissioner.~~ The commissioner shall
21.21 adopt rules to administer the MinnesotaCare program. Nothing in this chapter is intended
21.22 to violate the requirements of the Affordable Care Act. The commissioner shall not
21.23 implement any provision of this chapter if the provision is found to violate the Affordable
21.24 Care Act. The commissioner shall establish marketing efforts to encourage potentially
21.25 eligible persons to receive information about the program and about other medical care
21.26 programs administered or supervised by the Department of Human Services. A toll-free
21.27 telephone number and Web site must be used to provide information about medical
21.28 programs and to promote access to the covered services.

21.29 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
21.30 approval, whichever is later, except that the amendment related to "participating entities"
21.31 is effective January 1, 2015. The commissioner of human services shall notify the revisor
21.32 when federal approval is obtained.

22.1 Sec. 32. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
22.2 to read:

22.3 Subd. 6. **Federal approval.** (a) The commissioner of human services shall seek
22.4 federal approval to implement the MinnesotaCare program under this chapter as a basic
22.5 health program. In any agreement with the Centers for Medicare and Medicaid Services
22.6 to operate MinnesotaCare as a basic health program, the commissioner shall seek to
22.7 include procedures to ensure that federal funding is predictable, stable, and sufficient
22.8 to sustain ongoing operation of MinnesotaCare. These procedures must address issues
22.9 related to the timing of federal payments, payment reconciliation, enrollee risk adjustment,
22.10 and minimization of state financial risk. The commissioner shall consult with the
22.11 commissioner of management and budget when developing the proposal for establishing
22.12 MinnesotaCare as a basic health program to be submitted to the Centers for Medicare
22.13 and Medicaid Services.

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

22.21 (c) The commissioner of human services, through December 31, 2015, may modify
22.22 the MinnesotaCare program as specified in this chapter, if it is necessary to enhance
22.23 health benefits, expand provider access, or reduce cost-sharing and premiums in order
22.24 to comply with the terms and conditions of federal approval as a basic health program.
22.25 The commissioner may not reduce benefits, impose greater limits on access to providers,
22.26 or increase cost-sharing and premiums by enrollees under the authority granted by this
22.27 paragraph. If the commissioner modifies the terms and requirements for MinnesotaCare
22.28 under this paragraph, the commissioner shall provide the legislature with notice of
22.29 implementation of the modifications at least ten working days before notifying enrollees
22.30 and participating entities. The costs of any changes to the program necessary to comply
22.31 with federal approval shall become part of the program's base funding for purposes of
22.32 future budget forecasts.

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

22.34 Sec. 33. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
22.35 to read:

23.1 Subd. 7. Coordination with Minnesota Insurance Marketplace. MinnesotaCare
 23.2 shall be considered a public health care program for purposes of Minnesota Statutes,
 23.3 chapter 62V.

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

23.5 Sec. 34. Minnesota Statutes 2012, section 256L.03, subdivision 1, is amended to read:

23.6 Subdivision 1. **Covered health services.** (a) "Covered health services" means the
 23.7 health services reimbursed under chapter 256B, and all essential health benefits required
 23.8 under section 1302 of the Affordable Care Act, with the exception of inpatient hospital
 23.9 services, special education services, private duty nursing services, adult dental care
 23.10 services other than services covered under section 256B.0625, subdivision 9, orthodontic
 23.11 services, nonemergency medical transportation services, personal care assistance and case
 23.12 management services, and nursing home or intermediate care facilities services, inpatient
 23.13 mental health services, and chemical dependency services.

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

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

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

23.22 Sec. 35. Minnesota Statutes 2012, section 256L.03, subdivision 1a, is amended to read:

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

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

24.4 Sec. 36. Minnesota Statutes 2012, section 256L.03, subdivision 3, is amended to read:

24.5 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
24.6 inpatient hospital services, including inpatient hospital mental health services and inpatient
24.7 hospital and residential chemical dependency treatment, subject to those limitations
24.8 necessary to coordinate the provision of these services with eligibility under the medical
24.9 assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under~~
24.10 ~~section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and~~
24.11 ~~2, with family gross income that exceeds 200 percent of the federal poverty guidelines or~~
24.12 ~~215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not~~
24.13 ~~pregnant, is subject to an annual limit of \$10,000.~~

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

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

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

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

24.26 Sec. 37. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision
24.27 to read:

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

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

24.32 Sec. 38. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

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

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

25.6 (2) \$3 per prescription for adult enrollees;

25.7 (3) \$25 for eyeglasses for adult enrollees;

25.8 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
25.9 episode of service which is required because of a recipient's symptoms, diagnosis, or
25.10 established illness, and which is delivered in an ambulatory setting by a physician or
25.11 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
25.12 audiologist, optician, or optometrist;

25.13 (5) \$6 for nonemergency visits to a hospital-based emergency room for services
25.14 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

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

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

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

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

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

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

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

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

26.1 plans. Managed care plans and county-based purchasing plans shall certify annually to the
26.2 commissioner the dollar value of the family deductible.

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

26.6 Sec. 39. Minnesota Statutes 2012, section 256L.03, subdivision 6, is amended to read:

26.7 Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for
26.8 covered health services, the agency shall have a lien for the cost of the covered health
26.9 services upon any and all causes of action accruing to the enrollee, or to the enrollee's
26.10 legal representatives, as a result of the occurrence that necessitated the payment for the
26.11 covered health services. All liens under this section shall be subject to the provisions
26.12 of section 256.015. For purposes of this subdivision, "state agency" includes ~~prepaid~~
26.13 ~~health plans participating entities,~~ under contract with the commissioner according to
26.14 sections ~~256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12;~~ and county-based
26.15 ~~purchasing entities under section 256B.692~~ section 256L.121.

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

26.17 Sec. 40. Minnesota Statutes 2012, section 256L.04, subdivision 1, is amended to read:

26.18 Subdivision 1. **Families with children.** ~~(a)~~ Families with children with family
26.19 income above 133 percent of the federal poverty guidelines and equal to or less than
26.20 ~~275~~ 200 percent of the federal poverty guidelines for the applicable family size shall be
26.21 eligible for MinnesotaCare according to this section. All other provisions of sections
26.22 256L.01 to 256L.18, ~~including the insurance-related barriers to enrollment under section~~
26.23 ~~256L.07,~~ shall apply unless otherwise specified.

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

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

27.1 ~~(d) Parents are not eligible for MinnesotaCare if their gross income exceeds \$57,500.~~
 27.2 ~~(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision~~
 27.3 ~~8, are exempt from the eligibility requirements of this subdivision.~~

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

27.7 Sec. 41. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
 27.8 to read:

27.9 Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare,
 27.10 a person must meet the eligibility requirements of this section. A person eligible for
 27.11 MinnesotaCare shall not be treated as a qualified individual under section 1312 of the
 27.12 Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered
 27.13 through the health benefit exchange under section 1331 of the Affordable Care Act.

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

27.15 Sec. 42. Minnesota Statutes 2012, section 256L.04, subdivision 7, is amended to read:

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

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

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

27.26 Sec. 43. Minnesota Statutes 2012, section 256L.04, subdivision 8, is amended to read:

27.27 Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals
 27.28 who receive supplemental security income or retirement, survivors, or disability benefits
 27.29 due to a disability, or other disability-based pension, who qualify under subdivision 7, but
 27.30 who are potentially eligible for medical assistance without a spenddown shall be allowed
 27.31 to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other
 27.32 conditions of eligibility. The commissioner shall identify and refer the applications of

28.1 such individuals to their county social service agency. The county and the commissioner
28.2 shall cooperate to ensure that the individuals obtain medical assistance coverage for any
28.3 months for which they are eligible.

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

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

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

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

28.23 Sec. 44. Minnesota Statutes 2012, section 256L.04, subdivision 10, is amended to read:

28.24 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to
28.25 citizens or nationals of the United States, ~~qualified noncitizens, and other persons residing
28.26 and lawfully in the United States present noncitizens~~ as defined in Code of Federal
28.27 Regulations, title 8, section 103.12. Undocumented noncitizens ~~and nonimmigrants~~
28.28 are ineligible for MinnesotaCare. For purposes of this subdivision, ~~a nonimmigrant
28.29 is an individual in one or more of the classes listed in United States Code, title 8,
28.30 section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the
28.31 United States without the approval or acquiescence of the United States Citizenship and
28.32 Immigration Services. Families with children who are citizens or nationals of the United
28.33 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
28.34 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
28.35 Public Law 109-171.~~

29.1 (b) Eligible persons include individuals who are lawfully present and ineligible for
29.2 medical assistance by reason of immigration status, who have family income equal to or
29.3 less than 200 percent of the federal poverty guidelines for the applicable family size.

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

29.7 Sec. 45. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
29.8 to read:

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

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

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

29.18 Sec. 46. Minnesota Statutes 2012, section 256L.05, subdivision 1, is amended to read:

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

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

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

30.4 Sec. 47. Minnesota Statutes 2012, section 256L.05, subdivision 2, is amended to read:

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

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

30.15 Sec. 48. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

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

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

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

30.31 ~~(d)~~ (c) Notwithstanding any other law to the contrary, benefits under sections
30.32 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which
30.33 an eligible person may have coverage and the commissioner shall use cost avoidance

31.1 techniques to ensure coordination of any other health coverage for eligible persons. The
31.2 commissioner shall identify eligible persons who may have coverage or benefits under
31.3 other plans of insurance or who become eligible for medical assistance.

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

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

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

31.14 Sec. 49. Minnesota Statutes 2012, section 256L.06, subdivision 3, is amended to read:

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

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

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

31.32 (d) Nonpayment of the premium will result in disenrollment from the plan effective
31.33 for the calendar month for which the premium was due. ~~Persons disenrolled for~~
31.34 ~~nonpayment or who voluntarily terminate coverage from the program may not reenroll~~
31.35 ~~until four calendar months have elapsed.~~ Persons disenrolled for nonpayment who pay

32.1 all past due premiums as well as current premiums due, including premiums due for the
 32.2 period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively
 32.3 to the first day of disenrollment. ~~Persons disenrolled for nonpayment or who voluntarily~~
 32.4 ~~terminate coverage from the program may not reenroll for four calendar months unless~~
 32.5 ~~the person demonstrates good cause for nonpayment. Good cause does not exist if a~~
 32.6 ~~person chooses to pay other family expenses instead of the premium. The commissioner~~
 32.7 ~~shall define good cause in rule.~~

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

32.11 Sec. 50. Minnesota Statutes 2012, section 256L.07, subdivision 1, is amended to read:

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

32.19 Parents Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1,
 32.20 and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose
 32.21 income increases above 275 200 percent of the federal poverty guidelines, are no longer
 32.22 eligible for the program and shall be disenrolled by the commissioner. Beginning January
 32.23 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision
 32.24 7, whose income increases above 200 percent of the federal poverty guidelines or 250
 32.25 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for
 32.26 the program and shall be disenrolled by the commissioner. For persons disenrolled under
 32.27 this subdivision, MinnesotaCare coverage terminates the last day of the calendar month
 32.28 following the month in which the commissioner determines that the income of a family or
 32.29 individual exceeds program income limits.

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

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

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

33.4 Sec. 51. Minnesota Statutes 2012, section 256L.07, subdivision 2, is amended to read:

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

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

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

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

33.29 Sec. 52. Minnesota Statutes 2012, section 256L.07, subdivision 3, is amended to read:

33.30 Subd. 3. **Other health coverage.** (a) ~~Families and individuals enrolled in the~~
33.31 ~~MinnesotaCare program must have no~~ To be eligible, a family must not have minimum
33.32 essential health coverage while enrolled, as defined by section 5000A of the Internal
33.33 Revenue Code. ~~Children with family gross incomes equal to or greater than 200 percent~~
33.34 ~~of federal poverty guidelines, and adults, must have had no health coverage for at least~~

34.1 ~~four months prior to application and renewal. Children enrolled in the original children's~~
34.2 ~~health plan and children in families with income equal to or less than 200 percent of the~~
34.3 ~~federal poverty guidelines, who have other health insurance, are eligible if the coverage:~~

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

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

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

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

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

34.9 (v) ~~vision coverage;~~

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

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

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

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

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

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

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

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

35.1 Sec. 53. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

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

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

35.10 Sec. 54. Minnesota Statutes 2012, section 256L.11, subdivision 6, is amended to read:

35.11 Subd. 6. **Enrollees 18 or older Reimbursement of inpatient hospital services.**
35.12 Payment by the MinnesotaCare program for inpatient hospital services provided to
35.13 MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify
35.14 under section 256L.04, subdivisions subdivision 1 and 2, with family gross income that
35.15 ~~exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who~~
35.16 ~~are 18 years old or older on the date of admission to the inpatient hospital must be in~~
35.17 ~~accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are~~
35.18 ~~eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or~~
35.19 ~~less than 175 percent of the federal poverty guidelines, shall be as provided for under~~
35.20 ~~paragraph (e), shall be at the medical assistance rate minus any co-payment required~~
35.21 under section 256L.03, subdivision 5. The hospital must not seek payment from the
35.22 enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment
35.23 must be treated as payment in full.

35.24 ~~(a) If the medical assistance rate minus any co-payment required under section~~
35.25 ~~256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's~~
35.26 ~~benefit limit under section 256L.03, subdivision 3, payment must be the medical~~
35.27 ~~assistance rate minus any co-payment required under section 256L.03, subdivision 4. The~~
35.28 ~~hospital must not seek payment from the enrollee in addition to the co-payment. The~~
35.29 ~~MinnesotaCare payment plus the co-payment must be treated as payment in full.~~

35.30 ~~(b) If the medical assistance rate minus any co-payment required under section~~
35.31 ~~256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit~~
35.32 ~~under section 256L.03, subdivision 3, payment must be the lesser of:~~

35.33 ~~(1) the amount remaining in the enrollee's benefit limit; or~~

35.34 ~~(2) charges submitted for the inpatient hospital services less any co-payment~~
35.35 ~~established under section 256L.03, subdivision 4.~~

36.1 The hospital may seek payment from the enrollee for the amount by which usual and
36.2 customary charges exceed the payment under this paragraph. If payment is reduced under
36.3 section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the
36.4 enrollee for the amount of the reduction.

36.5 (e) For admissions occurring on or after July 1, 2011, for single adults and
36.6 households without children who are eligible under section 256L.04, subdivision 7, the
36.7 commissioner shall pay hospitals directly, up to the medical assistance payment rate,
36.8 for inpatient hospital benefits up to the \$10,000 annual inpatient benefit limit, minus
36.9 any co-payment required under section 256L.03, subdivision 5. Inpatient services paid
36.10 directly by the commissioner under this paragraph do not include chemical dependency
36.11 hospital-based and residential treatment.

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

36.15 Sec. 55. **[256L.121] SERVICE DELIVERY.**

36.16 Subdivision 1. **Competitive process.** The commissioner of human services shall
36.17 establish a competitive process for entering into contracts with participating entities for
36.18 the offering of standard health plans through MinnesotaCare. Coverage through standard
36.19 health plans must be available to enrollees beginning January 1, 2015. Each standard
36.20 health plan must cover the health services listed in and meet the requirements of section
36.21 256L.03. The competitive process must meet the requirements of section 1331 of the
36.22 Affordable Care Act and be designed to ensure enrollee access to high-quality health care
36.23 coverage options. The commissioner, to the extent feasible, shall seek to ensure that
36.24 enrollees have a choice of coverage from more than one participating entity within a
36.25 geographic area. In rural areas other than metropolitan statistical areas, the commissioner
36.26 shall use the medical assistance competitive procurement process under section 256B.69,
36.27 subdivisions 1 to 32, under which selection of entities is based on criteria related to
36.28 provider network access, coordination of health care with other local services, alignment
36.29 with local public health goals, and other factors.

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

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

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

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

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

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

37.10 (3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and
 37.11 256B.694, when contracting with MinnesotaCare participating entities;

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

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

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

37.22 Sec. 56. Minnesota Statutes 2012, section 256L.15, subdivision 1, is amended to read:

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

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

37.32 ~~(e)~~ (b) Members of the military and their families who meet the eligibility criteria
 37.33 for MinnesotaCare upon eligibility approval made within 24 months following the end
 37.34 of the member's tour of active duty shall have their premiums paid by the commissioner.
 37.35 The effective date of coverage for an individual or family who meets the criteria of this

38.1 paragraph shall be the first day of the month following the month in which eligibility is
38.2 approved. This exemption applies for 12 months.

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

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

38.11 Sec. 57. Minnesota Statutes 2012, section 256L.15, subdivision 2, is amended to read:

38.12 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
38.13 commissioner shall establish a sliding fee scale to determine the percentage of monthly
38.14 gross individual or family income that households at different income levels must pay to
38.15 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
38.16 on the enrollee's monthly ~~gross individual or family income~~. The sliding fee scale must
38.17 contain separate tables based on enrollment of one, two, or three or more persons. Until
38.18 June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross
38.19 individual or family income for individuals or families with incomes below the limits for
38.20 the medical assistance program for families and children in effect on January 1, 1999, and
38.21 proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and
38.22 8.8 percent. These percentages are matched to evenly spaced income steps ranging from
38.23 the medical assistance income limit for families and children in effect on January 1, 1999,
38.24 to 275 percent of the federal poverty guidelines for the applicable family size, up to a
38.25 family size of five. The sliding fee scale for a family of five must be used for families of
38.26 more than five. The sliding fee scale and percentages are not subject to the provisions of
38.27 chapter 14. If a family or individual reports increased income after enrollment, premiums
38.28 shall be adjusted at the time the change in income is reported.

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

39.1 ~~be excluded from the total. The maximum premium for two enrollees shall be twice the~~
 39.2 ~~maximum premium for one, and the maximum premium for three or more enrollees shall~~
 39.3 ~~be three times the maximum premium for one.~~

39.4 (e) (b) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums
 39.5 according to the premium scale specified in paragraph (d) (c) with the exception that
 39.6 children in families with income at or below 200 percent of the federal poverty guidelines
 39.7 shall pay no premiums. For purposes of paragraph (d) (c), "minimum" means a monthly
 39.8 premium of \$4.

39.9 (d) (c) The following premium scale is established for individuals and families with
 39.10 ~~gross family~~ incomes of ~~275~~ 200 percent of the federal poverty guidelines or less:

39.11 Federal Poverty Guideline Range	39.11 Percent of Average Gross Monthly Income
39.12 0-45%	39.12 minimum
39.13 46-54%	39.13 \$4 or 1.1% of family income, whichever is 39.14 greater
39.15 55-81%	39.15 1.6%
39.16 82-109%	39.16 2.2%
39.17 110-136%	39.17 2.9%
39.18 137-164%	39.18 3.6%
39.19 165-191	
39.20 <u>165-200</u> %	39.20 4.6%
39.21 192-219 %	39.21 5.6 %
39.22 220-248 %	39.22 6.5 %
39.23 249-275 %	39.23 7.2 %

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

39.27 Sec. 58. **DETERMINATION OF FUNDING ADEQUACY.**

39.28 The commissioners of revenue and management and budget, in consultation with
 39.29 the commissioner of human services, shall conduct an assessment of health care taxes,
 39.30 including the gross premiums tax, the provider tax, and Medicaid surcharges, and their
 39.31 relationship to the long-term solvency of the health care access fund, as part of the state
 39.32 revenue and expenditure forecast in November 2013. The commissioners shall determine
 39.33 the amount of state funding that will be required after December 31, 2019, in addition to
 39.34 the federal payments made available under section 1331 of the Affordable Care Act, for
 39.35 the MinnesotaCare program. The commissioners shall evaluate the stability and likelihood
 39.36 of long-term federal funding for the MinnesotaCare program under section 1331. The
 39.37 commissioners shall report the results of this assessment to the legislature by January 15,

40.1 2014, along with recommendations for changes to state revenue for the health care access
40.2 fund, if state funding will continue to be required beyond December 31, 2019.

40.3 **Sec. 59. STATE-BASED RISK ADJUSTMENT SYSTEM ASSESSMENT.**

40.4 (a) The commissioners of health, human services, and commerce, and the board of
40.5 MNsure, shall study whether Minnesota-based risk adjustment of the individual and small
40.6 group insurance market, using either the federal risk adjustment model or a state-based
40.7 alternative, can be more cost-effective and perform better than risk adjustment conducted
40.8 by federal agencies. The study shall assess the policies, infrastructure, and resources
40.9 necessary to satisfy the requirements of Code of Federal Regulations, title 45, section
40.10 153, subpart D. The study shall also evaluate the extent to which Minnesota-based risk
40.11 adjustment could meet requirements established in Code of Federal Regulations, title
40.12 45, section 153.330, including:

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

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

40.16 (3) encouraging favorable behavior among health care market participants and
40.17 discouraging unfavorable behavior;

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

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

40.21 (6) minimizing administrative costs;

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

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

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

40.26 (b) In conducting the study, and notwithstanding Minnesota Rules, chapter 4653,
40.27 and as part of responsibilities under Minnesota Statutes, section 62U.04, subdivision
40.28 4, paragraph (b), the commissioner of health shall collect from health carriers in the
40.29 individual and small group health insurance market, beginning on January 1, 2014, and for
40.30 service dates in calendar year 2014, all data required for conducting risk adjustment with
40.31 standard risk adjusters such as the Adjusted Clinical Groups or the Hierarchical Condition
40.32 Category System, including but not limited to:

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

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

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

41.3 (4) additional identified demographic data necessary to link individuals' data across
41.4 carriers and insurance affordability programs with 95 percent accuracy. The commissioner
41.5 shall not collect more than the last four digits of an individual's social security number.

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

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

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

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

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

41.18 For purposes of this paragraph, the commissioner of health shall have the authority to
41.19 use identified data to validate and audit a statistically valid sample of data for each
41.20 health carrier in the individual and small group market. In conducting the study, the
41.21 commissioners shall contract with entities that do not have an economic interest in the
41.22 outcome of Minnesota-based risk adjustment but do have demonstrated expertise in
41.23 actuarial science or health economics and demonstrated experience with designing and
41.24 implementing risk adjustment models.

41.25 (d) The commissioner of human services shall evaluate opportunities to maximize
41.26 federal funding under section 1331 of the federal Patient and Protection and Affordable
41.27 Care Act, Public Law 111-148, and further defined through amendments to the act and
41.28 regulations issued under the act. The commissioner of human services shall make
41.29 recommendations on risk adjustment strategies to maximize federal funding to the state
41.30 of Minnesota.

41.31 (e) The commissioners and board of MNsure shall submit to the legislature by March
41.32 15, 2014, an interim report with preliminary findings from the assessment conducted in
41.33 paragraphs (c) and (d). The interim report shall include legislative recommendations
41.34 for any necessary changes to Minnesota Statutes, section 62Q.03. A final report shall
41.35 be submitted by the commissioners and board of MNsure to the legislature by October

42.1 1, 2015. The final report must include findings from the overall assessment and a
42.2 recommendation whether to conduct state-based risk adjustment.

42.3 (f) For purposes of this section, the board of MNsure means the board established
42.4 under Minnesota Statutes, section 62V.03.

42.5 **Sec. 60. REQUEST FOR FEDERAL AUTHORITY.**

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

42.14 **Sec. 61. REVISOR'S INSTRUCTION.**

42.15 The revisor shall remove cross-references to the sections repealed in this article
42.16 wherever they appear in Minnesota Statutes and Minnesota Rules and make changes
42.17 necessary to correct the punctuation, grammar, or structure of the remaining text and
42.18 preserve its meaning.

42.19 **Sec. 62. REPEALER.**

42.20 (a) Minnesota Statutes 2012, sections 256L.01, subdivision 4a; 256L.031; 256L.04,
42.21 subdivisions 1b, 9, and 10a; 256L.05, subdivision 3b; 256L.07, subdivisions 5, 8, and 9;
42.22 256L.11, subdivision 5; and 256L.17, subdivisions 1, 2, 3, 4, and 5, are repealed effective
42.23 January 1, 2014.

42.24 (b) Minnesota Statutes 2012, section 256L.12, is repealed effective January 1, 2015.

42.25 (c) Minnesota Statutes 2012, sections 256B.055, subdivisions 3, 5, and 10b;
42.26 256B.056, subdivision 5b; and 256B.057, subdivisions 1c and 2, are repealed effective
42.27 January 1, 2014.

42.28 **ARTICLE 2**

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

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

42.31 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
42.32 electronically submit to the commissioner of health case mix assessments that conform

43.1 with the assessment schedule defined by Code of Federal Regulations, title 42, section
43.2 483.20, and published by the United States Department of Health and Human Services,
43.3 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
43.4 Instrument User's Manual, version 3.0, and subsequent updates when issued by the
43.5 Centers for Medicare and Medicaid Services. The commissioner of health may substitute
43.6 successor manuals or question and answer documents published by the United States
43.7 Department of Health and Human Services, Centers for Medicare and Medicaid Services,
43.8 to replace or supplement the current version of the manual or document.

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

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

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

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

43.16 (4) all quarterly assessments must have an assessment reference date (ARD) within
43.17 92 days of the ARD of the previous assessment.

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

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

43.24 (2) a nursing facility level of care determination as provided for under section
43.25 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment
43.26 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
43.27 managed care organization under contract with the Department of Human Services.

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

43.29 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
43.30 **REPORT AND STUDY REQUIRED.**

43.31 **Subdivision 1. Report requirements.** The commissioners of health and human
43.32 services, with the cooperation of counties and in consultation with stakeholders, including
43.33 persons who need or are using long-term care services and supports, lead agencies,
43.34 regional entities, senior, disability, and mental health organization representatives, service
43.35 providers, and community members shall prepare a report to the legislature by August 15,

44.1 2013, and biennially thereafter, regarding the status of the full range of long-term care
44.2 services and supports for the elderly and children and adults with disabilities and mental
44.3 illnesses in Minnesota. The report shall address:

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

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

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

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

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

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

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

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

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

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

44.29 (b) City, county, and state agencies employing social workers and staff who are
44.30 designated to perform mandated duties under sections 256.975, subdivisions 7 to 7c and
44.31 256.01, subdivision 24, are not required to employ licensed social workers.

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

45.1 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision
45.2 2, the commissioner of human services shall carry out the specific duties in paragraphs (a)
45.3 through ~~(ee)~~ (dd):

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

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

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

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

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

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

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

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

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

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

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

46.13 (e) Assist and actively cooperate with other departments, agencies and institutions,
46.14 local, state, and federal, by performing services in conformity with the purposes of Laws
46.15 1939, chapter 431.

46.16 (f) Act as the agent of and cooperate with the federal government in matters of
46.17 mutual concern relative to and in conformity with the provisions of Laws 1939, chapter
46.18 431, including the administration of any federal funds granted to the state to aid in the
46.19 performance of any functions of the commissioner as specified in Laws 1939, chapter 431,
46.20 and including the promulgation of rules making uniformly available medical care benefits
46.21 to all recipients of public assistance, at such times as the federal government increases its
46.22 participation in assistance expenditures for medical care to recipients of public assistance,
46.23 the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

46.26 (h) Act as designated guardian of both the estate and the person of all the wards of
46.27 the state of Minnesota, whether by operation of law or by an order of court, without any
46.28 further act or proceeding whatever, except as to persons committed as developmentally
46.29 disabled. For children under the guardianship of the commissioner or a tribe in Minnesota
46.30 recognized by the Secretary of the Interior whose interests would be best served by
46.31 adoptive placement, the commissioner may contract with a licensed child-placing agency
46.32 or a Minnesota tribal social services agency to provide adoption services. A contract
46.33 with a licensed child-placing agency must be designed to supplement existing county
46.34 efforts and may not replace existing county programs or tribal social services, unless the
46.35 replacement is agreed to by the county board and the appropriate exclusive bargaining
46.36 representative, tribal governing body, or the commissioner has evidence that child

47.1 placements of the county continue to be substantially below that of other counties. Funds
47.2 encumbered and obligated under an agreement for a specific child shall remain available
47.3 until the terms of the agreement are fulfilled or the agreement is terminated.

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

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

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

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

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

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

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

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

47.34 (1) one-half of the total amount of the disallowance shall be borne by the county
47.35 boards responsible for administering the programs. For the medical assistance and the
47.36 AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be

48.1 shared by each county board in the same proportion as that county's expenditures for the
48.2 sanctioned program are to the total of all counties' expenditures for the AFDC program
48.3 formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the
48.4 food stamp program, sanctions shall be shared by each county board, with 50 percent of
48.5 the sanction being distributed to each county in the same proportion as that county's
48.6 administrative costs for food stamps are to the total of all food stamp administrative costs
48.7 for all counties, and 50 percent of the sanctions being distributed to each county in the
48.8 same proportion as that county's value of food stamp benefits issued are to the total of
48.9 all benefits issued for all counties. Each county shall pay its share of the disallowance
48.10 to the state of Minnesota. When a county fails to pay the amount due hereunder, the
48.11 commissioner may deduct the amount from reimbursement otherwise due the county, or
48.12 the attorney general, upon the request of the commissioner, may institute civil action
48.13 to recover the amount due; and

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

48.20 (o) Develop and implement special projects that maximize reimbursements and
48.21 result in the recovery of money to the state. For the purpose of recovering state money,
48.22 the commissioner may enter into contracts with third parties. Any recoveries that result
48.23 from projects or contracts entered into under this paragraph shall be deposited in the
48.24 state treasury and credited to a special account until the balance in the account reaches
48.25 \$1,000,000. When the balance in the account exceeds \$1,000,000, the excess shall be
48.26 transferred and credited to the general fund. All money in the account is appropriated to
48.27 the commissioner for the purposes of this paragraph.

48.28 (p) Have the authority to make direct payments to facilities providing shelter
48.29 to women and their children according to section 256D.05, subdivision 3. Upon
48.30 the written request of a shelter facility that has been denied payments under section
48.31 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make
48.32 a determination within 30 days of the request for review regarding issuance of direct
48.33 payments to the shelter facility. Failure to act within 30 days shall be considered a
48.34 determination not to issue direct payments.

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

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

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

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

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

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

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

50.1 commissioner under clause (3) or (5), the county board may appeal the action according
50.2 to sections 14.57 to 14.69; and

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

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

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

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

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

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

51.1 (w) Have the authority to administer a supplemental drug rebate program for drugs
51.2 purchased under the medical assistance program. The commissioner may enter into
51.3 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
51.4 authorization for drugs that are from manufacturers that have not signed a supplemental
51.5 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
51.6 256B.0625, subdivision 13.

51.7 (x) Operate the department's communication systems account established in Laws
51.8 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
51.9 communication costs necessary for the operation of the programs the commissioner
51.10 supervises. A communications account may also be established for each regional
51.11 treatment center which operates communications systems. Each account must be used
51.12 to manage shared communication costs necessary for the operations of the programs the
51.13 commissioner supervises. The commissioner may distribute the costs of operating and
51.14 maintaining communication systems to participants in a manner that reflects actual usage.
51.15 Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and
51.16 other costs as determined by the commissioner. Nonprofit organizations and state, county,
51.17 and local government agencies involved in the operation of programs the commissioner
51.18 supervises may participate in the use of the department's communications technology and
51.19 share in the cost of operation. The commissioner may accept on behalf of the state any
51.20 gift, bequest, devise or personal property of any kind, or money tendered to the state for
51.21 any lawful purpose pertaining to the communication activities of the department. Any
51.22 money received for this purpose must be deposited in the department's communication
51.23 systems accounts. Money collected by the commissioner for the use of communication
51.24 systems must be deposited in the state communication systems account and is appropriated
51.25 to the commissioner for purposes of this section.

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

51.31 (z) Designate community information and referral call centers and incorporate
51.32 cost reimbursement claims from the designated community information and referral
51.33 call centers into the federal cost reimbursement claiming processes of the department
51.34 according to federal law, rule, and regulations. Existing information and referral centers
51.35 provided by Greater Twin Cities United Way or existing call centers for which Greater
51.36 Twin Cities United Way has legal authority to represent, shall be included in these

52.1 designations upon review by the commissioner and assurance that these services are
52.2 accredited and in compliance with national standards. Any reimbursement is appropriated
52.3 to the commissioner and all designated information and referral centers shall receive
52.4 payments according to normal department schedules established by the commissioner
52.5 upon final approval of allocation methodologies from the United States Department of
52.6 Health and Human Services Division of Cost Allocation or other appropriate authorities.

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

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

52.14 (cc) Have the authority to administer a drug rebate program for drugs purchased for
52.15 persons eligible for general assistance medical care under section 256D.03, subdivision 3.
52.16 For manufacturers that agree to participate in the general assistance medical care rebate
52.17 program, the commissioner shall enter into a rebate agreement for covered drugs as
52.18 defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the
52.19 rebate shall be equal to the rebate as defined for purposes of the federal rebate program in
52.20 United States Code, title 42, section 1396r-8. The manufacturers must provide payment
52.21 within the terms and conditions used for the federal rebate program established under
52.22 section 1927 of title XIX of the Social Security Act. The rebate program shall utilize
52.23 the terms and conditions used for the federal rebate program established under section
52.24 1927 of title XIX of the Social Security Act.

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

52.27 (1) are covered under the medical assistance program as described in section
52.28 256B.0625, subdivisions 13 and 13d; and

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

52.31 Prescription drug coverage under general assistance medical care shall conform to
52.32 coverage under the medical assistance program according to section 256B.0625,
52.33 subdivisions 13 to 13g.

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

53.1 (dd) Designate the agencies that operate the Senior LinkAge Line under section
 53.2 256.975, subdivision 7, and the Disability Linkage Line under subdivision 24 as the state
 53.3 of Minnesota Aging and the Disability Resource Centers under United States Code, title
 53.4 42, section 3001, the Older Americans Act Amendments of 2006 and incorporate cost
 53.5 reimbursement claims from the designated centers into the federal cost reimbursement
 53.6 claiming processes of the department according to federal law, rule, and regulations. Any
 53.7 reimbursement must be appropriated to the commissioner and all Aging and Disability
 53.8 Resource Center designated agencies shall receive payments of grant funding that supports
 53.9 the activity and generates the federal financial participation according to Board on Aging
 53.10 administrative granting mechanisms.

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

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

- 53.19 (1) deliver information and assistance based on national and state standards;
- 53.20 (2) provide information about state and federal eligibility requirements, benefits,
 53.21 and service options;
- 53.22 (3) provide benefits and options counseling;
- 53.23 (4) make referrals to appropriate support entities;
- 53.24 (5) educate people on their options so they can make well-informed choices and link
 53.25 them to quality profiles;
- 53.26 (6) help support the timely resolution of service access and benefit issues;
- 53.27 (7) inform people of their long-term community services and supports;
- 53.28 (8) provide necessary resources and supports that can lead to employment and
 53.29 increased economic stability of people with disabilities; ~~and~~
- 53.30 (9) serve as the technical assistance and help center for the Web-based tool,
 53.31 Minnesota's Disability Benefits 101.org; and
- 53.32 (10) provide preadmission screening for individuals under 60 years of age using
 53.33 the procedures as defined in section 256.975, subdivisions 7a to 7c, and 256B.0911,
 53.34 subdivision 4d.

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

54.2 Subd. 7. **Consumer information and assistance and long-term care options**
54.3 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
54.4 statewide service to aid older Minnesotans and their families in making informed choices
54.5 about long-term care options and health care benefits. Language services to persons
54.6 with limited English language skills may be made available. The service, known as
54.7 Senior LinkAge Line, shall serve older adults as the designated Aging and Disability
54.8 Resource Center under United States Code, title 42, section 3001, the Older Americans
54.9 Act Amendments of 2006 in partnership with the Disability LinkAge Line under section
54.10 256.01, subdivision 24, and must be available during business hours through a statewide
54.11 toll-free number and ~~must also be available through~~ the Internet. The Minnesota Board
54.12 on Aging shall consult with, and when appropriate work through, the area agencies on
54.13 aging counties, and other entities that serve aging and disabled populations of all ages,
54.14 to provide and maintain the telephone infrastructure and related support for the Aging
54.15 and Disability Resource Center partners which agree by memorandum to access the
54.16 infrastructure, including the designated providers of the Senior LinkAge Line and the
54.17 Disability Linkage Line.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

55.21 ~~(9)~~ (10) incorporate information about the availability of housing options, as well
 55.22 as registered housing with services and consumer rights within the MinnesotaHelp.info
 55.23 network long-term care database to facilitate consumer comparison of services and costs
 55.24 among housing with services establishments and with other in-home services and to
 55.25 support financial self-sufficiency as long as possible. Housing with services establishments
 55.26 and their arranged home care providers shall provide information that will facilitate price
 55.27 comparisons, including delineation of charges for rent and for services available. The
 55.28 commissioners of health and human services shall align the data elements required by
 55.29 section 144G.06, the Uniform Consumer Information Guide, and this section to provide
 55.30 consumers standardized information and ease of comparison of long-term care options.
 55.31 The commissioner of human services shall provide the data to the Minnesota Board on
 55.32 Aging for inclusion in the MinnesotaHelp.info network long-term care database;

55.33 ~~(10)~~ (11) provide long-term care options counseling. Long-term care options
 55.34 counselors shall:

55.35 (i) for individuals not eligible for case management under a public program or public
 55.36 funding source, provide interactive decision support under which consumers, family

56.1 members, or other helpers are supported in their deliberations to determine appropriate
56.2 long-term care choices in the context of the consumer's needs, preferences, values, and
56.3 individual circumstances, including implementing a community support plan;

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

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

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

56.14 ~~(11)~~ (12) using risk management and support planning protocols, provide long-term
56.15 care options counseling to current residents of nursing homes deemed appropriate for
56.16 discharge by the commissioner and older adults who request service after consultation
56.17 with the Senior LinkAge Line under clause (12). ~~In order to meet this requirement, The~~
56.18 Senior LinkAge Line shall also receive referrals from the residents or staff of nursing
56.19 homes. The Senior LinkAge Line shall identify and contact residents deemed appropriate
56.20 for discharge by developing targeting criteria in consultation with the commissioner who
56.21 shall provide designated Senior LinkAge Line contact centers with a list of nursing
56.22 home residents that meet the criteria as being appropriate for discharge planning via a
56.23 secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a
56.24 preference to receive long-term care options counseling, with initial assessment, review of
56.25 risk factors, independent living support consultation, or and, if appropriate, a referral to:

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

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

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

56.32 ~~(12)~~ (13) develop referral protocols and processes that will assist certified health
56.33 care homes and hospitals to identify at-risk older adults and determine when to refer these
56.34 individuals to the Senior LinkAge Line for long-term care options counseling under this
56.35 section. The commissioner is directed to work with the commissioner of health to develop
56.36 protocols that would comply with the health care home designation criteria and protocols

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

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

57.5 Subd. 7a. **Preadmission screening activities related to nursing facility**
57.6 **admissions.** (a) All individuals seeking admission to Medicaid certified nursing facilities,
57.7 including certified boarding care facilities, must be screened prior to admission regardless
57.8 of income, assets, or funding sources for nursing facility care, except as described in
57.9 subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the
57.10 need for nursing facility level of care as described in section 256B.0911, subdivision
57.11 4e, and to complete activities required under federal law related to mental illness and
57.12 developmental disability as outlined in paragraph (b).

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

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

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

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

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

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

57.30 (ii) a qualified developmental disability professional, for persons with a primary or
57.31 secondary diagnosis of developmental disability. For purposes of this requirement, a
57.32 qualified developmental disability professional must meet the standards for a qualified
57.33 developmental disability professional under Code of Federal Regulations, title 42, section
57.34 483.430.

58.1 (d) The local county mental health authority or the state developmental disability
58.2 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
58.3 nursing facility if the individual does not meet the nursing facility level of care criteria or
58.4 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
58.5 purposes of this section, "specialized services" for a person with developmental disability
58.6 means active treatment as that term is defined under Code of Federal Regulations, title
58.7 42, section 483.440(a)(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

59.3 (1) a person is admitted from the community to a certified nursing or certified
59.4 boarding care facility during Senior LinkAge Line nonworking hours for ages 60 and
59.5 older and Disability Linkage Line nonworking hours for under age 60;

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

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

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

59.13 (5) the Senior LinkAge Line or Disability Linkage Line is contacted on the first
59.14 working day following the emergency admission.

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

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

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

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

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

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

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

60.6 (3) the person may be exempt from screening requirements as outlined in subdivision
60.7 7b, but will need transitional assistance after admission or in-person follow-along after
60.8 a return home.

60.9 (b) Individuals between the ages of 60 and 64 who are admitted to nursing facilities
60.10 with only a telephone screening must receive a face-to-face assessment from the long-term
60.11 care consultation team member of the county in which the facility is located or from the
60.12 recipient's county case manager within 40 calendar days of admission as described in
60.13 section 256B.0911, subdivision 4d, paragraph (c).

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

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

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

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

60.22 Subd. 7d. **Payment for preadmission screening.** Funding for preadmission
60.23 screening shall be provided to the Minnesota Board on Aging for the population 60
60.24 years of age and older by the Department of Human Services to cover screener salaries
60.25 and expenses to provide the services described in subdivisions 7a to 7c. The Minnesota
60.26 Board on Aging shall employ, or contract with other agencies to employ, within the limits
60.27 of available funding, sufficient personnel to provide preadmission screening and level of
60.28 care determination services and shall seek to maximize federal funding for the service as
60.29 provided under section 256.01, subdivision 2, paragraph (dd).

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

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

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

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

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

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

61.15 Subd. 5. **Grant preference.** The commissioner of human services shall give
61.16 preference when awarding grants under this section to areas where nursing facility
61.17 closures have occurred or are occurring or areas with service needs identified by section
61.18 144A.351. The commissioner may award grants to the extent grant funds are available
61.19 and to the extent applications are approved by the commissioner. Denial of approval of an
61.20 application in one year does not preclude submission of an application in a subsequent
61.21 year. The maximum grant amount is limited to \$750,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

63.18 ~~(7)~~ (6) determination of home and community-based waiver and other service
63.19 eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level
63.20 of care determination for individuals who need an institutional level of care as determined
63.21 under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, based on assessment and
63.22 community support plan development, appropriate referrals to obtain necessary diagnostic
63.23 information, and including an eligibility determination for consumer-directed community
63.24 supports;

63.25 ~~(8)~~ (7) providing recommendations for institutional placement when there are no
63.26 cost-effective community services available;

63.27 ~~(9)~~ (8) providing access to assistance to transition people back to community settings
63.28 after institutional admission; and

63.29 ~~(10)~~ (9) providing information about competitive employment, with or without
63.30 supports, for school-age youth and working-age adults and referrals to the Disability
63.31 Linkage Line and Disability Benefits 101 to ensure that an informed choice about
63.32 competitive employment can be made. For the purposes of this subdivision, "competitive
63.33 employment" means work in the competitive labor market that is performed on a full-time
63.34 or part-time basis in an integrated setting, and for which an individual is compensated at or
63.35 above the minimum wage, but not less than the customary wage and level of benefits paid
63.36 by the employer for the same or similar work performed by individuals without disabilities.

64.1 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
64.2 2c, and 3a, "long-term care consultation services" also means:

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

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

64.5 (ii) section 256B.0657; or

64.6 (iii) consumer support grants under section 256.476;

64.7 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
64.8 determination of eligibility for case management services available under sections
64.9 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
64.10 9525.0016;

64.11 (3) determination of institutional level of care, home and community-based service
64.12 waiver, and other service eligibility as required under section 256B.092, determination
64.13 of eligibility for family support grants under section 252.32, semi-independent living
64.14 services under section 252.275, and day training and habilitation services under section
64.15 256B.092; and

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

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

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

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

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

64.29 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
64.30 services planning, or other assistance intended to support community-based living,
64.31 including persons who need assessment in order to determine waiver or alternative care
64.32 program eligibility, must be visited by a long-term care consultation team within 20
64.33 calendar days after the date on which an assessment was requested or recommended.
64.34 Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also
64.35 applies to an assessment of a person requesting personal care assistance services and

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

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

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

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

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

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

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

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

65.36 (4) referral information; and

66.1 (5) informal caregiver supports, if applicable.

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

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

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

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

66.16 (1) written recommendations for community-based services and consumer-directed
66.17 options;

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

66.24 (3) the need for and purpose of preadmission screening conducted by long-term
66.25 care options counselors according to section 256.975, subdivisions 7a to 7c, and section
66.26 256.01, subdivision 24, if the person selects nursing facility placement. If the individual
66.27 selects nursing facility placement, the lead agency shall forward information needed to
66.28 complete the level of care determinations and screening for developmental disability and
66.29 mental illness collected during the assessment to the long-term care options counselor
66.30 using forms provided by the commissioner;

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

66.35 (5) information about Minnesota health care programs;

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

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

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

67.7 (9) the person's right to appeal the certified assessor's decision regarding eligibility
67.8 for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and
67.9 (b), and incorporating the decision regarding the need for institutional level of care or the
67.10 lead agency's final decisions regarding public programs eligibility according to section
67.11 256.045, subdivision 3.

67.12 (i) Face-to-face assessment completed as part of eligibility determination for
67.13 the alternative care, elderly waiver, community alternatives for disabled individuals,
67.14 community alternative care, and brain injury waiver programs under sections 256B.0913,
67.15 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60
67.16 calendar days after the date of assessment.

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

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

67.27 Subd. 4d. **Preadmission screening of individuals under 65 60 years of age.** (a)

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

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

68.1 subdivisions 7a to 7c. This shall be provided by the Disability Linkage Line as required
68.2 under section 256.01, subdivision 24.

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

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

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

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

68.16 ~~(g)~~ (f) In the event that an individual under ~~65~~ 60 years of age is admitted to a
68.17 nursing facility on an emergency basis, the ~~county~~ Disability Linkage Line must be
68.18 notified of the admission on the next working day, and a face-to-face assessment as
68.19 described in paragraph (c) must be conducted within 40 calendar days of admission.

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

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

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

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

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

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

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

69.20 Sec. 22. Minnesota Statutes 2012, section 256B.0911, subdivision 7, is amended to read:

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

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

70.1 facility must include unreimbursed resident days in the nursing facility resident day totals
70.2 reported to the commissioner.

70.3 Sec. 23. Minnesota Statutes 2012, section 256B.0913, subdivision 4, is amended to read:

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

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

70.7 (1) the person has been determined by a community assessment under section
70.8 256B.0911 to be a person who would require the level of care provided in a nursing
70.9 facility, as determined under section 256B.0911, subdivision 4a, ~~paragraph (d)~~ 4e, but for
70.10 the provision of services under the alternative care program;

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

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

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

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

70.20 (6) except for individuals described in clause (7), the monthly cost of the alternative
70.21 care services funded by the program for this person does not exceed 75 percent of the
70.22 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
70.23 does not prohibit the alternative care client from payment for additional services, but in no
70.24 case may the cost of additional services purchased under this section exceed the difference
70.25 between the client's monthly service limit defined under section 256B.0915, subdivision
70.26 3, and the alternative care program monthly service limit defined in this paragraph. If
70.27 care-related supplies and equipment or environmental modifications and adaptations are or
70.28 will be purchased for an alternative care services recipient, the costs may be prorated on a
70.29 monthly basis for up to 12 consecutive months beginning with the month of purchase.
70.30 If the monthly cost of a recipient's other alternative care services exceeds the monthly
70.31 limit established in this paragraph, the annual cost of the alternative care services shall be
70.32 determined. In this event, the annual cost of alternative care services shall not exceed 12
70.33 times the monthly limit described in this paragraph;

70.34 (7) for individuals assigned a case mix classification A as described under section
70.35 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily

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

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

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

71.15 (i) the appointment of a representative payee;

71.16 (ii) automatic payment from a financial account;

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

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

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

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

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

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

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

72.13 Subd. 17. Essential community supports grants. (a) Notwithstanding subdivisions
 72.14 1 to 14, the purpose of the essential community supports grant program is to provide
 72.15 targeted services to persons age 65 and older who need essential community support, but
 72.16 whose needs do not meet the level of care required for nursing facility placement under
 72.17 section 144.0724, subdivision 11.

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

72.21 (1) is age 65 or older;

72.22 (2) is not eligible for medical assistance;

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

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

72.27 (5) has a community support plan; and

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

72.32 (i) caregiver support;

72.33 (ii) homemaker support;

72.34 (iii) chores; or

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

73.1 (c) The person receiving any of the essential community supports in this subdivision
73.2 must also receive service coordination, not to exceed \$600 in a 12-month authorization
73.3 period, as part of their community support plan.

73.4 (d) A person who has been determined to be eligible for an essential community
73.5 supports grant must be reassessed at least annually and continue to meet the criteria in
73.6 paragraph (b) to remain eligible for an essential community supports grant.

73.7 (e) The commissioner is authorized to use federal matching funds for essential
73.8 community supports as necessary and to meet demand for essential community supports
73.9 grants as outlined in paragraphs (f) and (g), and that amount of federal funds is
73.10 appropriated to the commissioner for this purpose.

73.11 (f) Upon federal approval and following a reasonable implementation period
73.12 determined by the commissioner, essential community supports are available to an
73.13 individual who:

73.14 (1) is receiving nursing facility services or home and community-based long-term
73.15 services and supports under section 256B.0915 or 256B.49 on the effective date of
73.16 implementation of the revised nursing facility level of care under section 144.0724,
73.17 subdivision 11;

73.18 (2) meets one of the following criteria:

73.19 (i) due to the implementation of the revised nursing facility level of care, loses
73.20 eligibility for continuing medical assistance payment of nursing facility services at the
73.21 first reassessment under section 144.0724, subdivision 11, paragraph (b), that occurs on or
73.22 after the effective date of the revised nursing facility level of care criteria under section
73.23 144.0724, subdivision 11; or

73.24 (ii) due to the implementation of the revised nursing facility level of care, loses
73.25 eligibility for continuing medical assistance payment of home and community-based
73.26 long-term services and supports under section 256B.0915 or 256B.49 at the first
73.27 reassessment required under those sections that occurs on or after the effective date of
73.28 implementation of the revised nursing facility level of care under section 144.0724,
73.29 subdivision 11;

73.30 (3) is not eligible for personal care attendant services; and

73.31 (4) has an assessed need for one or more of the supportive services offered under
73.32 essential community supports.

73.33 Individuals eligible under this paragraph includes individuals who continue to be
73.34 eligible for medical assistance state plan benefits and those who are not or are no longer
73.35 financially eligible for medical assistance.

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

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

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

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

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

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

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

75.1 (c) If extended medical supplies and equipment or environmental modifications are
75.2 or will be purchased for an elderly waiver client, the costs may be prorated for up to
75.3 12 consecutive months beginning with the month of purchase. If the monthly cost of a
75.4 recipient's waived services exceeds the monthly limit established in paragraph (a) or
75.5 (b), the annual cost of all waived services shall be determined. In this event, the annual
75.6 cost of all waived services shall not exceed 12 times the monthly limit of waived
75.7 services as described in paragraph (a) or (b).

75.8 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
75.9 any necessary home care services described in section 256B.0651, subdivision 2, for
75.10 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
75.11 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
75.12 amount established for home care services as described in section 256B.0652, subdivision
75.13 7, and the annual average contracted amount established by the commissioner for nursing
75.14 facility services for ventilator-dependent individuals. This monthly limit shall be increased
75.15 annually as described in paragraph (a).

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

75.18 Subd. 3j. **Individual community living support.** Upon federal approval, there
75.19 is established a new service called individual community living support (ICLS) that is
75.20 available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor
75.21 have any interest in the recipient's housing. ICLS must be delivered in a single-family
75.22 home or apartment where the service recipient or their family owns or rents, as
75.23 demonstrated by a lease agreement, and maintains control over the individual unit. Case
75.24 managers or care coordinators must develop individual ICLS plans in consultation with
75.25 the client using a tool developed by the commissioner. The commissioner shall establish
75.26 payment rates and mechanisms to align payments with the type and amount of service
75.27 provided, assure statewide uniformity for payment rates, and assure cost-effectiveness.
75.28 Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and
75.29 Human Services to avoid conflict with provider regulatory standards pursuant to section
75.30 144A.43 and chapter 245D.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

77.5 (9) strengthen programs that use volunteers.

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

77.11 Sec. 29. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
 77.12 subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.19 Sec. 31. Minnesota Statutes 2012, section 256B.0917, subdivision 6, is amended to read:

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

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

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

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

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

78.32 (4) identify at-risk caregivers;

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

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

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

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

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

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

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

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

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

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

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

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

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

79.32 ~~(2) recruit and train volunteer providers;~~

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

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

79.35 ~~(5) (4) advertise the availability of the caregiver support and respite care project; and~~

79.36 ~~(6) (5) purchase equipment to maintain a system of assigning workers to clients.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

81.12 (1) conduct a functional assessment of the crisis incident as defined in section
81.13 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
81.14 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
81.15 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

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

81.28 **Subdivision 1. Development and implementation of quality profiles.** (a) The
81.29 commissioner of human services, in cooperation with the commissioner of health,
81.30 shall develop and implement a quality ~~profile system~~ profiles for nursing facilities and,
81.31 beginning not later than July 1, ~~2004~~ 2014, other providers of long-term care services,
81.32 except when the quality profile system would duplicate requirements under section
81.33 256B.5011, 256B.5012, or 256B.5013. The ~~system~~ quality profiles must be developed
81.34 ~~and implemented to the extent possible without the collection of significant amounts of~~

82.1 ~~new data. To the extent possible, the system~~ using existing data sets maintained by the
 82.2 commissioners of health and human services to the extent possible. The profiles must
 82.3 incorporate or be coordinated with information on quality maintained by area agencies on
 82.4 aging, long-term care trade associations, the ombudsman offices, counties, tribes, health
 82.5 plans, and other entities and the long-term care database maintained under section 256.975,
 82.6 subdivision 7. The system profiles must be designed to provide information on quality to:

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

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

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

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

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

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

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

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

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

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

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

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

83.3 Subd. 3a. **Home and community-based services report card in cooperation with**
83.4 **the commissioner of health.** The profiles developed for home and community-based
83.5 services providers under this section shall be incorporated into a report card and
83.6 maintained by the Minnesota Board on Aging pursuant to section 256.975, subdivision
83.7 7, paragraph (b), clause (2), as data becomes available. The commissioner, in
83.8 cooperation with the commissioner of health, shall use consumer choice, quality of life,
83.9 care approaches, and cost or flexible purchasing categories to organize the consumer
83.10 information in the profiles. The final categories used shall include consumer input and
83.11 survey data to the extent that is available through the state agencies. The commissioner
83.12 shall develop and disseminate the qualify profiles for a limited number of provider types
83.13 initially, and develop quality profiles for additional provider types as measurement tools
83.14 are developed and data becomes available. This includes providers of services to older
83.15 adults and people with disabilities, regardless of payor source.

83.16 Sec. 39. Minnesota Statutes 2012, section 256B.439, subdivision 4, is amended to read:

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

83.24 Sec. 40. Minnesota Statutes 2012, section 256B.49, subdivision 12, is amended to read:

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

83.31 Sec. 41. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

83.32 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments
83.33 shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.

84.1 With the permission of the recipient or the recipient's designated legal representative,
84.2 the recipient's current provider of services may submit a written report outlining their
84.3 recommendations regarding the recipient's care needs prepared by a direct service
84.4 employee with at least 20 hours of service to that client. The person conducting the
84.5 assessment or reassessment must notify the provider of the date by which this information
84.6 is to be submitted. This information shall be provided to the person conducting the
84.7 assessment and the person or the person's legal representative and must be considered
84.8 prior to the finalization of the assessment or reassessment.

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

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

84.19 (d) Recipients who are found eligible for home and community-based services under
84.20 this section before their 65th birthday may remain eligible for these services after their
84.21 65th birthday if they continue to meet all other eligibility factors.

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

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

85.1 Subd. 25. **Reduce avoidable behavioral crisis emergency room, psychiatric**
85.2 **inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving
85.3 home and community-based services authorized under this section who have two or more
85.4 admissions within a calendar year to an emergency room, psychiatric unit, or institution
85.5 must receive consultation from a mental health professional as defined in section 245.462,
85.6 subdivision 18, or a behavioral professional as defined in the home and community-based
85.7 services state plan within 30 days of discharge. The mental health professional or
85.8 behavioral professional must:

85.9 (1) conduct a functional assessment of the crisis incident as defined in section
85.10 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
85.11 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
85.12 future avoidable hospitalizations due to a behavioral crisis;

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

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

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

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

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

85.28 (b) CFSS is a participant-controlled method of selecting and providing services
85.29 and supports that allows the participant maximum control of the services and supports.
85.30 Participants may choose the degree to which they direct and manage their supports by
85.31 choosing to have a significant and meaningful role in the management of services and
85.32 supports including by directly employing support workers with the necessary supports
85.33 to perform that function.

85.34 (c) CFSS is available statewide to eligible individuals to assist with accomplishing
85.35 activities of daily living (ADLs), instrumental activities of daily living (IADLs), and

86.1 health-related procedures and tasks through hands-on assistance to complete the task or
86.2 supervision and cueing to complete the task; and to assist with acquiring, maintaining, and
86.3 enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures
86.4 and tasks. CFSS allows payment for certain supports and goods such as environmental
86.5 modifications and technology that are intended to replace or decrease the need for human
86.6 assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

87.30 (1) under the direction of the participant or the participant's representative, bringing
87.31 medications to the participant including medications given through a nebulizer, opening a
87.32 container of previously set up medications, emptying the container into the participant's
87.33 hand, opening and giving the medication in the original container to the participant, or
87.34 bringing to the participant liquids or food to accompany the medication;

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

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

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

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

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

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

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

88.24 (1) include people chosen by the participant;

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

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

88.29 (4) reflect cultural considerations of the participant;

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

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

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

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

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

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

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

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

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

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

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

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

89.24 (1) is a recipient of medical assistance as determined under section 256B.055,
89.25 256B.056, or 256B.057, subdivisions 5 and 9;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

90.34 (c) The results of the assessment and any recommendations and authorizations for
90.35 CFSS must be determined and communicated in writing by the lead agency's certified
90.36 assessor as defined in section 256B.0911 to the participant and the agency-provider or

91.1 financial management services provider chosen by the participant within 40 calendar days
91.2 and must include the participant's right to appeal under section 256.045.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

93.3 (6) transition costs, including:

93.4 (i) deposits for rent and utilities;

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

93.6 (iii) bedding;

93.7 (iv) basic kitchen supplies;

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

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

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

93.16 **Subd. 8. Determination of CFSS service methodology.** (a) All community first
 93.17 services and supports must be authorized by the commissioner or the commissioner's
 93.18 designee before services begin except for the assessments established in section
 93.19 256B.0911. The authorization for CFSS must be completed within 30 days after receiving
 93.20 a complete request.

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

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

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

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

93.29 (c) For purposes meeting the criteria in paragraph (b), the methodology to determine
 93.30 the total minutes for CFSS for each home care rating is based on the median paid units
 93.31 per day for each home care rating from fiscal year 2007 data for the PCA program. Each
 93.32 home care rating has a base number of minutes assigned. Additional minutes are added
 93.33 through the assessment and identification of the following:

93.34 (1) 30 additional minutes per day for a dependency in each critical activity of daily
 93.35 living as defined in subdivision 2;

94.1 (2) 30 additional minutes per day for each complex health-related function as
94.2 defined in subdivision 2; and

94.3 (3) 30 additional minutes per day for each behavior issue as defined in subdivision 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

94.31 (8) medical supplies and equipment;

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

94.33 (10) expenses for travel, lodging, or meals related to training the participant, the
94.34 participant's representative, legal representative, or paid or unpaid caregivers that exceed
94.35 \$500 in a 12-month period;

94.36 (11) experimental treatments;

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

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

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

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

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

95.13 **Subd. 10. Provider qualifications and general requirements. (a)**

95.14 Agency-providers delivering services under the agency-provider model under subdivision
 95.15 11 or financial management service (FMS) contractors under subdivision 13 shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

96.36 (5) proof of liability insurance;

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

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

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

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

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

97.14 (iii) the CFSS provider agency's template for the written agreement in subdivision
97.15 21 for recipients using the CFSS choice option, if applicable;

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

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

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

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

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

97.28 (14) documentation that the agency does not burden recipients' free exercise of their
97.29 right to choose service providers by requiring personal care assistants to sign an agreement
97.30 not to work with any particular CFSS recipient or for another CFSS provider agency after
97.31 leaving the agency and that the agency is not taking action on any such agreements or
97.32 requirements regardless of the date signed.

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

97.35 (c) All CFSS provider agencies shall require all employees in management and
97.36 supervisory positions and owners of the agency who are active in the day-to-day

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

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

98.15 (1) participants directly employ support workers;

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

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

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

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

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

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

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

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

98.30 (1) information and consultation about CFSS;

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

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

98.34 (4) assisting participants in fulfilling employer-related requirements according to
98.35 Internal Revenue Code Procedure 70-6, section 3504, Agency Employer Tax Liability,

99.1 regulation 137036-08, which includes assistance with filing and paying payroll taxes, and
99.2 obtaining worker compensation coverage;

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

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

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

99.9 (e) The FMS contractor shall:

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

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

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

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

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

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

99.32 (f) The commissioner of human services shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

101.10 (3) full name of the participant;

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

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

101.14 (6) personal signature of the support worker;

101.15 (7) any shared care provided, if applicable;

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

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

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

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

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

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

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

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

101.30 (4) not be a participant of CFSS;

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

101.33 English and to those who need accommodations due to disabilities. Support worker

101.34 training must include successful completion of the following training components: basic

101.35 first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles

101.36 and responsibilities of support workers including information about basic body mechanics,

102.1 emergency preparedness, orientation to positive behavioral practices, orientation to
102.2 responding to a mental health crisis, fraud issues, time cards and documentation, and an
102.3 overview of person-centered planning and self-direction. Upon completion of the training
102.4 components, the support worker must pass the certification test to provide assistance
102.5 to participants;

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

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

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

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

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

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

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

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

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

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

102.27 Subd. 18. **Service unit and budget allocation requirements.** (a) For the
102.28 agency-provider model, services will be authorized in units of service. The total service
102.29 unit amount must be established based upon the assessed need for CFSS services, and
102.30 must not exceed the maximum number of units available as determined by section
102.31 256B.0652, subdivision 6. The unit rate established by the commissioner is used with
102.32 assessed units to determine the maximum available CFSS allocation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

104.32 Subd. 1o. **Supplementary service rate; exemptions.** A county agency shall not
104.33 negotiate a supplementary service rate under this section for any individual that has been
104.34 determined to be eligible for Housing Stability Services as approved by the Centers
104.35 for Medicare and Medicaid Services, and who resides in an establishment voluntarily

105.1 registered under section 144D.025, as a supportive housing establishment or participates
105.2 in the Minnesota supportive housing demonstration program under section 256I.04,
105.3 subdivision 3, paragraph (a), clause (4).

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

105.5 Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter
105.6 shall immediately make an oral report to the common entry point. The common entry
105.7 point may accept electronic reports submitted through a Web-based reporting system
105.8 established by the commissioner. Use of a telecommunications device for the deaf or other
105.9 similar device shall be considered an oral report. The common entry point may not require
105.10 written reports. To the extent possible, the report must be of sufficient content to identify
105.11 the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment,
105.12 any evidence of previous maltreatment, the name and address of the reporter, the time,
105.13 date, and location of the incident, and any other information that the reporter believes
105.14 might be helpful in investigating the suspected maltreatment. A mandated reporter may
105.15 disclose not public data, as defined in section 13.02, and medical records under sections
105.16 144.291 to 144.298, to the extent necessary to comply with this subdivision.

105.17 (b) A boarding care home that is licensed under sections 144.50 to 144.58 and
105.18 certified under Title 19 of the Social Security Act, a nursing home that is licensed under
105.19 section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a
105.20 hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under
105.21 Code of Federal Regulations, title 42, section 482.66, may submit a report electronically
105.22 to the common entry point instead of submitting an oral report. The report may be a
105.23 duplicate of the initial report the facility submits electronically to the commissioner of
105.24 health to comply with the reporting requirements under Code of Federal Regulations, title
105.25 42, section 483.13. The commissioner of health may modify these reporting requirements
105.26 to include items required under paragraph (a) that are not currently included in the
105.27 electronic reporting form.

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

105.29 Sec. 46. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:

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

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

106.4 (1) the time and date of the report;

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

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

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

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

106.10 (6) a description of the suspected maltreatment;

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

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

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

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

106.15 (11) whether law enforcement has been notified;

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

106.18 (13) if the report is from a facility with an internal reporting procedure, the name,
106.19 mailing address, and telephone number of the person who initiated the report internally.

106.20 (c) The common entry point is not required to complete each item on the form prior
106.21 to dispatching the report to the appropriate lead investigative agency.

106.22 (d) The common entry point shall immediately report to a law enforcement agency
106.23 any incident in which there is reason to believe a crime has been committed.

106.24 (e) If a report is initially made to a law enforcement agency or a lead investigative
106.25 agency, those agencies shall take the report on the appropriate common entry point intake
106.26 forms and immediately forward a copy to the common entry point.

106.27 (f) The common entry point staff must receive training on how to screen and
106.28 dispatch reports efficiently and in accordance with this section.

106.29 (g) The commissioner of human services shall maintain a centralized database
106.30 for the collection of common entry point data, lead investigative agency data including
106.31 maltreatment report disposition, and appeals data. The common entry point shall
106.32 have access to the centralized database and must log the reports into the database and
106.33 immediately identify and locate prior reports of abuse, neglect, or exploitation.

106.34 (h) When appropriate, the common entry point staff must refer calls that do not
106.35 allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations
106.36 that might resolve the reporter's concerns.

- 107.1 (i) a common entry point must be operated in a manner that enables the
107.2 commissioner of human services to:
- 107.3 (1) track critical steps in the reporting, evaluation, referral, response, disposition,
107.4 and investigative process to ensure compliance with all requirements for all reports;
- 107.5 (2) maintain data to facilitate the production of aggregate statistical reports for
107.6 monitoring patterns of abuse, neglect, or exploitation;
- 107.7 (3) serve as a resource for the evaluation, management, and planning of preventative
107.8 and remedial services for vulnerable adults who have been subject to abuse, neglect,
107.9 or exploitation;
- 107.10 (4) set standards, priorities, and policies to maximize the efficiency and effectiveness
107.11 of the common entry point; and
- 107.12 (5) track and manage consumer complaints related to the common entry point.
- 107.13 (j) The commissioners of human services and health shall collaborate on the
107.14 creation of a system for referring reports to the lead investigative agencies. This system
107.15 shall enable the commissioner of human services to track critical steps in the reporting,
107.16 evaluation, referral, response, disposition, investigation, notification, determination, and
107.17 appeal processes.

107.18 Sec. 47. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:

107.19 Subd. 9e. **Education requirements.** (a) The commissioners of health, human
107.20 services, and public safety shall cooperate in the development of a joint program for
107.21 education of lead investigative agency investigators in the appropriate techniques for
107.22 investigation of complaints of maltreatment. This program must be developed by July
107.23 1, 1996. The program must include but need not be limited to the following areas: (1)
107.24 information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4)
107.25 conclusions based on evidence; (5) interviewing skills, including specialized training to
107.26 interview people with unique needs; (6) report writing; (7) coordination and referral
107.27 to other necessary agencies such as law enforcement and judicial agencies; (8) human
107.28 relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family
107.29 systems and the appropriate methods for interviewing relatives in the course of the
107.30 assessment or investigation; (10) the protective social services that are available to protect
107.31 alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by
107.32 which lead investigative agency investigators and law enforcement workers cooperate in
107.33 conducting assessments and investigations in order to avoid duplication of efforts; and
107.34 (12) data practices laws and procedures, including provisions for sharing data.

108.1 (b) The commissioner of human services shall conduct an outreach campaign to
108.2 promote the common entry point for reporting vulnerable adult maltreatment. This
108.3 campaign shall use the Internet and other means of communication.

108.4 ~~(b)~~ (c) The commissioners of health, human services, and public safety shall offer at
108.5 least annual education to others on the requirements of this section, on how this section is
108.6 implemented, and investigation techniques.

108.7 ~~(e)~~ (d) The commissioner of human services, in coordination with the commissioner
108.8 of public safety shall provide training for the common entry point staff as required in this
108.9 subdivision and the program courses described in this subdivision, at least four times
108.10 per year. At a minimum, the training shall be held twice annually in the seven-county
108.11 metropolitan area and twice annually outside the seven-county metropolitan area. The
108.12 commissioners shall give priority in the program areas cited in paragraph (a) to persons
108.13 currently performing assessments and investigations pursuant to this section.

108.14 ~~(d)~~ (e) The commissioner of public safety shall notify in writing law enforcement
108.15 personnel of any new requirements under this section. The commissioner of public
108.16 safety shall conduct regional training for law enforcement personnel regarding their
108.17 responsibility under this section.

108.18 ~~(e)~~ (f) Each lead investigative agency investigator must complete the education
108.19 program specified by this subdivision within the first 12 months of work as a lead
108.20 investigative agency investigator.

108.21 A lead investigative agency investigator employed when these requirements take
108.22 effect must complete the program within the first year after training is available or as soon
108.23 as training is available.

108.24 All lead investigative agency investigators having responsibility for investigation
108.25 duties under this section must receive a minimum of eight hours of continuing education
108.26 or in-service training each year specific to their duties under this section.

108.27 Sec. 48. **REPEALER.**

108.28 (a) Minnesota Statutes 2012, sections 245A.655; and 256B.0917, subdivisions 1, 2,
108.29 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14, are repealed.

108.30 (b) Minnesota Statutes 2012, section 256B.0911, subdivisions 4a, 4b, and 4c, are
108.31 repealed effective October 1, 2013.

108.32 Sec. 49. **EFFECTIVE DATE; CONTINGENT SYSTEMS MODERNIZATION**
108.33 **APPROPRIATION.**

109.1 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this
109.2 subdivision have the meanings given.

109.3 (b) Unless otherwise indicated, "commissioner" means the commissioner of human
109.4 services.

109.5 (c) "Contingent systems modernization appropriation" refers to the appropriation in
109.6 article 15, section 2.

109.7 (d) "Department" means the Department of Human Services.

109.8 (e) "Plan" means the plan that outlines how the provisions in this article, and the
109.9 contingent appropriation for systems modernization, are implemented once federal action
109.10 on Reform 2020 has occurred.

109.11 (f) Unless otherwise indicated, "Reform 2020" means the commissioner's request
109.12 for any necessary federal approval of provisions in this article that modify or provide
109.13 new medical assistance services, or that otherwise modify the federal role in the state's
109.14 long-term care system.

109.15 Subd. 2. **Intent; effective dates generally.** (a) Because the changes contained in
109.16 this article generate savings that are contingent on federal approval of Reform 2020,
109.17 the legislature has also made an appropriation for systems modernization contingent on
109.18 federal approval of Reform 2020. The purpose of this section is to outline how this article
109.19 and the contingent systems modernization appropriation in article 15 are implemented if
109.20 Reform 2020 is fully, partially, or incrementally approved or denied.

109.21 (b) In order for sections 1 to 48 of this article to be effective, the commissioner must
109.22 follow the provisions of subdivisions 3 and 4, as applicable, notwithstanding any other
109.23 effective dates for those sections.

109.24 Subd. 3. **Federal approval.** (a) The implementation of this article is contingent
109.25 on federal approval.

109.26 (b) Upon full or partial approval of the waiver application, the commissioner shall
109.27 develop a plan for implementing the provisions in this article that received federal
109.28 approval as well as any that do not require federal approval. The plan must:

109.29 (1) include fiscal estimates for the 2014-2015 and 2016-2017 biennia;

109.30 (2) include the contingent systems modernization appropriation, which cannot
109.31 exceed \$16,992,000 for the biennium ending June 30, 2015; and

109.32 (3) include spending estimates that, with federal administrative reimbursement, do
109.33 not exceed the department's net general fund appropriations for the 2014-2015 biennium.

109.34 (c) Upon approval by the commissioner of management and budget, the department
109.35 may implement the plan.

110.1 (d) The commissioner may follow this plan and implement parts of Reform 2020
 110.2 consistent with federal law if federal approval is denied, received incrementally, or
 110.3 significantly delayed.

110.4 (e) The commissioner must notify the chairs and ranking minority members of the
 110.5 legislative committees with jurisdiction over health and human services funding of the
 110.6 plan. The plan must be made publicly available online.

110.7 Subd. 4. **Disbursement; implementation.** The commissioner of management and
 110.8 budget shall disburse the appropriations in article 15, section 2, to the commissioner to
 110.9 allow for implementation of the approved plan and make necessary adjustments in the
 110.10 accounting system to reflect any modified funding levels. Notwithstanding Minnesota
 110.11 Statutes, section 16A.11, subdivision 3, paragraph (b), these fiscal estimates must be
 110.12 considered in establishing the appropriation base for the biennium ending June 30, 2017.
 110.13 The commissioner of management and budget shall reflect the modified funding levels in
 110.14 the first fund balance following the approval of the plan.

110.15 **ARTICLE 3**

110.16 **HOME AND COMMUNITY-BASED SERVICES DISABILITY RATE SETTING**

110.17 Section 1. Minnesota Statutes 2012, section 256B.4912, subdivision 2, is amended to
 110.18 read:

110.19 Subd. 2. **Payment methodologies.** (a) The commissioner shall establish, as defined
 110.20 under section 256B.4914, statewide payment methodologies that meet federal waiver
 110.21 requirements for home and community-based waiver services for individuals with
 110.22 disabilities. The payment methodologies must abide by the principles of transparency
 110.23 and equitability across the state. The methodologies must involve a uniform process of
 110.24 structuring rates for each service and must promote quality and participant choice.

110.25 (b) As of January 1, 2012, counties shall not implement changes to established
 110.26 processes for rate-setting methodologies for individuals using components of or data
 110.27 from research rates.

110.28 Sec. 2. Minnesota Statutes 2012, section 256B.4912, subdivision 3, is amended to read:

110.29 Subd. 3. **Payment requirements.** The payment methodologies established under
 110.30 this section shall accommodate:

- 110.31 (1) supervision costs;
- 110.32 (2) ~~staffing patterns~~ staff compensation;
- 110.33 (3) staffing and supervisory patterns;
- 110.34 ~~(3)~~ (4) program-related expenses;

- 111.1 ~~(4)~~ (5) general and administrative expenses; and
111.2 ~~(5)~~ (6) consideration of recipient intensity.

111.3 Sec. 3. Minnesota Statutes 2012, section 256B.4913, is amended by adding a
111.4 subdivision to read:

111.5 Subd. 4a. **Rate stabilization adjustment.** (a) The commissioner of human services
111.6 shall adjust individual reimbursement rates by no more than 1.0 percent per year effective
111.7 January 1, 2016. Rates determined under section 256B.4914 must be adjusted so that
111.8 the unit rate varies no more than 1.0 percent per year from the rate effective December
111.9 1 of the prior calendar year. This adjustment is made annually for three calendar years
111.10 from the date of implementation.

111.11 (b) Rate stabilization adjustment applies to services that are authorized in a
111.12 recipient's service plan prior to January 1, 2016.

111.13 (c) Exemptions shall be made only when there is a significant change in the
111.14 recipient's assessed needs which results in a service authorization change. Exemption
111.15 adjustments shall be limited to the difference in the authorized framework rate specific to
111.16 change in assessed need. Exemptions shall be managed within lead agencies' budgets per
111.17 existing allocation procedures.

111.18 (d) This subdivision expires January 1, 2019.

111.19 Sec. 4. Minnesota Statutes 2012, section 256B.4913, subdivision 5, is amended to read:

111.20 **Subd. 5. Stakeholder consultation.** The commissioner shall continue consultation
111.21 on regular intervals with the existing stakeholder group established as part of the
111.22 rate-setting methodology process and others, to gather input, concerns, and data, ~~and~~
111.23 ~~exchange ideas for the legislative proposals for~~ to assist in the full implementation of
111.24 the new rate payment system and to make pertinent information available to the public
111.25 through the department's Web site.

111.26 Sec. 5. Minnesota Statutes 2012, section 256B.4913, subdivision 6, is amended to read:

111.27 **Subd. 6. Implementation.** (a) ~~The commissioner may~~ shall implement changes
111.28 ~~no sooner than~~ on January 1, 2014, to payment rates for individuals receiving home and
111.29 community-based waived services after the enactment of legislation that establishes
111.30 specific payment methodology frameworks, processes for rate calculations, and specific
111.31 values to populate the ~~payment methodology frameworks~~ disability waiver rates system.

111.32 (b) On January 1, 2014, all new service authorizations must use the disability waiver
111.33 rates system. Beginning January 1, 2014, all renewing individual service plans must use the

112.1 disability waiver rates system as reassessment and reauthorization occurs. By December
112.2 31, 2014, data for all recipients must be entered into the disability waiver rates system.

112.3 **Sec. 6. [256B.4914] HOME AND COMMUNITY-BASED SERVICES WAIVERS;**
112.4 **RATE SETTING.**

112.5 Subdivision 1. **Application.** The payment methodologies in this section apply to
112.6 home and community-based services waivers under sections 256B.092 and 256B.49. This
112.7 section does not change existing waiver policies and procedures.

112.8 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
112.9 meanings given them, unless the context clearly indicates otherwise.

112.10 (b) "Commissioner" means the commissioner of human services.

112.11 (c) "Component value" means underlying factors that are part of the cost of providing
112.12 services that are built into the waiver rates methodology to calculate service rates.

112.13 (d) "Customized living tool" means a methodology for setting service rates which
112.14 delineates and documents the amount of each component service included in a recipient's
112.15 customized living service plan.

112.16 (e) "Disability Waiver Rates System" means a statewide system which establishes
112.17 rates that are based on uniform processes and captures the individualized nature of waiver
112.18 services and recipient needs.

112.19 (f) "Lead agency" means a county, partnership of counties, or tribal agency charged
112.20 with administering waived services under sections 256B.092 and 256B.49.

112.21 (g) "Median" means the amount that divides distribution into two equal groups, half
112.22 above the median and half below the median.

112.23 (h) "Payment or rate" means reimbursement to an eligible provider for services
112.24 provided to a qualified individual based on an approved service authorization.

112.25 (i) "Rates management system" means a web-based software application that uses
112.26 a framework and component values, as determined by the commissioner, to establish
112.27 service rates.

112.28 (j) "Recipient" means a person receiving home and community-based services
112.29 funded under any of the disability waivers.

112.30 Subd. 3. **Applicable services.** Applicable services are those authorized under the
112.31 state's home and community-based services waivers under sections 256B.092 and 256B.49
112.32 including, as defined in the federally approved home and community-based services plan:

112.33 (1) 24-hour customized living;

112.34 (2) adult day care;

112.35 (3) adult day care bath;

- 113.1 (4) behavioral programming;
 113.2 (5) companion services;
 113.3 (6) customized living;
 113.4 (7) day training and habilitation;
 113.5 (8) housing access coordination;
 113.6 (9) independent living skills;
 113.7 (10) in-home family support;
 113.8 (11) night supervision;
 113.9 (12) personal support;
 113.10 (13) prevocational services;
 113.11 (14) residential care services;
 113.12 (15) residential support services;
 113.13 (16) respite services;
 113.14 (17) structured day services;
 113.15 (18) supported employment services;
 113.16 (19) supported living services;
 113.17 (20) transportation services; and
 113.18 (21) other services as approved by the federal government in the state home and
 113.19 community-based services plan.

113.20 Subd. 4. **Data collection for rate determination.** (a) Rates for all applicable home
 113.21 and community-based waived services, including rate exceptions under subdivision 12
 113.22 are set via the rates management system.

113.23 (b) Only data and information in the rates management system may be used to
 113.24 calculate an individual's rate.

113.25 (c) Service providers, with information from the community support plan, shall enter
 113.26 values and information needed to calculate an individual's rate into the rates management
 113.27 system. These values and information include:

- 113.28 (1) shared staffing hours;
 113.29 (2) individual staffing hours;
 113.30 (3) staffing ratios;
 113.31 (4) information to document variable levels of service qualification for variable
 113.32 levels of reimbursement in each framework;
 113.33 (5) shared or individualized arrangements for unit-based services, including the
 113.34 staffing ratio; and
 113.35 (6) number of trips and miles for transportation services.

113.36 (d) Updates to individual data shall include:

114.1 (1) data for each individual that is updated annually when renewing service plans; and
114.2 (2) requests by individuals or lead agencies to update a rate whenever there is a
114.3 change in an individual's service needs, with accompanying documentation.

114.4 (e) Lead agencies shall review and approve values to calculate the final payment rate
114.5 for each individual. Lead agencies must notify the individual and the service provider
114.6 of the final agreed upon values and rate. If a value used was mistakenly or erroneously
114.7 entered and used to calculate a rate, a provider may petition lead agencies to correct it.
114.8 Lead agencies must respond to these requests.

114.9 Subd. 5. **Base wage index and standard component values.** (a) The base wage
114.10 index is established to determine staffing costs associated with providing services to
114.11 individuals receiving home and community-based services. For purposes of developing
114.12 and calculating the proposed base wage, Minnesota-specific wages taken from job
114.13 descriptions and standard occupational classification (SOC) codes from the Bureau of
114.14 Labor Statistics, as defined in the most recent edition of the Occupational Handbook shall
114.15 be used. The base wage index shall be calculated as follows:

114.16 (1) for residential direct care basic staff, 50 percent of the median wage for personal
114.17 and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing
114.18 aide (SOC code 31-1012); and 20 percent of the median wage for social and human
114.19 services aide (SOC code 21-1093);

114.20 (2) for residential direct care intensive staff, 20 percent of the median wage for home
114.21 health aide (SOC code 31-1011); 20 percent of the median wage for personal and home
114.22 health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code
114.23 21-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
114.24 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

114.25 (3) for day services, 20 percent of the median wage for nursing aide (SOC Code
114.26 31-1012); 20 percent of the median wage for psychiatric technician (SOC Code 29-2053);
114.27 and 60 percent of the median wage for social and human services code (SOC Code
114.28 21-1093);

114.29 (4) for residential asleep overnight staff, the wage will be \$7.66 per hour, except
114.30 in a family foster care setting the wage is \$2.80 per hour;

114.31 (5) for behavior program analyst staff: 100 percent of the median wage for mental
114.32 health counselors (SOC code 21-1014);

114.33 (6) for behavior program professional staff: 100 percent of the median wage for
114.34 clinical counseling and school psychologist (SOC code 19-3031);

114.35 (7) for behavior program specialist staff: 100 percent of the median wage for
114.36 psychiatric technicians (SOC code 29-2053);

115.1 (8) for supportive living services staff: 20 percent of the median wage for nursing
115.2 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
115.3 code 29-2053); and 60 percent of the median wage for social and human services aide
115.4 (SOC code 21-1093);

115.5 (9) for housing access coordination staff: 50 percent of the median wage for
115.6 community and social services specialist (SOC code 21-1099); and 50 percent of the
115.7 median wage for social and human services aide (SOC code 21-1093);

115.8 (10) for in-home family support staff: 20 percent of the median wage for nursing
115.9 aide (SOC code 31-1012); 30 percent of community social service specialist (SOC code
115.10 21-1099); 40 percent of the median wage for social and human services aide (SOC code
115.11 21-1093); and 10 percent of the median wage for psychiatric technician (SOC code
115.12 29-2053);

115.13 (11) for independent living skills staff: 40 percent of the median wage for
115.14 community social service specialist (SOC code 21-1099); 50 percent of the median wage
115.15 for social and human services aide (SOC code 21-1093); and 10 percent of the median
115.16 wage for psychiatric technician (SOC code 29-2053);

115.17 (12) for supported employment staff: 20 percent of the median wage for nursing
115.18 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
115.19 code 29-2053); and 60 percent of the median wage for social and human services aide
115.20 (SOC code 21-1093);

115.21 (13) for adult companion staff: 50 percent of the median wage for personal and
115.22 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
115.23 orderlies, and attendants (SOC code 31-1012);

115.24 (14) for night supervision staff: 20 percent of the median wage for home health aide
115.25 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
115.26 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
115.27 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
115.28 percent of the median wage for social and human services aide (SOC code 21-1093);

115.29 (15) for respite staff: 50 percent of the median wage for personal and home care aide
115.30 (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and
115.31 attendants (SOC code 31-1012);

115.32 (16) for personal support staff: 50 percent of the median wage for personal and
115.33 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing
115.34 aides, orderlies, and attendants (SOC code 31-1012); and

115.35 (17) for supervisory staff: the basic wage is \$17.43 per hour with exception of the
115.36 supervisor of behavior analyst and behavior specialists which shall be \$30.75 per hour.

- 116.1 (b) Component values for residential support services, excluding family foster
116.2 care, are:
- 116.3 (1) supervisory span of control ratio: 11 percent;
116.4 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
116.5 (3) employee-related cost ratio: 23.6 percent;
116.6 (4) general administrative support ratio: 13.25 percent;
116.7 (5) program-related expense ratio: 1.3 percent; and
116.8 (6) absence and utilization factor ratio: 3.9 percent.
- 116.9 (c) Component values for family foster care are:
- 116.10 (1) supervisory span of control ratio: 11 percent;
116.11 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
116.12 (3) employee-related cost ratio: 23.6 percent;
116.13 (4) general administrative support ratio: 3.3 percent; and
116.14 (5) program-related expense ratio: 1.3 percent.
- 116.15 (d) Component values for day services for all services are:
- 116.16 (1) supervisory span of control ratio: 11 percent;
116.17 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
116.18 (3) employee-related cost ratio: 23.6 percent;
116.19 (4) program plan support ratio: 5.6 percent;
116.20 (5) client programming and support ratio: 10 percent;
116.21 (6) general administrative support ratio: 13.25 percent;
116.22 (7) program-related expense ratio: 1.8 percent; and
116.23 (8) absence and utilization factor ratio: 3.9 percent.
- 116.24 (e) Component values for unit-based with program services are:
- 116.25 (1) supervisory span of control ratio: 11 percent;
116.26 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
116.27 (3) employee-related cost ratio: 23.6 percent;
116.28 (4) program plan supports ratio: 3.1 percent;
116.29 (5) client programming and support ratio: 8.6 percent;
116.30 (6) general administrative support ratio: 13.25 percent;
116.31 (7) program-related expense ratio: 6.1 percent; and
116.32 (8) absence and utilization factor ratio: 3.9 percent.
- 116.33 (f) Component values for unit-based services without programming except respite
116.34 are:
- 116.35 (1) supervisory span of control ratio: 11 percent;
116.36 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

- 117.1 (3) employee-related cost ratio: 23.6 percent;
117.2 (4) program plan support ratio: 3.1 percent;
117.3 (5) client programming and support ratio: 8.6 percent;
117.4 (6) general administrative support ratio: 13.25 percent;
117.5 (7) program-related expense ratio: 6.1 percent; and
117.6 (8) absence and utilization factor ratio: 3.9 percent.
- 117.7 (g) Component values for unit-based services without programming for respite are:
117.8 (1) supervisory span of control ratio: 11 percent;
117.9 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
117.10 (3) employee-related cost ratio: 23.6 percent;
117.11 (4) general administrative support ratio: 13.25 percent;
117.12 (5) program-related expense ratio: 6.1 percent; and
117.13 (6) absence and utilization factor ratio: 3.9 percent.
- 117.14 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
117.15 (a) based on the wage data by standard occupational code (SOC) from the Bureau of
117.16 Labor Statistics available on December 31, 2016. The commissioner shall publish these
117.17 updated values and load them into the rate management system. This adjustment shall
117.18 occur every five years. For adjustments in 2021 and beyond, the commissioner shall use
117.19 the data available on December 31 of the calendar year five years prior.
- 117.20 (i) On July 1, 2017, the commissioner shall update the framework components in
117.21 paragraph (c) for changes in the Consumer Price Index. The commissioner must adjust
117.22 these values higher or lower by the percentage change in the Consumer Price Index-All
117.23 Items (United States city average) (CPI-U) from January 1, 2014, to January 1, 2017. The
117.24 commissioner shall publish these updated values and load them into the rate management
117.25 system. This adjustment shall occur every five years. For adjustments in 2021 and
117.26 beyond, the commissioner shall use the data available on January 1 of the calendar year
117.27 four years prior and January 1 of the current calendar year.
- 117.28 **Subd. 6. Payments for residential support services.** (a) Payments for residential
117.29 support services, as defined in sections 256B.092, subdivision 11, and 256B.49 subdivision
117.30 22, must be calculated as follows:
- 117.31 (1) determine the number of units of service to meet a recipient's needs;
117.32 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
117.33 national and Minnesota-specific rates or rates derived by the commissioner as provided in
117.34 subdivision 5. This is defined as the direct care rate;

118.1 (3) for a recipient requiring customization for deaf or hard-of-hearing language
118.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
118.3 to the result of clause (2). This is defined as the customized direct care rate;

118.4 (4) multiply the number of residential services direct staff hours by the appropriate
118.5 staff wage in subdivision 5, paragraph (a), or the customized direct care rate;

118.6 (5) multiply the number of direct staff hours by the product of the supervision span
118.7 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
118.8 wage in subdivision 5, paragraph (a), clause (17);

118.9 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
118.10 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
118.11 clause (2). This is defined as the direct staffing cost;

118.12 (7) for employee-related expenses, multiply the direct staffing cost by one plus the
118.13 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

118.14 (8) for client programming and supports, the commissioner shall add \$2,179; and

118.15 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
118.16 customized for adapted transport per year.

118.17 (b) The total rate shall be calculated using the following steps:

118.18 (1) subtotal paragraph (a), clauses (7) to (9);

118.19 (2) sum the standard general and administrative rate, the program-related expense
118.20 ratio, and the absence and utilization ratio; and

118.21 (3) divide the result of clause (1) by one minus the result of clause (2). This is
118.22 the total payment amount.

118.23 Subd. 7. **Payments for day programs.** Payments for services with day programs
118.24 including adult day care, day treatment and habilitation, prevocational services, and
118.25 structured day services must be calculated as follows:

118.26 (1) determine the number of units of service to meet a recipient's needs;

118.27 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
118.28 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

118.29 (3) for a recipient requiring customization for deaf or hard-of-hearing language
118.30 accessibility under subdivision 12, add the customization rate provided in subdivision 12
118.31 to the result of clause (2). This is defined as the customized direct care rate;

118.32 (4) multiply the number of day program direct staff hours by the appropriate staff
118.33 wage in subdivision 5, paragraph (a), or the customized direct care rate;

118.34 (5) multiply the number of day program direct staff hours by the product of the
118.35 supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the
118.36 appropriate supervision wage in subdivision 5, paragraph (a), clause (17);

119.1 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
119.2 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d),
119.3 clause (2). This is defined as the direct staffing rate;

119.4 (7) for program plan support, multiply the result of clause (6) by one plus the
119.5 program plan support ratio in subdivision 5, paragraph (d), clause (4);

119.6 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
119.7 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

119.8 (9) for client programming and supports, multiply the result of clause (8) by one plus
119.9 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

119.10 (10) for program facility costs, add \$8.30 per week with consideration of staffing
119.11 ratios to meet individual needs;

119.12 (11) for adult day bath services, add \$7.01 per 15 minute unit;

119.13 (12) this is the subtotal rate;

119.14 (13) sum the standard general and administrative rate, the program-related expense
119.15 ratio, and the absence and utilization factor ratio;

119.16 (14) divide the result of clause (12) by one minus the result of clause (13). This is
119.17 the total payment amount;

119.18 (15) for transportation provided as part of day training and habilitation for an
119.19 individual who does not require a lift, add:

119.20 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle
119.21 without a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared
119.22 ride in a vehicle with a lift;

119.23 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle
119.24 without a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared
119.25 ride in a vehicle with a lift;

119.26 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle
119.27 without a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared
119.28 ride in a vehicle with a lift; or

119.29 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a
119.30 lift, \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a
119.31 vehicle with a lift;

119.32 (16) for transportation provide as part of day training and habilitation for an
119.33 individual who does require a lift, add:

119.34 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with
119.35 a lift, and \$15.05 for a shared ride in a vehicle with a lift;

120.1 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
120.2 lift, and \$28.16 for a shared ride in a vehicle with a lift;

120.3 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with
120.4 a lift, and \$58.76 for a shared ride in a vehicle with a lift; or

120.5 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a
120.6 lift, and \$80.93 for a shared ride in a vehicle with a lift.

120.7 Subd. 8. **Payments for unit-based services with programming.** Payments for
120.8 unit-based services with programming, including behavior programming, housing access
120.9 coordination, in-home family support, independent living skills training, hourly supported
120.10 living services, and supported employment provided to an individual outside of any day or
120.11 residential service plan must be calculated as follows, unless the services are authorized
120.12 separately under subdivision 6 or 7:

120.13 (1) determine the number of units of service to meet a recipient's needs;

120.14 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
120.15 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

120.16 (3) for a recipient requiring customization for deaf or hard-of-hearing language
120.17 accessibility under subdivision 12, add the customization rate provided in subdivision 12
120.18 to the result of clause (2). This is defined as the customized direct care rate;

120.19 (4) multiply the number of direct staff hours by the appropriate staff wage in
120.20 subdivision 5, paragraph (a), or the customized direct care rate;

120.21 (5) multiply the number of direct staff hours by the product of the supervision span
120.22 of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
120.23 wage in subdivision 5, paragraph (a), clause (17);

120.24 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
120.25 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e),
120.26 clause (2). This is defined as the direct staffing rate;

120.27 (7) for program plan support, multiply the result of clause (6) by one plus the
120.28 program plan supports ratio in subdivision 5, paragraph (e), clause (4);

120.29 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
120.30 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

120.31 (9) for client programming and supports, multiply the result of clause (8) by one plus
120.32 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

120.33 (10) this is the subtotal rate;

120.34 (11) sum the standard general and administrative rate, the program-related expense
120.35 ratio, and the absence and utilization factor ratio; and

121.1 (12) divide the result of clause (10) by one minus the result of clause (11). This is
121.2 the total payment amount.

121.3 Subd. 9. **Payments for unit-based services without programming.** Payments
121.4 for unit-based without program services including night supervision, personal support,
121.5 respite, and companion care provided to an individual outside of any day or residential
121.6 service plan must be calculated as follows unless the services are authorized separately
121.7 under subdivision 6 or 7:

121.8 (1) for all services except respite, determine the number of units of service to meet
121.9 a recipient's needs;

121.10 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
121.11 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

121.12 (3) for a recipient requiring customization for deaf or hard-of-hearing language
121.13 accessibility under subdivision 12, add the customization rate provided in subdivision 12
121.14 to the result of clause (2). This is defined as the customized direct care rate;

121.15 (4) multiply the number of direct staff hours by the appropriate staff wage in
121.16 subdivision 5 or the customized direct care rate;

121.17 (5) multiply the number of direct staff hours by the product of the supervision span
121.18 of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
121.19 wage in subdivision 5, paragraph (a), clause (17);

121.20 (6) combine the results of clauses (4) and (5) and multiply the result by one plus
121.21 the employee vacation, sick, and training allowance ratio in, subdivision 5, paragraph (f),
121.22 clause (2). This is defined as the direct staffing rate;

121.23 (7) for program plan support, multiply the result of clause (6) by one plus the
121.24 program plan support ratio in subdivision 5, paragraph (f), clause (4);

121.25 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
121.26 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

121.27 (9) For client programming and supports, multiply the result of clause (8) by one
121.28 plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

121.29 (10) this is the subtotal rate;

121.30 (11) sum the standard general and administrative rate, the program-related expense
121.31 ratio, and the absence and utilization factor ratio;

121.32 (12) divide the result of clause (10) by one minus the result of clause (11). This is
121.33 the total payment amount;

121.34 (13) for respite services, determine the number of daily units of service to meet an
121.35 individual's needs;

- 122.1 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
122.2 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
122.3 (15) for a recipient requiring deaf or hard-of-hearing customization under
122.4 subdivision 12, add the customization rate provided in subdivision 12 to the result of
122.5 clause (14). This is defined as the customized direct care rate;
122.6 (16) multiply the number of direct staff hours by the appropriate staff wage in
122.7 subdivision 5, paragraph (a);
122.8 (17) multiply the number of direct staff hours by the product of the supervisory span
122.9 of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
122.10 wage in subdivision 5, paragraph (a), clause (17);
122.11 (18) combine the results of clauses (16) and (17) and multiply the result by one plus
122.12 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g),
122.13 clause (2). This is defined as the direct staffing rate;
122.14 (19) for employee-related expenses, multiply the result of clause (18) by one plus
122.15 the employee-related cost ratio in subdivision 5, paragraph (g), clause (3).
122.16 (20) this is the subtotal rate;
122.17 (21) sum the standard general and administrative rate, the program-related expense
122.18 ratio, and the absence and utilization factor ratio; and
122.19 (22) divide the result of clause (20) by one minus the result of clause (21). This is
122.20 the total payment amount.
122.21 **Subd. 10. Updating payment values and additional information.** (a) The
122.22 commissioner shall develop and implement uniform procedures to refine terms and update
122.23 or adjust values used to calculate payment rates in this section. For calendar year 2014,
122.24 the commissioner shall use the values, terms, and procedures provided in this section.
122.25 (b) The commissioner shall work with stakeholders to assess efficacy of values
122.26 and payment rates. The commissioner shall report back to the legislature with proposed
122.27 changes for component values and recommendations for revisions on the schedule
122.28 provided in paragraphs (c) and (d).
122.29 (c) The commissioner shall work with stakeholders to continue refining a
122.30 subset of component values, which are to be referred to as interim values, and report
122.31 recommendations to the legislature by February 15, 2014. Interim component values are:
122.32 transportation rates for day training and habilitation; transportation for adult day, structured
122.33 day, and prevocational services; geographic difference factor; day program facility rate;
122.34 services where monitoring technology replaces staff time; shared services for independent
122.35 living skills training; and supported employment and billing for indirect services.

123.1 (d) The commissioner shall report and make recommendations to the legislature on:
123.2 February 15, 2015, February 15, 2017, February 15, 2019, and February 15, 2021. After
123.3 2021, reports shall be provided on a four-year cycle.

123.4 (e) The commissioner shall provide a public notice via list serve in October of each
123.5 year beginning October 1, 2014. The notice shall contain information detailing legislatively
123.6 approved changes in: calculation values including derived wage rates and related employee
123.7 and administrative factors; services utilization; county and tribal allocation changes
123.8 and; information on adjustments to be made to calculation values and timing of those
123.9 adjustments. Information in this notice shall be effective January 1 of the following year.

123.10 Subd. 11. **Payment implementation.** Upon implementation of the payment
123.11 methodologies under this section, those payment rates supersede rates established in county
123.12 contracts for recipients receiving waiver services under sections 256B.092 or 256B.49.

123.13 Subd. 12. **Customization of rates for individuals.** (a) For persons determined to
123.14 have higher needs based on being deaf or hard-of-hearing, the direct care costs must be
123.15 increased by an adjustment factor prior to calculating the rate under subdivisions 6, 7, 8,
123.16 and 9. The customization rate with respect to deaf or hard-of-hearing persons shall be
123.17 \$2.50 per hour for waiver recipients who meet the respective criteria as determined by
123.18 the commissioner.

123.19 (b) For the purposes of this section, "Deaf or Hard of Hearing" means:

123.20 (1)(i) the person has a developmental disability and an assessment score which
123.21 indicates a hearing impairment that is severe or that the person has no useful hearing;

123.22 (ii) the person has a developmental disability and an expressive communications
123.23 score that indicates the person uses single signs or gestures, uses an augmentative
123.24 communication aid, or does not have functional communication, or the person's expressive
123.25 communications are unknown; and

123.26 (iii) the person has a developmental disability and a communication score which
123.27 indicates the person comprehends signs, gestures, and modeling prompts or does not
123.28 comprehend verbal, visual, or gestural communication or that the person's receptive
123.29 communications score is unknown; or

123.30 (2)(i) the person receives long-term care services and has an assessment score which
123.31 indicates they hear only very loud sounds, have no useful hearing, or a determination
123.32 cannot be made; and

123.33 (ii) the person receives long-term care services and has an assessment which
123.34 indicates the person communicates needs with sign language, symbol board, written
123.35 messages, gestures or an interpreter; communicates with inappropriate content; makes
123.36 garbled sounds or displays echolalia; or does not communicate needs.

124.1 Subd. 13. **Transportation.** The commissioner shall require that the purchase
124.2 of transportation services be cost-effective and be limited to market rates where the
124.3 transportation mode is generally available and accessible.

124.4 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead
124.5 agencies must identify individuals with exceptional needs that cannot be met under the
124.6 disability waiver rate system. The commissioner shall use that information to evaluate
124.7 and, if necessary, approve an alternative payment rate for those individuals.

124.8 (b) Lead agencies must submit exception requests to the state.

124.9 (c) An application for a rate exception may be submitted for the following criteria:

124.10 (1) an individual has service needs that cannot be met through additional units
124.11 of service; or

124.12 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results in an
124.13 individual being discharged.

124.14 (d) Exception requests must include the following information:

124.15 (1) the service needs required by each individual that are not accounted for in
124.16 subdivisions 6, 7, 8, and 9;

124.17 (2) the service rate requested and the difference from the rate determined in
124.18 subdivisions 6, 7, 8, and 9;

124.19 (3) a basis for the underlying costs used for the rate exception and any accompanying
124.20 documentation;

124.21 (4) the duration of the rate exception; and

124.22 (5) any contingencies for approval.

124.23 (e) Approved rate exceptions shall be managed within lead agency allocations under
124.24 sections 256B.092 and 256B.49.

124.25 (f) Individual disability waiver recipients may request that a lead agency submit an
124.26 exception request. A lead agency that denies such a request shall notify the individual
124.27 waiver recipient of its decision and the reasons for denying the request in writing no later
124.28 than 30 days after the individual's request has been made.

124.29 (g) The commissioner shall determine whether to approve or deny an exception
124.30 request no more than 30 days after receiving the request. If the commissioner denies the
124.31 request, the commissioner shall notify the lead agency and the individual disability waiver
124.32 recipient in writing of the reasons for the denial.

124.33 (h) The individual disability waiver recipient may appeal any denial of an exception
124.34 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
124.35 256.0451. When the denial of an exception request results in the proposed demission of a
124.36 waiver recipient from a residential or day habilitation program, the commissioner shall

125.1 issue a temporary stay of demission, when requested by the disability waiver recipient,
125.2 consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c).
125.3 The temporary stay shall remain in effect until the lead agency can provide an informed
125.4 choice of appropriate, alternative services to the disability waiver.

125.5 (i) Providers may petition lead agencies to update values that were entered
125.6 incorrectly or erroneously into the rate management system, based on past service level
125.7 discussions and determination in subdivision 4, without applying for a rate exception.

125.8 Subd. 15. **County or tribal allocations.** (a) Upon implementation of the Disability
125.9 Waiver Rates Management System on January 1, 2014, the commissioner shall establish
125.10 a method of tracking and reporting the fiscal impact of the Disability Waiver Rates
125.11 Management System on individual lead agencies.

125.12 (b) Beginning January 1, 2014, and continuing through full implementation on
125.13 December 31, 2017, the commissioner shall make annual adjustments to lead agencies'
125.14 home and community-based waived service budget allocations to adjust for rate
125.15 differences and the resulting impact on county allocations upon implementation of the
125.16 disability waiver rates system.

125.17 Subd. 16. **Budget neutrality adjustment.** The commissioner shall calculate the
125.18 total spending for all home and community-based waiver services under the payments as
125.19 defined in subdivisions 6, 7, 8, and 9 for all recipients as of July 1, 2013, and compare it to
125.20 spending for services defined for subdivisions 6, 7, 8, and 9 under current law. If spending
125.21 for services in one particular subdivision differs, there will be a percentage adjustment
125.22 to increase or decrease individual rates for the services defined in each subdivision so
125.23 aggregate spending matches projections under current law.

125.24 Subd. 17. **Implementation.** (a) On January 1, 2014, the commissioner shall fully
125.25 implement the calculation of rates for waived services under sections 256B.092 and
125.26 256B.49, without additional legislative approval.

125.27 (b) The commissioner shall phase in the application of rates determined in
125.28 subdivisions 6 to 9 for two years.

125.29 (c) The commissioner shall preserve rates in effect on December 31, 2013, for
125.30 the two-year period.

125.31 (d) The commissioner shall calculate and measure the difference in cost per
125.32 individual using the historical rate and the rates under subdivisions 6 to 9, for all
125.33 individuals enrolled as of December 31, 2013. This measurement shall occur statewide,
125.34 and for individuals in every county.

126.1 The commissioner shall provide the results of this analysis, by county for calendar
126.2 year 2014, to the legislative committees with jurisdiction over health and human services
126.3 finance by February 15, 2015.

126.4 (e) The commissioner shall calculate the average rate per unit for each service by
126.5 county. For individuals enrolled after January 1, 2014, individuals will receive the higher
126.6 of the rate produced under subdivisions 6 to 9, or the by-county average rate.

126.7 (f) On January 1, 2016, the rates determined in subdivisions 6 to 9 shall be applied.

126.8 **Sec. 7. REPEALER.**

126.9 Minnesota Statutes 2012, section 256B.4913, subdivisions 1, 2, 3, and 4, are repealed.

126.10 **ARTICLE 4**

126.11 **STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES**

126.12 Section 1. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

126.13 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with
126.14 the exception of the placement of a Minnesota specialty treatment facility as defined in
126.15 paragraph (c), must be developed under the direction of the county board, or multiple
126.16 county boards acting jointly, as the local mental health authority. The planning process
126.17 for each pilot shall include, but not be limited to, mental health consumers, families,
126.18 advocates, local mental health advisory councils, local and state providers, representatives
126.19 of state and local public employee bargaining units, and the department of human services.
126.20 As part of the planning process, the county board or boards shall designate a managing
126.21 entity responsible for receipt of funds and management of the pilot project.

126.22 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a
126.23 request for proposal for regions in which a need has been identified for services.

126.24 (c) For purposes of this section, Minnesota specialty treatment facility is defined as
126.25 an intensive rehabilitative mental health service under section 256B.0622, subdivision 2,
126.26 paragraph (b).

126.27 Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

126.28 Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the
126.29 commissioner shall facilitate integration of funds or other resources as needed and
126.30 requested by each project. These resources may include:

126.31 (1) residential services funds administered under Minnesota Rules, parts 9535.2000
126.32 to 9535.3000, in an amount to be determined by mutual agreement between the project's
126.33 managing entity and the commissioner of human services after an examination of the

127.1 county's historical utilization of facilities located both within and outside of the county
127.2 and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

127.3 (2) community support services funds administered under Minnesota Rules, parts
127.4 9535.1700 to 9535.1760;

127.5 (3) other mental health special project funds;

127.6 (4) medical assistance, general assistance medical care, MinnesotaCare and group
127.7 residential housing if requested by the project's managing entity, and if the commissioner
127.8 determines this would be consistent with the state's overall health care reform efforts; and

127.9 (5) regional treatment center resources consistent with section 246.0136, subdivision
127.10 1.; and

127.11 (6) funds transferred from section 246.18, subdivision 8, for grants to providers to
127.12 participate in mental health specialty treatment services, awarded to providers through
127.13 a request for proposal process.

127.14 (b) The commissioner shall consider the following criteria in awarding start-up and
127.15 implementation grants for the pilot projects:

127.16 (1) the ability of the proposed projects to accomplish the objectives described in
127.17 subdivision 2;

127.18 (2) the size of the target population to be served; and

127.19 (3) geographical distribution.

127.20 (c) The commissioner shall review overall status of the projects initiatives at least
127.21 every two years and recommend any legislative changes needed by January 15 of each
127.22 odd-numbered year.

127.23 (d) The commissioner may waive administrative rule requirements which are
127.24 incompatible with the implementation of the pilot project.

127.25 (e) The commissioner may exempt the participating counties from fiscal sanctions
127.26 for noncompliance with requirements in laws and rules which are incompatible with the
127.27 implementation of the pilot project.

127.28 (f) The commissioner may award grants to an entity designated by a county board or
127.29 group of county boards to pay for start-up and implementation costs of the pilot project.

127.30 Sec. 3. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

127.31 Subd. 2. **General provisions.** (a) In the design and implementation of reforms to
127.32 the mental health system, the commissioner shall:

127.33 (1) consult with consumers, families, counties, tribes, advocates, providers, and
127.34 other stakeholders;

128.1 (2) bring to the legislature, and the State Advisory Council on Mental Health, by
128.2 January 15, 2008, recommendations for legislation to update the role of counties and to
128.3 clarify the case management roles, functions, and decision-making authority of health
128.4 plans and counties, and to clarify county retention of the responsibility for the delivery of
128.5 social services as required under subdivision 3, paragraph (a);

128.6 (3) withhold implementation of any recommended changes in case management
128.7 roles, functions, and decision-making authority until after the release of the report due
128.8 January 15, 2008;

128.9 (4) ensure continuity of care for persons affected by these reforms including
128.10 ensuring client choice of provider by requiring broad provider networks and developing
128.11 mechanisms to facilitate a smooth transition of service responsibilities;

128.12 (5) provide accountability for the efficient and effective use of public and private
128.13 resources in achieving positive outcomes for consumers;

128.14 (6) ensure client access to applicable protections and appeals; and

128.15 (7) make budget transfers necessary to implement the reallocation of services and
128.16 client responsibilities between counties and health care programs that do not increase the
128.17 state and county costs and efficiently allocate state funds.

128.18 (b) When making transfers under paragraph (a) necessary to implement movement
128.19 of responsibility for clients and services between counties and health care programs,
128.20 the commissioner, in consultation with counties, shall ensure that any transfer of state
128.21 grants to health care programs, including the value of case management transfer grants
128.22 under section 256B.0625, subdivision 20, does not exceed the value of the services being
128.23 transferred for the latest 12-month period for which data is available. The commissioner
128.24 may make quarterly adjustments based on the availability of additional data during the
128.25 first four quarters after the transfers first occur. If case management transfer grants under
128.26 section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior
128.27 to repeal, exceeds the value of the services being transferred, the difference becomes an
128.28 ongoing part of each county's adult and children's mental health grants under sections
128.29 245.4661, ~~245.4889~~, and 256E.12.

128.30 (c) This appropriation is not authorized to be expended after December 31, 2010,
128.31 unless approved by the legislature.

128.32 Sec. 4. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:

128.33 Subd. 8. **State-operated services account.** (a) The state-operated services account is
128.34 established in the special revenue fund. Revenue generated by new state-operated services

129.1 listed under this section established after July 1, 2010, that are not enterprise activities must
129.2 be deposited into the state-operated services account, unless otherwise specified in law:

129.3 (1) intensive residential treatment services;

129.4 (2) foster care services; and

129.5 (3) psychiatric extensive recovery treatment services.

129.6 (b) Funds deposited in the state-operated services account are available to the
129.7 commissioner of human services for the purposes of:

129.8 (1) providing services needed to transition individuals from institutional settings
129.9 within state-operated services to the community when those services have no other
129.10 adequate funding source;

129.11 (2) grants to providers participating in mental health specialty treatment services
129.12 under section 245.4661; and

129.13 (3) to fund the operation of the Intensive Residential Treatment Service program in
129.14 Willmar.

129.15 Sec. 5. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision
129.16 to read:

129.17 Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds
129.18 to the account in subdivision 8 for noncovered allowable costs of a provider certified and
129.19 licensed under section 256B.0622, and operating under section 246.014.

129.20 Sec. 6. Minnesota Statutes 2012, section 254B.13, is amended to read:

129.21 **254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.**

129.22 Subdivision 1. **Authorization for navigator pilot projects.** The commissioner may
129.23 approve and implement navigator pilot projects developed under the planning process
129.24 required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and
129.25 enhance coordination of the delivery of chemical health services required under section
129.26 254B.03.

129.27 Subd. 2. **Program design and implementation.** (a) The commissioner and
129.28 counties participating in the navigator pilot projects shall continue to work in partnership
129.29 to refine and implement the navigator pilot projects initiated under Laws 2009, chapter
129.30 79, article 7, section 26.

129.31 (b) The commissioner and counties participating in the navigator pilot projects shall
129.32 complete the planning phase ~~by June 30, 2010~~, and, if approved by the commissioner for
129.33 implementation, enter into agreements governing the operation of the navigator pilot
129.34 projects ~~with implementation scheduled no earlier than July 1, 2010.~~

130.1 Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for
 130.2 participation in a navigator pilot program, an individual must:

130.3 (1) be a resident of a county with an approved navigator program;

130.4 (2) be eligible for consolidated chemical dependency treatment fund services;

130.5 (3) be a voluntary participant in the navigator program;

130.6 (4) satisfy one of the following items:

130.7 (i) have at least one severity rating of three or above in dimension four, five, or six in
 130.8 a comprehensive assessment under Minnesota Rules, part 9530.6422; or

130.9 (ii) have at least one severity rating of two or above in dimension four, five, or six in
 130.10 a comprehensive assessment under Minnesota Rules, part 9530.6422, and be currently
 130.11 participating in a Rule 31 treatment program under Minnesota Rules, parts 9530.6405 to
 130.12 9530.6505, or be within 60 days following discharge after participation in a Rule 31
 130.13 treatment program; and

130.14 (5) have had at least two treatment episodes in the past two years, not limited
 130.15 to episodes reimbursed by the consolidated chemical dependency treatment funds. An
 130.16 admission to an emergency room, a detoxification program, or a hospital may be substituted
 130.17 for one treatment episode if it resulted from the individual's substance use disorder.

130.18 (b) New eligibility criteria may be added as mutually agreed upon by the
 130.19 commissioner and participating navigator programs.

130.20 **Subd. 3. Program evaluation.** The commissioner shall evaluate navigator pilot
 130.21 projects under this section and report the results of the evaluation to the chairs and
 130.22 ranking minority members of the legislative committees with jurisdiction over chemical
 130.23 health issues by January 15, 2014. Evaluation of the navigator pilot projects must be
 130.24 based on outcome evaluation criteria negotiated with the navigator pilot projects prior
 130.25 to implementation.

130.26 **Subd. 4. Notice of navigator project discontinuation.** Each county's participation
 130.27 in the navigator pilot project may be discontinued for any reason by the county or the
 130.28 commissioner of human services after 30 days' written notice to the other party. ~~Any~~
 130.29 ~~unspent funds held for the exiting county's pro rata share in the special revenue fund under~~
 130.30 ~~the authority in subdivision 5, paragraph (d), shall be transferred to the consolidated~~
 130.31 ~~chemical dependency treatment fund following discontinuation of the pilot project.~~

130.32 **Subd. 5. Duties of commissioner.** (a) Notwithstanding any other provisions in
 130.33 this chapter, the commissioner may authorize navigator pilot projects to use chemical
 130.34 dependency treatment funds to pay for nontreatment navigator pilot services:

130.35 (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph
 130.36 (a); and

131.1 (2) by vendors in addition to those authorized under section 254B.05 when not
131.2 providing chemical dependency treatment services.

131.3 (b) For purposes of this section, "nontreatment navigator pilot services" include
131.4 navigator services, peer support, family engagement and support, housing support, rent
131.5 subsidies, supported employment, and independent living skills.

131.6 (c) State expenditures for chemical dependency services and nontreatment navigator
131.7 pilot services provided by or through the navigator pilot projects must not be greater than
131.8 the chemical dependency treatment fund expected share of forecasted expenditures in the
131.9 absence of the navigator pilot projects. The commissioner may restructure the schedule of
131.10 payments between the state and participating counties under the local agency share and
131.11 division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to
131.12 facilitate the operation of the navigator pilot projects.

131.13 ~~(d) To the extent that state fiscal year expenditures within a pilot project are less~~
131.14 ~~than the expected share of forecasted expenditures in the absence of the pilot projects,~~
131.15 ~~the commissioner shall deposit the unexpended funds in a separate account within the~~
131.16 ~~consolidated chemical dependency treatment fund, and make these funds available for~~
131.17 ~~expenditure by the pilot projects the following year. To the extent that treatment and~~
131.18 ~~nontreatment pilot services expenditures within the pilot project exceed the amount~~
131.19 ~~expected in the absence of the pilot projects, the pilot project county or counties are~~
131.20 ~~responsible for the portion of nontreatment pilot services expenditures in excess of the~~
131.21 ~~otherwise expected share of forecasted expenditures.~~

131.22 ~~(e)~~ (d) The commissioner may waive administrative rule requirements that are
131.23 incompatible with the implementation of the navigator pilot project, except that any
131.24 chemical dependency treatment funded under this section must continue to be provided
131.25 by a licensed treatment provider.

131.26 ~~(f)~~ (e) The commissioner shall not approve or enter into any agreement related to
131.27 navigator pilot projects authorized under this section that puts current or future federal
131.28 funding at risk.

131.29 (f) The commissioner shall provide participating navigator pilot projects with
131.30 transactional data, reports, provider data, and other data generated by county activity to
131.31 assess and measure outcomes. This information must be transmitted or made available in
131.32 an acceptable form to participating navigator pilot projects at least once every six months
131.33 or within a reasonable time following the commissioner's receipt of information from the
131.34 counties needed to comply with this paragraph.

131.35 Subd. 6. **Duties of county board.** The county board, or other county entity that
131.36 is approved to administer a navigator pilot project, shall:

132.1 (1) administer the navigator pilot project in a manner consistent with the objectives
132.2 described in subdivision 2 and the planning process in subdivision 5;

132.3 (2) ensure that no one is denied chemical dependency treatment services for which
132.4 they would otherwise be eligible under section 254A.03, subdivision 3; and

132.5 (3) provide the commissioner with timely and pertinent information as negotiated in
132.6 agreements governing operation of the navigator pilot projects.

132.7 Subd. 7. **Managed care.** An individual who is eligible for the navigator pilot
132.8 program under subdivision 2a is excluded from mandatory enrollment in managed care
132.9 until these services are included in the health plan's benefit set.

132.10 Subd. 8. **Authorization for continuation of navigator pilots.** The navigator pilot
132.11 projects implemented pursuant to subdivision 1 are authorized to continue operation after
132.12 July 1, 2013, under existing agreements governing operation of the pilot projects.

132.13 **EFFECTIVE DATE.** The amendments to subdivisions 1 to 6 and 8 are effective
132.14 August 1, 2013. Subdivision 7 is effective July 1, 2013.

132.15 Sec. 7. **[254B.14] CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL**
132.16 **HEALTH CARE.**

132.17 Subdivision 1. **Authorization for continuum of care pilot projects.** The
132.18 commissioner shall establish chemical dependency continuum of care pilot projects to
132.19 begin implementing the measures developed with stakeholder input and identified in the
132.20 report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot
132.21 projects are intended to improve the effectiveness and efficiency of the service continuum
132.22 for chemically dependent individuals in Minnesota while reducing duplication of efforts
132.23 and promoting scientifically supported practices.

132.24 Subd. 2. **Program implementation.** (a) The commissioner, in coordination with
132.25 representatives of the Minnesota Association of County Social Service Administrators
132.26 and the Minnesota Inter-County Association, shall develop a process for identifying and
132.27 selecting interested counties and providers for participation in the continuum of care pilot
132.28 projects. There will be three pilot projects; one representing the northern region, one for
132.29 the metro region, and one for the southern region. The selection process of counties and
132.30 providers must include consideration of population size, geographic distribution, cultural
132.31 and racial demographics, and provider accessibility. The commissioner shall identify
132.32 counties and providers that are selected for participation in the continuum of care pilot
132.33 projects no later than September 30, 2013.

132.34 (b) The commissioner and entities participating in the continuum of care pilot
132.35 projects shall enter into agreements governing the operation of the continuum of care pilot

133.1 projects. The agreements shall identify pilot project outcomes and include timelines for
133.2 implementation and beginning operation of the pilot projects.

133.3 (c) Entities that are currently participating in the navigator pilot project are
133.4 eligible to participate in the continuum of care pilot project subsequent to or instead of
133.5 participating in the navigator pilot project.

133.6 (d) The commissioner may waive administrative rule requirements that are
133.7 incompatible with implementation of the continuum of care pilot projects.

133.8 (e) Notwithstanding section 254A.19, the commissioner may designate noncounty
133.9 entities to complete chemical use assessments and placement authorizations required
133.10 under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section
133.11 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the
133.12 discretion of the commissioner.

133.13 Subd. 3. **Program design.** (a) The operation of the pilot projects shall include:

133.14 (1) new services that are responsive to the chronic nature of substance use disorder;

133.15 (2) telehealth services, when appropriate to address barriers to services;

133.16 (3) services that assure integration with the mental health delivery system when
133.17 appropriate;

133.18 (4) services that address the needs of diverse populations; and

133.19 (5) an assessment and access process that permits clients to present directly to a
133.20 service provider for a substance use disorder assessment and authorization of services.

133.21 (b) Prior to implementation of the continuum of care pilot projects, a utilization
133.22 review process must be developed and agreed to by the commissioner, participating
133.23 counties, and providers. The utilization review process shall be described in the
133.24 agreements governing operation of the continuum of care pilot projects.

133.25 Subd. 4. **Notice of project discontinuation.** Each entity's participation in the
133.26 continuum of care pilot project may be discontinued for any reason by the county or the
133.27 commissioner after 30 days' written notice to the entity.

133.28 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this
133.29 chapter, the commissioner may authorize chemical dependency treatment funds to pay for
133.30 nontreatment services arranged by continuum of care pilot projects. Individuals who are
133.31 currently accessing Rule 31 treatment services are eligible for concurrent participation in
133.32 the continuum of care pilot projects.

133.33 (b) County expenditures for continuum of care pilot project services shall not
133.34 be greater than their expected share of forecasted expenditures in the absence of the
133.35 continuum of care pilot projects.

133.36 **EFFECTIVE DATE.** This section is effective August 1, 2013.

134.1 Sec. 8. [256.478] HOME AND COMMUNITY-BASED SERVICES

134.2 TRANSITIONS GRANTS.

134.3 (a) The commissioner shall make available home and community-based services
134.4 transition grants to serve individuals who do not meet eligibility criteria for the medical
134.5 assistance program under section 256B.056 or 256B.057, but who otherwise meet the
134.6 criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

134.7 (b) For the purposes of this section, the commissioner has the authority to transfer
134.8 funds between the medical assistance account and the home and community-based
134.9 services transitions grants account.

134.10 **EFFECTIVE DATE.** This section is effective July 1, 2015.

134.11 Sec. 9. Minnesota Statutes 2012, section 256B.0623, subdivision 2, is amended to read:

134.12 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
134.13 meanings given them.

134.14 (a) "Adult rehabilitative mental health services" means mental health services
134.15 which are rehabilitative and enable the recipient to develop and enhance psychiatric
134.16 stability, social competencies, personal and emotional adjustment, ~~and~~ independent living,
134.17 parenting skills, and community skills, when these abilities are impaired by the symptoms
134.18 of mental illness. Adult rehabilitative mental health services are also appropriate when
134.19 provided to enable a recipient to retain stability and functioning, if the recipient would
134.20 be at risk of significant functional decompensation or more restrictive service settings
134.21 without these services.

134.22 (1) Adult rehabilitative mental health services instruct, assist, and support the
134.23 recipient in areas such as: interpersonal communication skills, community resource
134.24 utilization and integration skills, crisis assistance, relapse prevention skills, health care
134.25 directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking
134.26 and nutrition skills, transportation skills, medication education and monitoring, mental
134.27 illness symptom management skills, household management skills, employment-related
134.28 skills, parenting skills, and transition to community living services.

134.29 (2) These services shall be provided to the recipient on a one-to-one basis in the
134.30 recipient's home or another community setting or in groups.

134.31 (b) "Medication education services" means services provided individually or in
134.32 groups which focus on educating the recipient about mental illness and symptoms; the role
134.33 and effects of medications in treating symptoms of mental illness; and the side effects of
134.34 medications. Medication education is coordinated with medication management services

135.1 and does not duplicate it. Medication education services are provided by physicians,
135.2 pharmacists, physician's assistants, or registered nurses.

135.3 (c) "Transition to community living services" means services which maintain
135.4 continuity of contact between the rehabilitation services provider and the recipient and
135.5 which facilitate discharge from a hospital, residential treatment program under Minnesota
135.6 Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community
135.7 living services are not intended to provide other areas of adult rehabilitative mental health
135.8 services.

135.9 Sec. 10. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
135.10 subdivision to read:

135.11 Subd. 35c. **School-linked mental health services.** Medical assistance covers mental
135.12 health services provided in a school as part of a school-linked mental health program by
135.13 an individual who is licensed by the Board of Behavioral Health and Therapy, Board of
135.14 Marriage and Family Therapy, Board of Psychology, or Board of Social Work, and who also
135.15 meets the definition of a mental health practitioner under section 245.462, subdivision 17,
135.16 or 245.4871, subdivision 26. For purposes of this subdivision, an individual who meets the
135.17 definition of mental health practitioner under section 245.462, subdivision 17, or 245.4871,
135.18 subdivision 26, is not limited to having less than 4,000 hours of post-master's experience.
135.19 The mental health practitioner must be supervised by a licensed mental health professional.

135.20 Sec. 11. Minnesota Statutes 2012, section 256B.0625, subdivision 48, is amended to
135.21 read:

135.22 Subd. 48. **Psychiatric consultation to primary care practitioners.** Effective
135.23 January 1, 2006, Medical assistance covers consultation provided by a psychiatrist or
135.24 psychologist via telephone, e-mail, facsimile, or other means of communication to primary
135.25 care practitioners, including pediatricians. The need for consultation and the receipt of the
135.26 consultation must be documented in the patient record maintained by the primary care
135.27 practitioner. If the patient consents, and subject to federal limitations and data privacy
135.28 provisions, the consultation may be provided without the patient present.

135.29 Sec. 12. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
135.30 subdivision to read:

135.31 Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon
135.32 federal approval, whichever is later, medical assistance covers family psychoeducation
135.33 services provided to a child up to age 21 with a diagnosed mental health condition when

136.1 identified in the child's individual treatment plan and provided by a licensed mental health
136.2 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a
136.3 clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who
136.4 has determined it medically necessary to involve family members in the child's care. For
136.5 the purposes of this subdivision, "family psychoeducation services" means information
136.6 or demonstration provided to an individual or family as part of an individual, family,
136.7 multifamily group, or peer group session to explain, educate, and support the child and
136.8 family in understanding a child's symptoms of mental illness, the impact on the child's
136.9 development, and needed components of treatment and skill development so that the
136.10 individual, family, or group can help the child to prevent relapse, prevent the acquisition
136.11 of comorbid disorders, and to achieve optimal mental health and long-term resilience.

136.12 Sec. 13. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
136.13 subdivision to read:

136.14 Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon
136.15 federal approval, whichever is later, medical assistance covers clinical care consultation
136.16 for a person up to age 21 who is diagnosed with a complex mental health condition or a
136.17 mental health condition that co-occurs with other complex and chronic conditions, when
136.18 described in the person's individual treatment plan and provided by a licensed mental
136.19 health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A. For
136.20 the purposes of this subdivision, "clinical care consultation" means communication from a
136.21 treating mental health professional to other providers not under the clinical supervision of
136.22 the treating mental health professional who are working with the same client to inform,
136.23 inquire, and instruct regarding the client's symptoms; strategies for effective engagement,
136.24 care, and intervention needs; and treatment expectations across service settings; and to
136.25 direct and coordinate clinical service components provided to the client and family.

136.26 Sec. 14. Minnesota Statutes 2012, section 256B.092, is amended by adding a
136.27 subdivision to read:

136.28 Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner
136.29 shall make available additional waiver allocations and additional necessary resources
136.30 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
136.31 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:
136.32 (1) are otherwise eligible for the developmental disabilities waiver under this section;
136.33 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
136.34 the Minnesota Security Hospital;

137.1 (3) whose discharge would be significantly delayed without the available waiver
 137.2 allocation; and

137.3 (4) who have met treatment objectives and no longer meet hospital level of care.

137.4 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
 137.5 requirements of the federal approved waiver plan.

137.6 (c) Any corporate foster care home developed under this subdivision must be
 137.7 considered an exception under section 245A.03, subdivision 7, paragraph (a).

137.8 **EFFECTIVE DATE.** This section is effective July 1, 2015.

137.9 Sec. 15. Minnesota Statutes 2012, section 256B.0946, is amended to read:

137.10 **256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.**

137.11 Subdivision 1. **Required covered service components.** (a) ~~Effective July 1, 2006,~~

137.12 ~~upon enactment~~ and subject to federal approval, medical assistance covers medically

137.13 necessary intensive treatment services described under paragraph (b) that are provided

137.14 by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2

137.15 who is placed in a ~~treatment~~ foster home licensed under Minnesota Rules, parts 2960.3000

137.16 to 2960.3340.

137.17 (b) Intensive treatment services to children with ~~severe emotional disturbance~~ mental

137.18 illness residing in ~~treatment foster care~~ family settings ~~must meet the relevant standards~~

137.19 ~~for mental health services under sections 245.487 to 245.4889. In addition, that comprise~~

137.20 specific required service components provided in clauses (1) to (5), are reimbursed by

137.21 medical assistance ~~must~~ when they meet the following standards:

137.22 ~~(1) case management service component must meet the standards in Minnesota~~

137.23 ~~Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;~~

137.24 (1) psychotherapy provided by a mental health professional as defined in Minnesota

137.25 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota

137.26 Rules, part 9505.0371, subpart 5, item C;

137.27 ~~(2) psychotherapy, crisis assistance, and skills training components must meet the~~

137.28 provided according to standards for children's therapeutic services and supports in section

137.29 256B.0943; ~~and~~

137.30 ~~(3) individual family, and group psychoeducation services under supervision of,~~

137.31 defined in subdivision 1a, paragraph (q), provided by a mental health professional; or a

137.32 clinical trainee;

137.33 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental

137.34 health professional or a clinical trainee; and

138.1 (5) service delivery payment requirements as provided under subdivision 4.

138.2 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have
138.3 the meanings given them.

138.4 (a) "Clinical care consultation" means communication from a treating clinician to
138.5 other providers working with the same client to inform, inquire, and instruct regarding
138.6 the client's symptoms, strategies for effective engagement, care and intervention needs,
138.7 and treatment expectations across service settings, including but not limited to the client's
138.8 school, social services, day care, probation, home, primary care, medication prescribers,
138.9 disabilities services, and other mental health providers and to direct and coordinate clinical
138.10 service components provided to the client and family.

138.11 (b) "Clinical supervision" means the documented time a clinical supervisor and
138.12 supervisee spend together to discuss the supervisee's work, to review individual client
138.13 cases, and for the supervisee's professional development. It includes the documented
138.14 oversight and supervision responsibility for planning, implementation, and evaluation of
138.15 services for a client's mental health treatment.

138.16 (c) "Clinical supervisor" means the mental health professional who is responsible
138.17 for clinical supervision.

138.18 (d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,
138.19 subpart 5, item C;

138.20 (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a,
138.21 including the development of a plan that addresses prevention and intervention strategies
138.22 to be used in a potential crisis, but does not include actual crisis intervention.

138.23 (f) "Culturally appropriate" means providing mental health services in a manner that
138.24 incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370,
138.25 subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural
138.26 strengths and resources to promote overall wellness.

138.27 (g) "Culture" means the distinct ways of living and understanding the world that
138.28 are used by a group of people and are transmitted from one generation to another or
138.29 adopted by an individual.

138.30 (h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part
138.31 9505.0370, subpart 11.

138.32 (i) "Family" means a person who is identified by the client or the client's parent or
138.33 guardian as being important to the client's mental health treatment. Family may include,
138.34 but is not limited to, parents, foster parents, children, spouse, committed partners, former
138.35 spouses, persons related by blood or adoption, persons who are a part of the client's
138.36 permanency plan, or persons who are presently residing together as a family unit.

- 139.1 (j) "Foster care" has the meaning given in section 260C.007, subdivision 18.
- 139.2 (k) "Foster family setting" means the foster home in which the license holder resides.
- 139.3 (l) "Individual treatment plan" has the meaning given in Minnesota Rules, part
- 139.4 9505.0370, subpart 15.
- 139.5 (m) "Mental health practitioner" has the meaning given in Minnesota Rules, part
- 139.6 9505.0370, subpart 17.
- 139.7 (n) "Mental health professional" has the meaning given in Minnesota Rules, part
- 139.8 9505.0370, subpart 18.
- 139.9 (o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370,
- 139.10 subpart 20.
- 139.11 (p) "Parent" has the meaning given in section 260C.007, subdivision 25.
- 139.12 (q) "Psychoeducation services" means information or demonstration provided to
- 139.13 an individual, family, or group to explain, educate, and support the individual, family, or
- 139.14 group in understanding a child's symptoms of mental illness, the impact on the child's
- 139.15 development, and needed components of treatment and skill development so that the
- 139.16 individual, family, or group can help the child to prevent relapse, prevent the acquisition
- 139.17 of comorbid disorders, and to achieve optimal mental health and long-term resilience.
- 139.18 (r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370,
- 139.19 subpart 27.
- 139.20 (s) "Team consultation and treatment planning" means the coordination of treatment
- 139.21 plans and consultation among providers in a group concerning the treatment needs of the
- 139.22 child, including disseminating the child's treatment service schedule to all members of the
- 139.23 service team. Team members must include all mental health professionals working with
- 139.24 the child, a parent, the child unless the team lead or parent deem it clinically inappropriate,
- 139.25 and at least two of the following: an individualized education program case manager;
- 139.26 probation agent; children's mental health case manager; child welfare worker, including
- 139.27 adoption or guardianship worker; primary care provider; foster parent; and any other
- 139.28 member of the child's service team.
- 139.29 **Subd. 2. Determination of client eligibility.** ~~A client's eligibility to receive~~
- 139.30 ~~treatment foster care under this section shall be determined by~~ An eligible recipient is an
- 139.31 individual, from birth through age 20, who is currently placed in a foster home licensed
- 139.32 under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic
- 139.33 assessment; and an evaluation of level of care needed, and development of an individual
- 139.34 treatment plan, as defined in paragraphs (a) to (e) and (b).
- 139.35 (a) The diagnostic assessment must:

140.1 (1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be
140.2 conducted by a psychiatrist, licensed psychologist, or licensed independent clinical social
140.3 worker that is mental health professional or a clinical trainee;

140.4 (2) determine whether or not a child meets the criteria for mental illness, as defined
140.5 in Minnesota Rules, part 9505.0370, subpart 20;

140.6 (3) document that intensive treatment services are medically necessary within a
140.7 foster family setting to ameliorate identified symptoms and functional impairments;

140.8 (4) be performed within 180 days prior to before the start of service; and

140.9 (2) ~~include current diagnoses on all five axes of the client's current mental health~~
140.10 ~~status;~~

140.11 (3) ~~determine whether or not a child meets the criteria for severe emotional~~
140.12 ~~disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness~~
140.13 ~~in section 245.462, subdivision 20; and~~

140.14 (4) ~~be completed annually until age 18. For individuals between age 18 and 21,~~
140.15 ~~unless a client's mental health condition has changed markedly since the client's most~~
140.16 ~~recent diagnostic assessment, annual updating is necessary. For the purpose of this section,~~
140.17 ~~"updating" means a written summary, including current diagnoses on all five axes, by a~~
140.18 ~~mental health professional of the client's current mental status and service needs.~~

140.19 (5) be completed as either a standard or extended diagnostic assessment annually to
140.20 determine continued eligibility for the service.

140.21 (b) The evaluation of level of care must be conducted by the placing county with
140.22 an instrument, tribe, or case manager in conjunction with the diagnostic assessment as
140.23 described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool
140.24 approved by the commissioner of human services and not subject to the rulemaking
140.25 process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which
140.26 evaluation demonstrates that the child requires intensive intervention without 24-hour
140.27 medical monitoring. The commissioner shall update the list of approved level of care
140.28 instruments tools annually and publish on the department's Web site.

140.29 (c) The individual treatment plan must be:

140.30 (1) ~~based on the information in the client's diagnostic assessment;~~

140.31 (2) ~~developed through a child-centered, family driven planning process that identifies~~
140.32 ~~service needs and individualized, planned, and culturally appropriate interventions that~~
140.33 ~~contain specific measurable treatment goals and objectives for the client and treatment~~
140.34 ~~strategies for the client's family and foster family;~~

140.35 (3) ~~reviewed at least once every 90 days and revised; and~~

141.1 ~~(4) signed by the client or, if appropriate, by the client's parent or other person~~
141.2 ~~authorized by statute to consent to mental health services for the client.~~

141.3 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for
141.4 intensive children's mental health services in a foster family setting must be certified
141.5 by the state and have a service provision contract with a county board or a reservation
141.6 tribal council and must be able to demonstrate the ability to provide all of the services
141.7 required in this section.

141.8 (b) For purposes of this section, a provider agency must ~~have an individual~~
141.9 ~~placement agreement for each recipient and must be a licensed child placing agency, under~~
141.10 ~~Minnesota Rules, parts 9543.0010 to 9543.0150, and either be:~~

141.11 (1) a county county-operated entity certified by the state;

141.12 (2) an Indian Health Services facility operated by a tribe or tribal organization under
141.13 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
141.14 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

141.15 (3) a noncounty entity ~~under contract with a county board.~~

141.16 (c) Certified providers that do not meet the service delivery standards required in
141.17 this section shall be subject to a decertification process.

141.18 (d) For the purposes of this section, all services delivered to a client must be
141.19 provided by a mental health professional or a clinical trainee.

141.20 Subd. 4. **~~Eligible provider responsibilities~~ Service delivery payment**
141.21 **requirements.** (a) ~~To be an eligible provider for payment under this section, a provider~~
141.22 ~~must develop and practice written policies and procedures for treatment foster care services~~
141.23 ~~intensive treatment in foster care, consistent with subdivision 1, paragraph (b), clauses (1),~~
141.24 ~~(2), and (3) and comply with the following requirements in paragraphs (b) to (n).~~

141.25 (b) ~~In delivering services under this section, a treatment foster care provider must~~
141.26 ~~ensure that staff caseload size reasonably enables the provider to play an active role in~~
141.27 ~~service planning, monitoring, delivering, and reviewing for discharge planning to meet~~
141.28 ~~the needs of the client, the client's foster family, and the birth family, as specified in each~~
141.29 ~~client's individual treatment plan.~~

141.30 (b) A qualified clinical supervisor, as defined in and performing in compliance with
141.31 Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and
141.32 provision of services described in this section.

141.33 (c) Each client receiving treatment services must receive an extended diagnostic
141.34 assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within
141.35 30 days of enrollment in this service unless the client has a previous extended diagnostic

142.1 assessment that the client, parent, and mental health professional agree still accurately
142.2 describes the client's current mental health functioning.

142.3 (d) Each previous and current mental health, school, and physical health treatment
142.4 provider must be contacted to request documentation of treatment and assessments that the
142.5 eligible client has received and this information must be reviewed and incorporated into
142.6 the diagnostic assessment and team consultation and treatment planning review process.

142.7 (e) Each client receiving treatment must be assessed for a trauma history and
142.8 the client's treatment plan must document how the results of the assessment will be
142.9 incorporated into treatment.

142.10 (f) Each client receiving treatment services must have an individual treatment plan
142.11 that is reviewed, evaluated, and signed every 90 days using the team consultation and
142.12 treatment planning process, as defined in subdivision 1a, paragraph (s).

142.13 (g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided
142.14 in accordance with the client's individual treatment plan.

142.15 (h) Each client must have a crisis assistance plan within ten days of initiating
142.16 services and must have access to clinical phone support 24 hours per day, seven days per
142.17 week, during the course of treatment, and the crisis plan must demonstrate coordination
142.18 with the local or regional mobile crisis intervention team.

142.19 (i) Services must be delivered and documented at least three days per week, equaling
142.20 at least six hours of treatment per week, unless reduced units of service are specified on
142.21 the treatment plan as part of transition or on a discharge plan to another service or level of
142.22 care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

142.23 (j) Location of service delivery must be in the client's home, day care setting,
142.24 school, or other community-based setting that is specified on the client's individualized
142.25 treatment plan.

142.26 (k) Treatment must be developmentally and culturally appropriate for the client.

142.27 (l) Services must be delivered in continual collaboration and consultation with the
142.28 client's medical providers and, in particular, with prescribers of psychotropic medications,
142.29 including those prescribed on an off-label basis, and members of the service team must be
142.30 aware of the medication regimen and potential side effects.

142.31 (m) Parents, siblings, foster parents, and members of the child's permanency plan
142.32 must be involved in treatment and service delivery unless otherwise noted in the treatment
142.33 plan.

142.34 (n) Transition planning for the child must be conducted starting with the first
142.35 treatment plan and must be addressed throughout treatment to support the child's
142.36 permanency plan and postdischarge mental health service needs.

143.1 Subd. 5. **Service authorization.** The commissioner will administer authorizations
143.2 for services under this section in compliance with section 256B.0625, subdivision 25.

143.3 Subd. 6. **Excluded services.** (a) Services in clauses (1) to ~~(4)~~ (7) are not covered
143.4 under this section and are not eligible for medical assistance payment as components of
143.5 intensive treatment in foster care services, but may be billed separately:

143.6 ~~(1) treatment foster care services provided in violation of medical assistance policy~~
143.7 ~~in Minnesota Rules, part 9505.0220;~~

143.8 ~~(2) service components of children's therapeutic services and supports~~
143.9 ~~simultaneously provided by more than one treatment foster care provider;~~

143.10 ~~(3) home and community-based waiver services; and~~

143.11 ~~(4) treatment foster care services provided to a child without a level of care~~
143.12 ~~determination according to section 245.4885, subdivision 1.~~

143.13 (1) inpatient psychiatric hospital treatment;

143.14 (2) mental health targeted case management;

143.15 (3) partial hospitalization;

143.16 (4) medication management;

143.17 (5) children's mental health day treatment services;

143.18 (6) crisis response services under section 256B.0944; and

143.19 (7) transportation.

143.20 (b) Children receiving intensive treatment in foster care services are not eligible for
143.21 medical assistance reimbursement for the following services while receiving intensive
143.22 treatment in foster care:

143.23 ~~(1) mental health case management services under section 256B.0625, subdivision~~
143.24 ~~20; and~~

143.25 ~~(2) (1) psychotherapy and skill skills training components of children's therapeutic~~
143.26 ~~services and supports under section 256B.0625, subdivision 35b;~~

143.27 (2) mental health behavioral aide services as defined in section 256B.0943,
143.28 subdivision 1, paragraph (m);

143.29 (3) home and community-based waiver services;

143.30 (4) mental health residential treatment; and

143.31 (5) room and board costs as defined in section 256I.03, subdivision 6.

143.32 Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall
143.33 establish a single daily per-client encounter rate for intensive treatment in foster care
143.34 services. The rate must be constructed to cover only eligible services delivered to an
143.35 eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

144.1 Sec. 16. Minnesota Statutes 2012, section 256B.49, is amended by adding a
144.2 subdivision to read:

144.3 Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner
144.4 shall make available additional waiver allocations and additional necessary resources
144.5 to assure timely discharges from the Anoka Metro Regional Treatment Center and the
144.6 Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

144.7 (1) are otherwise eligible for the brain injury, community alternatives for disabled
144.8 individuals, or community alternative care waivers under this section;

144.9 (2) who would otherwise remain at the Anoka Metro Regional Treatment Center or
144.10 the Minnesota Security Hospital;

144.11 (3) whose discharge would be significantly delayed without the available waiver
144.12 allocation; and

144.13 (4) who have met treatment objectives and no longer meet hospital level of care.

144.14 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
144.15 requirements of the federal approved waiver plan.

144.16 (c) Any corporate foster care home developed under this subdivision must be
144.17 considered an exception under section 245A.03, subdivision 7, paragraph (a).

144.18 **EFFECTIVE DATE.** This section is effective July 1, 2015.

144.19 Sec. 17. Minnesota Statutes 2012, section 256B.761, is amended to read:

144.20 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

144.21 (a) Effective for services rendered on or after July 1, 2001, payment for medication
144.22 management provided to psychiatric patients, outpatient mental health services, day
144.23 treatment services, home-based mental health services, and family community support
144.24 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
144.25 50th percentile of 1999 charges.

144.26 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
144.27 services provided by an entity that operates: (1) a Medicare-certified comprehensive
144.28 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
144.29 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
144.30 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
144.31 when those services are provided within the comprehensive outpatient rehabilitation
144.32 facility and provided to residents of nursing facilities owned by the entity.

144.33 (c) The commissioner shall establish three levels of payment for mental health
144.34 diagnostic assessment, based on three levels of complexity. The aggregate payment under

145.1 the tiered rates must not exceed the projected aggregate payments for mental health
145.2 diagnostic assessment under the previous single rate. The new rate structure is effective
145.3 January 1, 2011, or upon federal approval, whichever is later.

145.4 (d) In addition to rate increases otherwise provided, the commissioner may
145.5 restructure coverage policy and rates to improve access to adult rehabilitative mental
145.6 health services under section 256B.0623 and related mental health support services under
145.7 section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and
145.8 2016, the projected state share of increased costs due to this paragraph is transferred
145.9 from adult mental health grants under sections 245.4661 and 256E.12. The transfer for
145.10 fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments
145.11 made to managed care plans and county-based purchasing plans under sections 256B.69,
145.12 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

145.13 Sec. 18. **STATE ASSISTANCE TO COUNTIES; TRANSITIONS FOR HIGH**
145.14 **NEEDS POPULATIONS.**

145.15 (a) Effective immediately, the commissioner of human services shall work with
145.16 counties that request assistance to assure timely discharge from Anoka Metro Regional
145.17 Treatment Center and the Minnesota Security Hospital for individuals who are ready
145.18 for discharge but for whom the county may not have provider resources or appropriate
145.19 placement available. Special consideration must be given to uninsured individuals who are
145.20 not eligible for medical assistance and who may need continued treatment, and individuals
145.21 with complex needs and other factors that hinder county efforts to place the individual in a
145.22 safe, affordable setting.

145.23 (b) The commissioner shall assure that, given Olmstead court directives and the
145.24 role family and friends play in treatment progress, metropolitan area residents are asked
145.25 whether they wished to be placed in an Intensive Residential Treatment Service program
145.26 at Willmar or Cambridge or to be placed in a location more accessible to family, friends,
145.27 and health providers.

145.28 Sec. 19. **INSTRUCTIONS TO THE COMMISSIONER.**

145.29 In consultation with labor organizations, the commissioner of human services shall
145.30 develop clear and consistent standards for state-operated services programs to:

145.31 (1) address direct service staffing shortages;

145.32 (2) identify and help resolve workplace safety issues; and

145.33 (3) elevate the use and visibility of performance measures and objectives related to
145.34 overtime use.

146.1 **ARTICLE 5**146.2 **DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY**

146.3 Section 1. Minnesota Statutes 2012, section 243.166, subdivision 7, is amended to read:

146.4 Subd. 7. **Use of data.** (a) Except as otherwise provided in subdivision 7a or sections
146.5 244.052 and 299C.093, the data provided under this section is private data on individuals
146.6 under section 13.02, subdivision 12.

146.7 (b) The data may be used only for by law enforcement and corrections agencies for
146.8 law enforcement and corrections purposes.

146.9 (c) The commissioner of human services is authorized to have access to the data for:

146.10 (1) state-operated services, as defined in section 246.014, are also authorized to
146.11 have access to the data for the purposes described in section 246.13, subdivision 2,
146.12 paragraph (b); and

146.13 (2) purposes of completing background studies under chapter 245C.

146.14 Sec. 2. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision
146.15 to read:

146.16 Subd. 4a. **Agency background studies.** (a) The commissioner shall develop
146.17 and implement an electronic process for the regular transfer of new criminal history
146.18 information that is added to the Minnesota court information system. The commissioner's
146.19 system must include for review only information that relates to individuals who have been
146.20 the subject of a background study under this chapter that remain affiliated with the agency
146.21 that initiated the background study. For purposes of this paragraph, an individual remains
146.22 affiliated with an agency that initiated the background study until the agency informs the
146.23 commissioner that the individual is no longer affiliated. When any individual no longer
146.24 affiliated according to this paragraph returns to a position requiring a background study
146.25 under this chapter, the agency with whom the individual is again affiliated shall initiate
146.26 a new background study regardless of the length of time the individual was no longer
146.27 affiliated with the agency.

146.28 (b) The commissioner shall develop and implement an online system for agencies that
146.29 initiate background studies under this chapter to access and maintain records of background
146.30 studies initiated by that agency. The system must show all active background study subjects
146.31 affiliated with that agency and the status of each individual's background study. Each
146.32 agency that initiates background studies must use this system to notify the commissioner
146.33 of discontinued affiliation for purposes of the processes required under paragraph (a).

147.1 Sec. 3. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:

147.2 Subdivision 1. **Background studies conducted by Department of Human**
147.3 **Services.** (a) For a background study conducted by the Department of Human Services,
147.4 the commissioner shall review:

147.5 (1) information related to names of substantiated perpetrators of maltreatment of
147.6 vulnerable adults that has been received by the commissioner as required under section
147.7 626.557, subdivision 9c, paragraph (j);

147.8 (2) the commissioner's records relating to the maltreatment of minors in licensed
147.9 programs, and from findings of maltreatment of minors as indicated through the social
147.10 service information system;

147.11 (3) information from juvenile courts as required in subdivision 4 for individuals
147.12 listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

147.13 (4) information from the Bureau of Criminal Apprehension, including information
147.14 regarding a background study subject's registration in Minnesota as a predatory offender
147.15 under section 243.166;

147.16 (5) except as provided in clause (6), information from the national crime information
147.17 system when the commissioner has reasonable cause as defined under section 245C.05,
147.18 subdivision 5; and

147.19 (6) for a background study related to a child foster care application for licensure or
147.20 adoptions, the commissioner shall also review:

147.21 (i) information from the child abuse and neglect registry for any state in which the
147.22 background study subject has resided for the past five years; and

147.23 (ii) information from national crime information databases, when the background
147.24 study subject is 18 years of age or older.

147.25 (b) Notwithstanding expungement by a court, the commissioner may consider
147.26 information obtained under paragraph (a), clauses (3) and (4), unless the commissioner
147.27 received notice of the petition for expungement and the court order for expungement is
147.28 directed specifically to the commissioner.

147.29 (c) The commissioner shall also review criminal history information received
147.30 according to section 245C.04, subdivision 4a, from the Minnesota court information
147.31 system that relates to individuals who have already been studied under this chapter and
147.32 who remain affiliated with the agency that initiated the background study.

147.33 Sec. 4. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

147.34 Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for
147.35 Medicare and Medicaid Services determines that a provider is designated "high-risk," the

148.1 commissioner may withhold payment from providers within that category upon initial
148.2 enrollment for a 90-day period. The withholding for each provider must begin on the date
148.3 of the first submission of a claim.

148.4 (b) An enrolled provider that is also licensed by the commissioner under chapter
148.5 245A must designate an individual as the entity's compliance officer. The compliance
148.6 officer must:

148.7 (1) develop policies and procedures to assure adherence to medical assistance laws
148.8 and regulations and to prevent inappropriate claims submissions;

148.9 (2) train the employees of the provider entity, and any agents or subcontractors of
148.10 the provider entity including billers, on the policies and procedures under clause (1);

148.11 (3) respond to allegations of improper conduct related to the provision or billing of
148.12 medical assistance services, and implement action to remediate any resulting problems;

148.13 (4) use evaluation techniques to monitor compliance with medical assistance laws
148.14 and regulations;

148.15 (5) promptly report to the commissioner any identified violations of medical
148.16 assistance laws or regulations; and

148.17 (6) within 60 days of discovery by the provider of a medical assistance
148.18 reimbursement overpayment, report the overpayment to the commissioner and make
148.19 arrangements with the commissioner for the commissioner's recovery of the overpayment.

148.20 The commissioner may require, as a condition of enrollment in medical assistance, that a
148.21 provider within a particular industry sector or category establish a compliance program that
148.22 contains the core elements established by the Centers for Medicare and Medicaid Services.

148.23 (c) The commissioner may revoke the enrollment of an ordering or rendering
148.24 provider for a period of not more than one year, if the provider fails to maintain and, upon
148.25 request from the commissioner, provide access to documentation relating to written orders
148.26 or requests for payment for durable medical equipment, certifications for home health
148.27 services, or referrals for other items or services written or ordered by such provider, when
148.28 the commissioner has identified a pattern of a lack of documentation. A pattern means a
148.29 failure to maintain documentation or provide access to documentation on more than one
148.30 occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a
148.31 provider under the provisions of section 256B.064.

148.32 (d) The commissioner shall terminate or deny the enrollment of any individual or
148.33 entity if the individual or entity has been terminated from participation in Medicare or
148.34 under the Medicaid program or Children's Health Insurance Program of any other state.

148.35 (e) As a condition of enrollment in medical assistance, the commissioner shall
148.36 require that a provider designated "moderate" or "high-risk" by the Centers for Medicare

149.1 and Medicaid Services or the ~~Minnesota Department of Human Services~~ commissioner
149.2 permit the Centers for Medicare and Medicaid Services, its agents, or its designated
149.3 contractors and the state agency, its agents, or its designated contractors to conduct
149.4 unannounced on-site inspections of any provider location. The commissioner shall publish
149.5 in the Minnesota Health Care Program Provider Manual a list of provider types designated
149.6 "limited," "moderate," or "high-risk," based on the criteria and standards used to designate
149.7 Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and
149.8 criteria are not subject to the requirements of chapter 14. The commissioner's designations
149.9 are not subject to administrative appeal.

149.10 (f) As a condition of enrollment in medical assistance, the commissioner shall
149.11 require that a high-risk provider, or a person with a direct or indirect ownership interest in
149.12 the provider of five percent or higher, consent to criminal background checks, including
149.13 fingerprinting, when required to do so under state law or by a determination by the
149.14 commissioner or the Centers for Medicare and Medicaid Services that a provider is
149.15 designated high-risk for fraud, waste, or abuse.

149.16 (g) As a condition of enrollment, all durable medical equipment, prosthetics,
149.17 orthotics, and supplies (DMEPOS) suppliers operating in Minnesota are required to name
149.18 the Department of Human Services, in addition to the Centers for Medicare and Medicaid
149.19 Services, as an obligee on all surety performance bonds required pursuant to section
149.20 4312(a) of the Balanced Budget Act of 1997, Public Law 105-33, amending Social
149.21 Security Act, section 1834(a). The performance bond must also allow for recovery of
149.22 costs and fees in pursuing a claim on the bond.

149.23 (h) The Department of Human Services may require a provider to purchase a
149.24 performance surety bond as a condition of initial enrollment, reenrollment, reinstatement,
149.25 or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the
149.26 department determines there is significant evidence of or potential for fraud and abuse by
149.27 the provider, or (3) the provider or category of providers is designated high-risk pursuant
149.28 to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450, or the
149.29 department otherwise finds it is in the best interest of the Medicaid program to do so. The
149.30 performance bond must be in an amount of \$100,000 or ten percent of the provider's
149.31 payments from Medicaid during the immediately preceding 12 months, whichever is
149.32 greater. The performance bond must name the Department of Human Services as an
149.33 obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

149.34 **EFFECTIVE DATE.** This section is effective the day following final enactment.

150.1 Sec. 5. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
150.2 to read:

150.3 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
150.4 required nonrefundable application fees to pay for provider screening activities in
150.5 accordance with Code of Federal Regulations, title 42, section 455, subpart E. The
150.6 enrollment application must be made under the procedures specified by the commissioner,
150.7 in the form specified by the commissioner, and accompanied by an application fee
150.8 described in paragraph (b), or a request for a hardship exception as described in the
150.9 specified procedures. Application fees must be deposited in the provider screening account
150.10 in the special revenue fund. Amounts in the provider screening account are appropriated
150.11 to the commissioner for costs associated with the provider screening activities required
150.12 in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner
150.13 shall conduct screening activities as required by Code of Federal Regulations, title 42,
150.14 section 455, subpart E, and as otherwise provided by law, to include database checks,
150.15 unannounced pre- and postenrollment site visits, fingerprinting, and criminal background
150.16 studies. The commissioner must revalidate all providers under this subdivision at least
150.17 once every five years.

150.18 (b) The application fee under this subdivision is \$532 for the calendar year 2013.
150.19 For calendar year 2014 and subsequent years, the fee:

150.20 (1) is adjusted by the percentage change to the consumer price index for all urban
150.21 consumers, United States city average, for the 12-month period ending with June of the
150.22 previous year. The resulting fee must be announced in the Federal Register;

150.23 (2) is effective from January 1 to December 31 of a calendar year;

150.24 (3) is required on the submission of an initial application, an application to establish
150.25 a new practice location, an application for re-enrollment when the provider is not enrolled
150.26 at the time of application of re-enrollment, or at revalidation when required by federal
150.27 regulation; and

150.28 (4) must be in the amount in effect for the calendar year during which the application
150.29 for enrollment, new practice location, or re-enrollment is being submitted.

150.30 (c) The application fee under this subdivision cannot be charged to:

150.31 (1) providers who are enrolled in Medicare or who provide documentation of
150.32 payment of the fee to, and enrollment with, another state;

150.33 (2) providers who are enrolled but are required to submit new applications for
150.34 purposes of re-enrollment; or

150.35 (3) a provider who enrolls as an individual.

150.36 **EFFECTIVE DATE.** This section is effective the day following final enactment.

151.1 Sec. 6. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

151.2 Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may
151.3 impose sanctions against a vendor of medical care for any of the following: (1) fraud,
151.4 theft, or abuse in connection with the provision of medical care to recipients of public
151.5 assistance; (2) a pattern of presentment of false or duplicate claims or claims for services
151.6 not medically necessary; (3) a pattern of making false statements of material facts for
151.7 the purpose of obtaining greater compensation than that to which the vendor is legally
151.8 entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state
151.9 agency access during regular business hours to examine all records necessary to disclose
151.10 the extent of services provided to program recipients and appropriateness of claims for
151.11 payment; (6) failure to repay an overpayment or a fine finally established under this
151.12 section; ~~and~~ (7) failure to correct errors in the maintenance of health service or financial
151.13 records for which a fine was imposed or after issuance of a warning by the commissioner;
151.14 and (8) any reason for which a vendor could be excluded from participation in the
151.15 Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.
151.16 The determination of services not medically necessary may be made by the commissioner
151.17 in consultation with a peer advisory task force appointed by the commissioner on the
151.18 recommendation of appropriate professional organizations. The task force expires as
151.19 provided in section 15.059, subdivision 5.

151.20 Sec. 7. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:

151.21 Subd. 1b. **Sanctions available.** The commissioner may impose the following
151.22 sanctions for the conduct described in subdivision 1a: suspension or withholding of
151.23 payments to a vendor and suspending or terminating participation in the program, or
151.24 imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under
151.25 this section, the commissioner shall consider the nature, chronicity, or severity of the
151.26 conduct and the effect of the conduct on the health and safety of persons served by the
151.27 vendor. Regardless of imposition of sanctions, the commissioner may make a referral
151.28 to the appropriate state licensing board.

151.29 Sec. 8. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:

151.30 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner
151.31 shall determine any monetary amounts to be recovered and sanctions to be imposed upon
151.32 a vendor of medical care under this section. Except as provided in paragraphs (b) and
151.33 (d), neither a monetary recovery nor a sanction will be imposed by the commissioner
151.34 without prior notice and an opportunity for a hearing, according to chapter 14, on the

152.1 commissioner's proposed action, provided that the commissioner may suspend or reduce
152.2 payment to a vendor of medical care, except a nursing home or convalescent care facility,
152.3 after notice and prior to the hearing if in the commissioner's opinion that action is
152.4 necessary to protect the public welfare and the interests of the program.

152.5 (b) Except when the commissioner finds good cause not to suspend payments under
152.6 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall
152.7 withhold or reduce payments to a vendor of medical care without providing advance
152.8 notice of such withholding or reduction if either of the following occurs:

152.9 (1) the vendor is convicted of a crime involving the conduct described in subdivision
152.10 1a; or

152.11 (2) the commissioner determines there is a credible allegation of fraud for which an
152.12 investigation is pending under the program. A credible allegation of fraud is an allegation
152.13 which has been verified by the state, from any source, including but not limited to:

152.14 (i) fraud hotline complaints;

152.15 (ii) claims data mining; and

152.16 (iii) patterns identified through provider audits, civil false claims cases, and law
152.17 enforcement investigations.

152.18 Allegations are considered to be credible when they have an indicia of reliability
152.19 and the state agency has reviewed all allegations, facts, and evidence carefully and acts
152.20 judiciously on a case-by-case basis.

152.21 (c) The commissioner must send notice of the withholding or reduction of payments
152.22 under paragraph (b) within five days of taking such action unless requested in writing by a
152.23 law enforcement agency to temporarily withhold the notice. The notice must:

152.24 (1) state that payments are being withheld according to paragraph (b);

152.25 (2) set forth the general allegations as to the nature of the withholding action, but
152.26 need not disclose any specific information concerning an ongoing investigation;

152.27 (3) except in the case of a conviction for conduct described in subdivision 1a, state
152.28 that the withholding is for a temporary period and cite the circumstances under which
152.29 withholding will be terminated;

152.30 (4) identify the types of claims to which the withholding applies; and

152.31 (5) inform the vendor of the right to submit written evidence for consideration by
152.32 the commissioner.

152.33 The withholding or reduction of payments will not continue after the commissioner
152.34 determines there is insufficient evidence of fraud by the vendor, or after legal proceedings
152.35 relating to the alleged fraud are completed, unless the commissioner has sent notice of
152.36 intention to impose monetary recovery or sanctions under paragraph (a).

153.1 (d) The commissioner shall suspend or terminate a vendor's participation in the
153.2 program without providing advance notice and an opportunity for a hearing when the
153.3 suspension or termination is required because of the vendor's exclusion from participation
153.4 in Medicare. Within five days of taking such action, the commissioner must send notice of
153.5 the suspension or termination. The notice must:

153.6 (1) state that suspension or termination is the result of the vendor's exclusion from
153.7 Medicare;

153.8 (2) identify the effective date of the suspension or termination; and

153.9 (3) inform the vendor of the need to be reinstated to Medicare before reapplying
153.10 for participation in the program.

153.11 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or
153.12 sanction is to be imposed, a vendor may request a contested case, as defined in section
153.13 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The
153.14 appeal request must be received by the commissioner no later than 30 days after the date
153.15 the notification of monetary recovery or sanction was mailed to the vendor. The appeal
153.16 request must specify:

153.17 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
153.18 amount involved for each disputed item;

153.19 (2) the computation that the vendor believes is correct;

153.20 (3) the authority in statute or rule upon which the vendor relies for each disputed item;

153.21 (4) the name and address of the person or entity with whom contacts may be made
153.22 regarding the appeal; and

153.23 (5) other information required by the commissioner.

153.24 (f) The commissioner may order a vendor to forfeit a fine for failure to fully
153.25 document services according to standards in this chapter and Minnesota Rules, chapter
153.26 9505. Fines may be assessed when the commissioner has no evidence that services were
153.27 not provided and services are partially documented in the health service or financial
153.28 record, but specific required components of documentation are missing. The fine for
153.29 incomplete documentation shall equal 20 percent of the amount paid on the claims for
153.30 reimbursement submitted by the vendor, or up to \$5,000, whichever is less.

153.31 (g) The vendor shall pay the fine assessed on or before the payment date specified. If
153.32 the vendor fails to pay the fine, the commissioner may withhold or reduce payments and
153.33 recover the amount of the fine. A timely appeal shall stay payment of the fine until the
153.34 commissioner issues a final order.

153.35 Sec. 9. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to read:

- 154.1 Subd. 21. **Requirements for initial enrollment of personal care assistance**
154.2 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
154.3 time of enrollment as a personal care assistance provider agency in a format determined
154.4 by the commissioner, information and documentation that includes, but is not limited to,
154.5 the following:
- 154.6 (1) the personal care assistance provider agency's current contact information
154.7 including address, telephone number, and e-mail address;
- 154.8 (2) proof of surety bond coverage in the amount of ~~\$50,000~~ \$100,000 or ten percent
154.9 of the provider's payments from Medicaid in the previous year, whichever is less more.
154.10 The performance bond must be in a form approved by the commissioner, must be renewed
154.11 annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;
- 154.12 (3) proof of fidelity bond coverage in the amount of \$20,000;
- 154.13 (4) proof of workers' compensation insurance coverage;
- 154.14 (5) proof of liability insurance;
- 154.15 (6) a description of the personal care assistance provider agency's organization
154.16 identifying the names of all owners, managing employees, staff, board of directors, and
154.17 the affiliations of the directors, owners, or staff to other service providers;
- 154.18 (7) a copy of the personal care assistance provider agency's written policies and
154.19 procedures including: hiring of employees; training requirements; service delivery;
154.20 and employee and consumer safety including process for notification and resolution
154.21 of consumer grievances, identification and prevention of communicable diseases, and
154.22 employee misconduct;
- 154.23 (8) copies of all other forms the personal care assistance provider agency uses in
154.24 the course of daily business including, but not limited to:
- 154.25 (i) a copy of the personal care assistance provider agency's time sheet if the time
154.26 sheet varies from the standard time sheet for personal care assistance services approved
154.27 by the commissioner, and a letter requesting approval of the personal care assistance
154.28 provider agency's nonstandard time sheet;
- 154.29 (ii) the personal care assistance provider agency's template for the personal care
154.30 assistance care plan; and
- 154.31 (iii) the personal care assistance provider agency's template for the written
154.32 agreement in subdivision 20 for recipients using the personal care assistance choice
154.33 option, if applicable;
- 154.34 (9) a list of all training and classes that the personal care assistance provider agency
154.35 requires of its staff providing personal care assistance services;

155.1 (10) documentation that the personal care assistance provider agency and staff have
155.2 successfully completed all the training required by this section;

155.3 (11) documentation of the agency's marketing practices;

155.4 (12) disclosure of ownership, leasing, or management of all residential properties
155.5 that is used or could be used for providing home care services;

155.6 (13) documentation that the agency will use the following percentages of revenue
155.7 generated from the medical assistance rate paid for personal care assistance services
155.8 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
155.9 personal care assistance choice option and 72.5 percent of revenue from other personal
155.10 care assistance providers. The revenue generated by the qualified professional and the
155.11 reasonable costs associated with the qualified professional shall not be used in making
155.12 this calculation; and

155.13 (14) effective May 15, 2010, documentation that the agency does not burden
155.14 recipients' free exercise of their right to choose service providers by requiring personal
155.15 care assistants to sign an agreement not to work with any particular personal care
155.16 assistance recipient or for another personal care assistance provider agency after leaving
155.17 the agency and that the agency is not taking action on any such agreements or requirements
155.18 regardless of the date signed.

155.19 (b) Personal care assistance provider agencies shall provide the information specified
155.20 in paragraph (a) to the commissioner at the time the personal care assistance provider
155.21 agency enrolls as a vendor or upon request from the commissioner. The commissioner
155.22 shall collect the information specified in paragraph (a) from all personal care assistance
155.23 providers beginning July 1, 2009.

155.24 (c) All personal care assistance provider agencies shall require all employees in
155.25 management and supervisory positions and owners of the agency who are active in the
155.26 day-to-day management and operations of the agency to complete mandatory training
155.27 as determined by the commissioner before enrollment of the agency as a provider.
155.28 Employees in management and supervisory positions and owners who are active in
155.29 the day-to-day operations of an agency who have completed the required training as
155.30 an employee with a personal care assistance provider agency do not need to repeat
155.31 the required training if they are hired by another agency, if they have completed the
155.32 training within the past three years. By September 1, 2010, the required training must
155.33 be available with meaningful access according to title VI of the Civil Rights Act and
155.34 federal regulations adopted under that law or any guidance from the United States Health
155.35 and Human Services Department. The required training must be available online or by
155.36 electronic remote connection. The required training must provide for competency testing.

156.1 Personal care assistance provider agency billing staff shall complete training about
156.2 personal care assistance program financial management. This training is effective July 1,
156.3 2009. Any personal care assistance provider agency enrolled before that date shall, if it
156.4 has not already, complete the provider training within 18 months of July 1, 2009. Any new
156.5 owners or employees in management and supervisory positions involved in the day-to-day
156.6 operations are required to complete mandatory training as a requisite of working for the
156.7 agency. Personal care assistance provider agencies certified for participation in Medicare
156.8 as home health agencies are exempt from the training required in this subdivision. When
156.9 available, Medicare-certified home health agency owners, supervisors, or managers must
156.10 successfully complete the competency test.

156.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

156.12 **ARTICLE 6**

156.13 **HEALTH CARE**

156.14 Section 1. Minnesota Statutes 2012, section 256.9657, subdivision 2, is amended to read:

156.15 Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota
156.16 hospital except facilities of the federal Indian Health Service and regional treatment
156.17 centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net
156.18 patient revenues excluding net Medicare revenues reported by that provider to the health
156.19 care cost information system according to the schedule in subdivision 4.

156.20 (b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56
156.21 percent.

156.22 (c) Effective July 1, 2013, the surcharge under paragraph (b) is increased to 2.68
156.23 percent for all nongovernment-owned hospitals.

156.24 (d) Notwithstanding the Medicare cost finding and allowable cost principles, the
156.25 hospital surcharge is not an allowable cost for purposes of rate setting under sections
156.26 256.9685 to 256.9695.

156.27 **EFFECTIVE DATE.** This section is effective July 1, 2013.

156.28 Sec. 2. Minnesota Statutes 2012, section 256.9685, subdivision 2, is amended to read:

156.29 Subd. 2. **Federal requirements.** (a) If it is determined that a provision of this
156.30 section or section 256.9686, 256.969, or 256.9695 conflicts with existing or future
156.31 requirements of the United States government with respect to federal financial participation
156.32 in medical assistance, the federal requirements prevail. The commissioner may, in the
156.33 aggregate, prospectively and retrospectively, reduce payment rates and payments to avoid

157.1 reduced federal financial participation resulting from rates and payments determined by
 157.2 the commissioner that are in excess of the Medicare upper payment limitations.

157.3 (b) For rates and payments determined by the commissioner to be in excess of the
 157.4 Medicare upper payment limits for the nongovernment-owned limit category, rates and
 157.5 payments shall be reduced to the limits according to clauses (1) to (4):

157.6 (1) rates and payments under section 256.969, subdivision 3a, paragraph (j), shall be
 157.7 reduced proportionately;

157.8 (2) if rates and payments remain above the limit, medical education payments under
 157.9 section 62J.692, subdivision 8, shall be the first reduction for the government-owned
 157.10 limit category;

157.11 (3) if rates and payments remain above the limit, rates and payments not included
 157.12 under clause (1) shall be reduced in total; and

157.13 (4) the state share of payments under clauses (1) and (2) shall be returned to the
 157.14 hospital.

157.15 Sec. 3. Minnesota Statutes 2012, section 256.969, subdivision 3a, is amended to read:

157.16 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
 157.17 assistance program must not be submitted until the recipient is discharged. However,
 157.18 the commissioner shall establish monthly interim payments for inpatient hospitals that
 157.19 have individual patient lengths of stay over 30 days regardless of diagnostic category.
 157.20 Except as provided in section 256.9693, medical assistance reimbursement for treatment
 157.21 of mental illness shall be reimbursed based on diagnostic classifications. Individual
 157.22 hospital payments established under this section and sections 256.9685, 256.9686, and
 157.23 256.9695, in addition to third-party and recipient liability, for discharges occurring during
 157.24 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
 157.25 inpatient services paid for the same period of time to the hospital. ~~This payment limitation~~
 157.26 ~~shall be calculated separately for medical assistance and general assistance medical~~
 157.27 ~~care services. The limitation on general assistance medical care shall be effective for~~
 157.28 ~~admissions occurring on or after July 1, 1991.~~ Services that have rates established under
 157.29 subdivision 11 or 12, must be limited separately from other services. After consulting with
 157.30 the affected hospitals, the commissioner may consider related hospitals one entity and
 157.31 may merge the payment rates while maintaining separate provider numbers. The operating
 157.32 and property base rates per admission or per day shall be derived from the best Medicare
 157.33 and claims data available when rates are established. The commissioner shall determine
 157.34 the best Medicare and claims data, taking into consideration variables of recency of the
 157.35 data, audit disposition, settlement status, and the ability to set rates in a timely manner.

158.1 The commissioner shall notify hospitals of payment rates by December 1 of the year
158.2 preceding the rate year. The rate setting data must reflect the admissions data used to
158.3 establish relative values. Base year changes from 1981 to the base year established for the
158.4 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
158.5 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
158.6 1. The commissioner may adjust base year cost, relative value, and case mix index data
158.7 to exclude the costs of services that have been discontinued by the October 1 of the year
158.8 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
158.9 that encompass portions of two or more rate years shall have payments established based
158.10 on payment rates in effect at the time of admission unless the date of admission preceded
158.11 the rate year in effect by six months or more. In this case, operating payment rates for
158.12 services rendered during the rate year in effect and established based on the date of
158.13 admission shall be adjusted to the rate year in effect by the hospital cost index.

158.14 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
158.15 payment, before third-party liability and spenddown, made to hospitals for inpatient
158.16 services is reduced by .5 percent from the current statutory rates.

158.17 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
158.18 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
158.19 before third-party liability and spenddown, is reduced five percent from the current
158.20 statutory rates. Mental health services within diagnosis related groups 424 to 432, and
158.21 facilities defined under subdivision 16 are excluded from this paragraph.

158.22 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
158.23 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
158.24 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
158.25 from the current statutory rates. Mental health services within diagnosis related groups
158.26 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
158.27 ~~Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical~~
158.28 ~~assistance does not include general assistance medical care.~~ Payments made to managed
158.29 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
158.30 this reduction.

158.31 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
158.32 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
158.33 to hospitals for inpatient services before third-party liability and spenddown, is reduced
158.34 3.46 percent from the current statutory rates. Mental health services with diagnosis related
158.35 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this

159.1 paragraph. Payments made to managed care plans shall be reduced for services provided
159.2 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

159.3 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
159.4 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
159.5 to hospitals for inpatient services before third-party liability and spenddown, is reduced
159.6 1.9 percent from the current statutory rates. Mental health services with diagnosis related
159.7 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
159.8 paragraph. Payments made to managed care plans shall be reduced for services provided
159.9 on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

159.10 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
159.11 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
159.12 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
159.13 from the current statutory rates. Mental health services with diagnosis related groups
159.14 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
159.15 Payments made to managed care plans shall be reduced for services provided on or after
159.16 July 1, 2011, to reflect this reduction.

159.17 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
159.18 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
159.19 hospitals for inpatient services before third-party liability and spenddown, is reduced
159.20 one percent from the current statutory rates. Facilities defined under subdivision 16 are
159.21 excluded from this paragraph. Payments made to managed care plans shall be reduced for
159.22 services provided on or after October 1, 2009, to reflect this reduction.

159.23 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
159.24 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
159.25 hospitals for inpatient services before third-party liability and spenddown, is reduced
159.26 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are
159.27 excluded from this paragraph. Payments made to managed care plans shall be reduced for
159.28 services provided on or after January 1, 2011, to reflect this reduction.

159.29 (j) In order to offset the rateable reductions provided for in this subdivision, the total
159.30 payment rate for medical assistance admissions for nongovernment-owned hospitals
159.31 occurring on or after July 1, 2013, made to Minnesota hospitals for inpatient services
159.32 before third-party liability and spenddown, shall be increased by 30 percent from the
159.33 current statutory rates. The commissioner shall not adjust rates paid to a prepaid health
159.34 plan under contract with the commissioner to reflect payments provided in this paragraph.
159.35 The commissioner shall adjust rates and payments in excess of the Medicare upper limits
159.36 on payments according to section 256.9685, subdivision 2.

160.1 **EFFECTIVE DATE.** This section is effective July 1, 2013.

160.2 Sec. 4. Minnesota Statutes 2012, section 256.969, subdivision 29, is amended to read:

160.3 Subd. 29. **Reimbursement for the fee increase for the early hearing detection**
160.4 **and intervention program.** (a) For admissions occurring on or after July 1, 2010,
160.5 payment rates shall be adjusted to include the increase to the fee that is effective on July 1,
160.6 2010, for the early hearing detection and intervention program recipients under section
160.7 144.125, subdivision 1, that is paid by the hospital for public program recipients. This
160.8 payment increase shall be in effect until the increase is fully recognized in the base year
160.9 cost under subdivision 2b. This payment shall be included in payments to contracted
160.10 managed care organizations.

160.11 (b) For admissions occurring on or after July 1, 2013, payment rates shall be
160.12 adjusted to include the increase to the fee that is effective July 1, 2013, for the early
160.13 hearing detection and intervention program recipients under section 144.125, subdivision
160.14 1, that is paid by the hospital for public program recipients. This payment increase shall
160.15 be in effect until the increase is fully recognized in the base year cost under subdivision
160.16 2b. This payment shall be included in payments to contracted managed care organizations.

160.17 Sec. 5. Minnesota Statutes 2012, section 256B.055, subdivision 14, is amended to read:

160.18 Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an
160.19 inmate of a correctional facility who is conditionally released as authorized under section
160.20 241.26, 244.065, or 631.425, if the individual does not require the security of a public
160.21 detention facility and is housed in a halfway house or community correction center, or
160.22 under house arrest and monitored by electronic surveillance in a residence approved
160.23 by the commissioner of corrections, and if the individual meets the other eligibility
160.24 requirements of this chapter.

160.25 (b) An individual who is enrolled in medical assistance, and who is charged with a
160.26 crime and incarcerated for less than 12 months shall be suspended from eligibility at the
160.27 time of incarceration until the individual is released. Upon release, medical assistance
160.28 eligibility is reinstated without reapplication using a reinstatement process and form, if the
160.29 individual is otherwise eligible.

160.30 (c) An individual, regardless of age, who is considered an inmate of a public
160.31 institution as defined in Code of Federal Regulations, title 42, section 435.1010, and
160.32 who meets the eligibility requirements in section 256B.056, is not eligible for medical
160.33 assistance, except for covered services received while an inpatient in a medical institution
160.34 as defined in the Code of Federal Regulations, title 42, section 435.1010. Security issues

161.1 related to the inpatient treatment of an inmate are the responsibility of the entity with
161.2 jurisdiction over the inmate.

161.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

161.4 Sec. 6. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

161.5 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
161.6 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
161.7 other persons residing lawfully in the United States. Citizens or nationals of the United
161.8 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
161.9 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
161.10 Public Law 109-171.

161.11 (b) "Qualified noncitizen" means a person who meets one of the following
161.12 immigration criteria:

161.13 (1) admitted for lawful permanent residence according to United States Code, title 8;

161.14 (2) admitted to the United States as a refugee according to United States Code,
161.15 title 8, section 1157;

161.16 (3) granted asylum according to United States Code, title 8, section 1158;

161.17 (4) granted withholding of deportation according to United States Code, title 8,
161.18 section 1253(h);

161.19 (5) paroled for a period of at least one year according to United States Code, title 8,
161.20 section 1182(d)(5);

161.21 (6) granted conditional entrant status according to United States Code, title 8,
161.22 section 1153(a)(7);

161.23 (7) determined to be a battered noncitizen by the United States Attorney General
161.24 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
161.25 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

161.26 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
161.27 States Attorney General according to the Illegal Immigration Reform and Immigrant
161.28 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
161.29 Public Law 104-200; or

161.30 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
161.31 Law 96-422, the Refugee Education Assistance Act of 1980.

161.32 (c) All qualified noncitizens who were residing in the United States before August
161.33 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
161.34 medical assistance with federal financial participation.

162.1 (d) Beginning December 1, 1996, qualified noncitizens who entered the United
162.2 States on or after August 22, 1996, and who otherwise meet the eligibility requirements
162.3 of this chapter are eligible for medical assistance with federal participation for five years
162.4 if they meet one of the following criteria:

162.5 (1) refugees admitted to the United States according to United States Code, title 8,
162.6 section 1157;

162.7 (2) persons granted asylum according to United States Code, title 8, section 1158;

162.8 (3) persons granted withholding of deportation according to United States Code,
162.9 title 8, section 1253(h);

162.10 (4) veterans of the United States armed forces with an honorable discharge for
162.11 a reason other than noncitizen status, their spouses and unmarried minor dependent
162.12 children; or

162.13 (5) persons on active duty in the United States armed forces, other than for training,
162.14 their spouses and unmarried minor dependent children.

162.15 Beginning July 1, 2010, children and pregnant women who are noncitizens
162.16 described in paragraph (b) or who are lawfully present in the United States as defined
162.17 in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet
162.18 eligibility requirements of this chapter, are eligible for medical assistance with federal
162.19 financial participation as provided by the federal Children's Health Insurance Program
162.20 Reauthorization Act of 2009, Public Law 111-3.

162.21 (e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
162.22 are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this
162.23 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
162.24 Code, title 8, section 1101(a)(15).

162.25 (f) Payment shall also be made for care and services that are furnished to noncitizens,
162.26 regardless of immigration status, who otherwise meet the eligibility requirements of
162.27 this chapter, if such care and services are necessary for the treatment of an emergency
162.28 medical condition.

162.29 (g) For purposes of this subdivision, the term "emergency medical condition" means
162.30 a medical condition that meets the requirements of United States Code, title 42, section
162.31 1396b(v).

162.32 (h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment
162.33 of an emergency medical condition are limited to the following:

162.34 (i) services delivered in an emergency room or by an ambulance service licensed
162.35 under chapter 144E that are directly related to the treatment of an emergency medical
162.36 condition;

163.1 (ii) services delivered in an inpatient hospital setting following admission from an
 163.2 emergency room or clinic for an acute emergency condition; and

163.3 (iii) follow-up services that are directly related to the original service provided
 163.4 to treat the emergency medical condition and are covered by the global payment made
 163.5 to the provider.

163.6 (2) Services for the treatment of emergency medical conditions do not include:

163.7 (i) services delivered in an emergency room or inpatient setting to treat a
 163.8 nonemergency condition;

163.9 (ii) organ transplants, stem cell transplants, and related care;

163.10 (iii) services for routine prenatal care;

163.11 (iv) continuing care, including long-term care, nursing facility services, home health
 163.12 care, adult day care, day training, or supportive living services;

163.13 (v) elective surgery;

163.14 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
 163.15 part of an emergency room visit;

163.16 (vii) preventative health care and family planning services;

163.17 ~~(viii) dialysis;~~

163.18 ~~(ix) chemotherapy or therapeutic radiation services;~~

163.19 ~~(x) (viii) rehabilitation services;~~

163.20 ~~(xi) (ix) physical, occupational, or speech therapy;~~

163.21 ~~(xii) (x) transportation services;~~

163.22 ~~(xiii) (xi) case management;~~

163.23 ~~(xiv) (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;~~

163.24 ~~(xv) (xiii) dental services;~~

163.25 ~~(xvi) (xiv) hospice care;~~

163.26 ~~(xvii) (xv) audiology services and hearing aids;~~

163.27 ~~(xviii) (xvi) podiatry services;~~

163.28 ~~(xix) (xvii) chiropractic services;~~

163.29 ~~(xx) (xviii) immunizations;~~

163.30 ~~(xxi) (xix) vision services and eyeglasses;~~

163.31 ~~(xxii) (xx) waiver services;~~

163.32 ~~(xxiii) (xxi) individualized education programs; or~~

163.33 ~~(xxiv) (xxii) chemical dependency treatment.~~

163.34 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
 163.35 nonimmigrants, or lawfully present in the United States as defined in Code of Federal
 163.36 Regulations, title 8, section 103.12, are not covered by a group health plan or health

164.1 insurance coverage according to Code of Federal Regulations, title 42, section 457.310,
164.2 and who otherwise meet the eligibility requirements of this chapter, are eligible for
164.3 medical assistance through the period of pregnancy, including labor and delivery, and 60
164.4 days postpartum, to the extent federal funds are available under title XXI of the Social
164.5 Security Act, and the state children's health insurance program.

164.6 (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation
164.7 services from a nonprofit center established to serve victims of torture and are otherwise
164.8 ineligible for medical assistance under this chapter are eligible for medical assistance
164.9 without federal financial participation. These individuals are eligible only for the period
164.10 during which they are receiving services from the center. Individuals eligible under this
164.11 paragraph shall not be required to participate in prepaid medical assistance.

164.12 (k) Notwithstanding paragraph (h), clause (2), the following services are covered as
164.13 emergency medical conditions under paragraph (f) except where coverage is prohibited
164.14 under federal law:

164.15 (1) dialysis services provided in a hospital or freestanding dialysis facility; and

164.16 (2) surgery and the administration of chemotherapy, radiation, and related services
164.17 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission
164.18 and requires surgery, chemotherapy, or radiation treatment.

164.19 **EFFECTIVE DATE.** This section is effective July 1, 2013.

164.20 Sec. 7. Minnesota Statutes 2012, section 256B.0625, subdivision 9, is amended to read:

164.21 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

164.22 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
164.23 following services:

164.24 (1) comprehensive exams, limited to once every five years;

164.25 (2) periodic exams, limited to one per year;

164.26 (3) limited exams;

164.27 (4) bitewing x-rays, limited to one per year;

164.28 (5) periapical x-rays;

164.29 (6) panoramic x-rays, limited to one every five years except (1) when medically
164.30 necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma
164.31 or (2) once every two years for patients who cannot cooperate for intraoral film due to
164.32 a developmental disability or medical condition that does not allow for intraoral film
164.33 placement;

164.34 (7) prophylaxis, limited to one per year;

164.35 (8) application of fluoride varnish, limited to one per year;

- 165.1 (9) posterior fillings, all at the amalgam rate;
- 165.2 (10) anterior fillings;
- 165.3 (11) endodontics, limited to root canals on the anterior and premolars only;
- 165.4 (12) removable prostheses, each dental arch limited to one every six years;
- 165.5 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of
- 165.6 abscesses;
- 165.7 (14) palliative treatment and sedative fillings for relief of pain; and
- 165.8 (15) full-mouth debridement, limited to one every five years.
- 165.9 (c) In addition to the services specified in paragraph (b), medical assistance
- 165.10 covers the following services for adults, if provided in an outpatient hospital setting or
- 165.11 freestanding ambulatory surgical center as part of outpatient dental surgery:
- 165.12 (1) periodontics, limited to periodontal scaling and root planing once every two years;
- 165.13 (2) general anesthesia; and
- 165.14 (3) full-mouth survey once every five years.
- 165.15 (d) Medical assistance covers medically necessary dental services for children and
- 165.16 pregnant women. The following guidelines apply:
- 165.17 (1) posterior fillings are paid at the amalgam rate;
- 165.18 (2) application of sealants are covered once every five years per permanent molar for
- 165.19 children only;
- 165.20 (3) application of fluoride varnish is covered once every six months; and
- 165.21 (4) orthodontia is eligible for coverage for children only.
- 165.22 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance
- 165.23 covers the following services for adults:
- 165.24 (1) house calls or extended care facility calls for on-site delivery of covered services;
- 165.25 (2) behavioral management when additional staff time is required to accommodate
- 165.26 behavioral challenges and sedation is not used;
- 165.27 (3) oral or IV sedation, if the covered dental service cannot be performed safely
- 165.28 without it or would otherwise require the service to be performed under general anesthesia
- 165.29 in a hospital or surgical center; and
- 165.30 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
- 165.31 no more than four times per year.

165.32 Sec. 8. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to

165.33 read:

165.34 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment

165.35 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable

166.1 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
166.2 charged to the public. The amount of payment basis must be reduced to reflect all discount
166.3 amounts applied to the charge by any provider/insurer agreement or contract for submitted
166.4 charges to medical assistance programs. The net submitted charge may not be greater
166.5 than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65,
166.6 except that the dispensing fee for intravenous solutions which must be compounded by
166.7 the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and
166.8 \$30 per bag for total parenteral nutritional products dispensed in one liter quantities,
166.9 or \$44 per bag for total parenteral nutritional products dispensed in quantities greater
166.10 than one liter. Actual acquisition cost includes quantity and other special discounts
166.11 except time and cash discounts. The actual acquisition cost of a drug shall be estimated
166.12 by the commissioner at wholesale acquisition cost plus four percent for independently
166.13 owned pharmacies located in a designated rural area within Minnesota, and at wholesale
166.14 acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently
166.15 owned" if it is one of four or fewer pharmacies under the same ownership nationally.
166.16 A "designated rural area" means an area defined as a small rural area or isolated rural
166.17 area according to the four-category classification of the Rural Urban Commuting Area
166.18 system developed for the United States Health Resources and Services Administration.
166.19 The actual acquisition cost of a drug acquired through the federal 340B Drug Pricing
166.20 Program shall be estimated by the commissioner at wholesale acquisition cost minus 44
166.21 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or
166.22 biological to wholesalers or direct purchasers in the United States, not including prompt
166.23 pay or other discounts, rebates, or reductions in price, for the most recent month for which
166.24 information is available, as reported in wholesale price guides or other publications of
166.25 drug or biological pricing data. The maximum allowable cost of a multisource drug may
166.26 be set by the commissioner and it shall be comparable to, but no higher than, the maximum
166.27 amount paid by other third-party payors in this state who have maximum allowable cost
166.28 programs. Establishment of the amount of payment for drugs shall not be subject to the
166.29 requirements of the Administrative Procedure Act.

166.30 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
166.31 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
166.32 facilities when a unit dose blister card system, approved by the department, is used. Under
166.33 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The
166.34 National Drug Code (NDC) from the drug container used to fill the blister card must be
166.35 identified on the claim to the department. The unit dose blister card containing the drug
166.36 must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that

167.1 govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will
167.2 be required to credit the department for the actual acquisition cost of all unused drugs that
167.3 are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in
167.4 a quantity that is less than a 30-day supply.

167.5 (c) Whenever a maximum allowable cost has been set for a multisource drug,
167.6 payment shall be the lower of the usual and customary price charged to the public or the
167.7 maximum allowable cost established by the commissioner unless prior authorization
167.8 for the brand name product has been granted according to the criteria established by
167.9 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the
167.10 prescriber has indicated "dispense as written" on the prescription in a manner consistent
167.11 with section 151.21, subdivision 2.

167.12 (d) The basis for determining the amount of payment for drugs administered in an
167.13 outpatient setting shall be the lower of the usual and customary cost submitted by the
167.14 provider or 106 percent of the average sales price as determined by the United States
167.15 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
167.16 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
167.17 set by the commissioner. If average sales price is unavailable, the amount of payment
167.18 must be lower of the usual and customary cost submitted by the provider or the wholesale
167.19 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the
167.20 commissioner. The commissioner shall discount the payment rate for drugs obtained
167.21 through the federal 340B Drug Pricing Program by 33 percent. The payment for drugs
167.22 administered in an outpatient setting shall be made to the administering facility or
167.23 practitioner. A retail or specialty pharmacy dispensing a drug for administration in an
167.24 outpatient setting is not eligible for direct reimbursement.

167.25 (e) The commissioner may negotiate lower reimbursement rates for specialty
167.26 pharmacy products than the rates specified in paragraph (a). The commissioner may
167.27 require individuals enrolled in the health care programs administered by the department
167.28 to obtain specialty pharmacy products from providers with whom the commissioner has
167.29 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
167.30 used by a small number of recipients or recipients with complex and chronic diseases
167.31 that require expensive and challenging drug regimens. Examples of these conditions
167.32 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
167.33 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
167.34 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
167.35 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
167.36 that require complex care. The commissioner shall consult with the formulary committee

168.1 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
168.2 with the formulary committee in developing this list, the commissioner shall take into
168.3 consideration the population served by specialty pharmacy products, the current delivery
168.4 system and standard of care in the state, and access to care issues. The commissioner shall
168.5 have the discretion to adjust the reimbursement rate to prevent access to care issues.

168.6 (f) Home infusion therapy services provided by home infusion therapy pharmacies
168.7 must be paid at rates according to subdivision 8d.

168.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

168.9 Sec. 9. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to read:

168.10 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
168.11 supplies and equipment. Separate payment outside of the facility's payment rate shall
168.12 be made for wheelchairs and wheelchair accessories for recipients who are residents
168.13 of intermediate care facilities for the developmentally disabled. Reimbursement for
168.14 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same
168.15 conditions and limitations as coverage for recipients who do not reside in institutions. A
168.16 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
168.17 The commissioner may set reimbursement rates for specified categories of medical
168.18 supplies at levels below the Medicare payment rate.

168.19 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
168.20 must enroll as a Medicare provider.

168.21 (c) When necessary to ensure access to durable medical equipment, prosthetics,
168.22 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
168.23 enrollment requirement if:

168.24 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
168.25 orthotic, or medical supply;

168.26 (2) the vendor serves ten or fewer medical assistance recipients per year;

168.27 (3) the commissioner finds that other vendors are not available to provide same or
168.28 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

168.29 (4) the vendor complies with all screening requirements in this chapter and Code of
168.30 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
168.31 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
168.32 and Medicaid Services approved national accreditation organization as complying with
168.33 the Medicare program's supplier and quality standards and the vendor serves primarily
168.34 pediatric patients.

168.35 (d) Durable medical equipment means a device or equipment that:

- 169.1 (1) can withstand repeated use;
- 169.2 (2) is generally not useful in the absence of an illness, injury, or disability; and
- 169.3 (3) is provided to correct or accommodate a physiological disorder or physical
- 169.4 condition or is generally used primarily for a medical purpose.

169.5 (e) Electronic tablets may be considered durable medical equipment if the electronic

169.6 tablet will be used as an augmentative and alternative communication system as defined

169.7 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device

169.8 must be locked in order to prevent use not related to communication.

169.9 Sec. 10. Minnesota Statutes 2012, section 256B.0625, is amended by adding a

169.10 subdivision to read:

169.11 Subd. 31b. Preferred diabetic testing supply program. (a) The commissioner

169.12 shall adopt and implement a point of sale preferred diabetic testing supply program by

169.13 January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform

169.14 to the limitations established under the program. The commissioner may enter into a

169.15 contract with a vendor for the purpose of participating in a preferred diabetic testing

169.16 supply list and supplemental rebate program. The commissioner shall ensure that any

169.17 contract meets all federal requirements and maximizes federal financial participation. The

169.18 commissioner shall maintain an accurate and up-to-date list on the agency Web site.

169.19 (b) The commissioner may add to, delete from, and otherwise modify the preferred

169.20 diabetic testing supply program drug list after consulting with the Drug Formulary

169.21 Committee and appropriate medial specialists and providing public notice and the

169.22 opportunity for public comment.

169.23 (c) The commissioner shall adopt and administer the preferred diabetic testing

169.24 supply program as part of the administration of the diabetic testing supply rebate program.

169.25 Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply

169.26 list may be subject to prior authorization.

169.27 (d) All claims for diabetic testing supplies in categories on the preferred diabetic

169.28 testing supply list must be submitted by enrolled pharmacy providers using the most

169.29 current National Council of Prescription Drug Providers electronic claims standard.

169.30 (e) For purposes of this subdivision, "preferred diabetic testing supply list" means a

169.31 list of diabetic testing supplies selected by the commissioner, for which prior authorization

169.32 is not required.

169.33 (f) The commissioner shall seek any federal waivers or approvals necessary to

169.34 implement this subdivision.

170.1 Sec. 11. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to
170.2 read:

170.3 Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines
170.4 within the scope of their licensure, and who are enrolled as a medical assistance provider,
170.5 must enroll in the pediatric vaccine administration program established by section 13631
170.6 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an~~
170.7 ~~\$8.50 fee per dose~~ for administration of the vaccine to children eligible for medical
170.8 assistance. Medical assistance does not pay for vaccines that are available at no cost from
170.9 the pediatric vaccine administration program.

170.10 Sec. 12. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to
170.11 read:

170.12 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**
170.13 Medical assistance covers early and periodic screening, diagnosis, and treatment services
170.14 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges
170.15 for vaccines that are available at no cost to the provider and shall not exceed the rate
170.16 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

170.17 Sec. 13. Minnesota Statutes 2012, section 256B.0631, subdivision 1, is amended to read:

170.18 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
170.19 assistance benefit plan shall include the following cost-sharing for all recipients, effective
170.20 for services provided on or after September 1, 2011:

170.21 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes
170.22 of this subdivision, a visit means an episode of service which is required because of
170.23 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
170.24 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
170.25 midwife, advanced practice nurse, audiologist, optician, or optometrist;

170.26 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that
170.27 this co-payment shall be increased to \$20 upon federal approval;

170.28 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
170.29 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
170.30 shall apply to antipsychotic drugs when used for the treatment of mental illness;

170.31 (4) effective January 1, 2012, a family deductible equal to the maximum amount
170.32 allowed under Code of Federal Regulations, title 42, part 447.54; and

170.33 (5) for individuals identified by the commissioner with income at or below 100
170.34 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five

171.1 percent of family income. For purposes of this paragraph, family income is the total
 171.2 earned and unearned income of the individual and the individual's spouse, if the spouse is
 171.3 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

171.4 (b) Recipients of medical assistance are responsible for all co-payments and
 171.5 deductibles in this subdivision.

171.6 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
 171.7 process under sections 256B.69 and 256B.692, may allow managed care plans and
 171.8 county-based purchasing plans to waive the family deductible under paragraph (a),
 171.9 clause (4). The value of the family deductible shall not be included in the capitation
 171.10 payment to managed care plans and county-based purchasing plans. Managed care plans
 171.11 and county-based purchasing plans shall certify annually to the commissioner the dollar
 171.12 value of the family deductible.

171.13 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of
 171.14 the family deductible described under paragraph (a), clause (4), from individuals and
 171.15 allow long-term care and waived service providers to assume responsibility for payment.

171.16 (e) Notwithstanding paragraph (b), the commissioner, through the contracting
 171.17 process under section 256B.0756 shall allow the pilot program in Hennepin County to
 171.18 waive co-payments. The value of the co-payments shall not be included in the capitation
 171.19 amount to the managed care organization.

171.20 Sec. 14. Minnesota Statutes 2012, section 256B.0756, is amended to read:

171.21 **256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.**

171.22 (a) The commissioner, upon federal approval of a new waiver request or amendment
 171.23 of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey
 171.24 County, or both, to test alternative and innovative integrated health care delivery networks.

171.25 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
 171.26 medical assistance under section 256B.055, ~~subdivision 15~~, and who reside in Hennepin
 171.27 County or Ramsey County. The commissioner may identify individuals to be enrolled in
 171.28 the Hennepin County pilot program based on zip code in Hennepin County or whether the
 171.29 individuals would benefit from an integrated health care delivery network.

171.30 (c) Individuals enrolled in the pilot program shall be enrolled in an integrated
 171.31 health care delivery network in their county of residence. The integrated health care
 171.32 delivery network in Hennepin County shall be a network, such as an accountable care
 171.33 organization or a community-based collaborative care network, created by or including
 171.34 Hennepin County Medical Center. The integrated health care delivery network in Ramsey

172.1 County shall be a network, such as an accountable care organization or community-based
172.2 collaborative care network, created by or including Regions Hospital.

172.3 ~~(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for~~
172.4 ~~Hennepin County and 3,500 enrollees for Ramsey County.~~

172.5 ~~(e)~~ (d) In developing a payment system for the pilot programs, the commissioner
172.6 shall establish a total cost of care for the recipients enrolled in the pilot programs that
172.7 equals the cost of care that would otherwise be spent for these enrollees in the prepaid
172.8 medical assistance program.

172.9 ~~(f) Counties may transfer funds necessary to support the nonfederal share of~~
172.10 ~~payments for integrated health care delivery networks in their county. Such transfers per~~
172.11 ~~county shall not exceed 15 percent of the expected expenses for county enrollees.~~

172.12 ~~(g)~~ (e) The commissioner shall apply to the federal government for, or as appropriate,
172.13 cooperate with counties, providers, or other entities that are applying for any applicable
172.14 grant or demonstration under the Patient Protection and Affordable Health Care Act, Public
172.15 Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law
172.16 111-152, that would further the purposes of or assist in the creation of an integrated health
172.17 care delivery network for the purposes of this subdivision, including, but not limited to, a
172.18 global payment demonstration or the community-based collaborative care network grants.

172.19 Sec. 15. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:

172.20 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
172.21 services shall transfer each year to the medical education and research fund established
172.22 under section 62J.692, an amount specified in this subdivision. The commissioner shall
172.23 calculate the following:

172.24 (1) an amount equal to the reduction in the prepaid medical assistance payments as
172.25 specified in this clause. Until January 1, 2002, the county medical assistance capitation
172.26 base rate prior to plan specific adjustments and after the regional rate adjustments under
172.27 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
172.28 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
172.29 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
172.30 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining
172.31 metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing
172.32 facility and elderly waiver payments and demonstration project payments operating
172.33 under subdivision 23 are excluded from this reduction. The amount calculated under
172.34 this clause shall not be adjusted for periods already paid due to subsequent changes to
172.35 the capitation payments;

173.1 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this
173.2 section;

173.3 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates
173.4 paid under this section; and

173.5 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid
173.6 under this section.

173.7 (b) This subdivision shall be effective upon approval of a federal waiver which
173.8 allows federal financial participation in the medical education and research fund. The
173.9 amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount
173.10 transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under
173.11 paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally
173.12 reduce the amount specified under paragraph (a), clause (1).

173.13 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
173.14 shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

173.15 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the
173.16 transfer under paragraph (c), the commissioner shall transfer to the medical education
173.17 research fund \$23,936,000 in fiscal years 2012 and 2013 and ~~\$36,744,000~~ \$49,552,000 in
173.18 fiscal year 2014 and thereafter.

173.19 Sec. 16. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

173.20 Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner
173.21 shall reduce payments and limit future rate increases paid to managed care plans and
173.22 county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved
173.23 on a statewide aggregate basis by program. The commissioner may use competitive
173.24 bidding, payment reductions, or other reductions to achieve the reductions and limits
173.25 in this subdivision.

173.26 (b) Beginning September 1, 2011, the commissioner shall reduce payments to
173.27 managed care plans and county-based purchasing plans as follows:

173.28 (1) 2.0 percent for medical assistance elderly basic care. This shall not apply
173.29 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
173.30 services;

173.31 (2) 2.82 percent for medical assistance families and children;

173.32 (3) 10.1 percent for medical assistance adults without children; and

173.33 (4) 6.0 percent for MinnesotaCare families and children.

174.1 (c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed
174.2 care plans and county-based purchasing plans for calendar year 2012 to a percentage of
174.3 the rates in effect on August 31, 2011, as follows:

174.4 (1) 98 percent for medical assistance elderly basic care. This shall not apply to
174.5 Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
174.6 services;

174.7 (2) 97.18 percent for medical assistance families and children;

174.8 (3) 89.9 percent for medical assistance adults without children; and

174.9 (4) 94 percent for MinnesotaCare families and children.

174.10 (d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit
174.11 the maximum annual trend increases to rates paid to managed care plans and county-based
174.12 purchasing plans as follows:

174.13 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply
174.14 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
174.15 services;

174.16 (2) 5.0 percent for medical assistance special needs basic care;

174.17 (3) 2.0 percent for medical assistance families and children;

174.18 (4) 3.0 percent for medical assistance adults without children;

174.19 (5) 3.0 percent for MinnesotaCare families and children; and

174.20 (6) 3.0 percent for MinnesotaCare adults without children.

174.21 (e) The commissioner may limit trend increases to less than the maximum.

174.22 Beginning ~~July~~ January 1, 2014, the commissioner shall limit the maximum annual trend
174.23 increases to rates paid to managed care plans and county-based purchasing plans as
174.24 follows for calendar years 2014 and 2015:

174.25 (1) ~~7.5~~ 3.25 percent for medical assistance elderly basic care. This shall not apply
174.26 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
174.27 services;

174.28 (2) ~~5.0~~ 2.5 percent for medical assistance special needs basic care;

174.29 (3) 2.0 percent for medical assistance families and children;

174.30 (4) 3.0 percent for medical assistance adults without children;

174.31 (5) 3.0 percent for MinnesotaCare families and children; and

174.32 (6) ~~4.0~~ 3.0 percent for MinnesotaCare adults without children.

174.33 The commissioner may limit trend increases to less than the maximum.

174.34 Sec. 17. Minnesota Statutes 2012, section 256B.76, subdivision 2, is amended to read:

175.1 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after
175.2 October 1, 1992, the commissioner shall make payments for dental services as follows:

175.3 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
175.4 percent above the rate in effect on June 30, 1992; and

175.5 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
175.6 percentile of 1989, less the percent in aggregate necessary to equal the above increases.

175.7 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
175.8 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

175.9 (c) Effective for services rendered on or after January 1, 2000, payment rates for
175.10 dental services shall be increased by three percent over the rates in effect on December
175.11 31, 1999.

175.12 (d) Effective for services provided on or after January 1, 2002, payment for
175.13 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
175.14 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

175.15 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
175.16 2000, for managed care.

175.17 (f) Effective for dental services rendered on or after October 1, 2010, by a
175.18 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
175.19 on the Medicare principles of reimbursement. This payment shall be effective for services
175.20 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
175.21 county-based purchasing plans.

175.22 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
175.23 in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal
175.24 year, a supplemental state payment equal to the difference between the total payments
175.25 in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated
175.26 services for the operation of the dental clinics.

175.27 (h) If the cost-based payment system for state-operated dental clinics described in
175.28 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
175.29 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
175.30 receive the critical access dental reimbursement rate as described under subdivision 4,
175.31 paragraph (a).

175.32 (i) Effective for services rendered on or after September 1, 2011, through June 30,
175.33 2013, payment rates for dental services shall be reduced by three percent. This reduction
175.34 does not apply to state-operated dental clinics in paragraph (f).

175.35 (j) Effective for services rendered on or after January 1, 2014, payment rates for
175.36 dental services shall be increased by five percent from the rates in effect on December

176.1 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
 176.2 federally qualified health centers, rural health centers, and Indian health services. Effective
 176.3 January 1, 2014, payments made to managed care plans and county-based purchasing
 176.4 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
 176.5 described in this paragraph.

176.6 Sec. 18. Minnesota Statutes 2012, section 256B.76, subdivision 4, is amended to read:

176.7 Subd. 4. **Critical access dental providers.** (a) Effective for dental services
 176.8 rendered on or after January 1, 2002, the commissioner shall increase reimbursements
 176.9 to dentists and dental clinics deemed by the commissioner to be critical access dental
 176.10 providers. For dental services rendered on or after July 1, 2007, the commissioner shall
 176.11 increase reimbursement by 30 percent above the reimbursement rate that would otherwise
 176.12 be paid to the critical access dental provider. The commissioner shall pay the managed
 176.13 care plans and county-based purchasing plans in amounts sufficient to reflect increased
 176.14 reimbursements to critical access dental providers as approved by the commissioner.

176.15 (b) The commissioner shall designate the following dentists and dental clinics as
 176.16 critical access dental providers:

176.17 (1) nonprofit community clinics that:

176.18 (i) have nonprofit status in accordance with chapter 317A;

176.19 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
 176.20 501(c)(3);

176.21 (iii) are established to provide oral health services to patients who are low income,
 176.22 uninsured, have special needs, and are underserved;

176.23 (iv) have professional staff familiar with the cultural background of the clinic's
 176.24 patients;

176.25 (v) charge for services on a sliding fee scale designed to provide assistance to
 176.26 low-income patients based on current poverty income guidelines and family size;

176.27 (vi) do not restrict access or services because of a patient's financial limitations
 176.28 or public assistance status; and

176.29 (vii) have free care available as needed;

176.30 (2) federally qualified health centers, rural health clinics, and public health clinics;

176.31 (3) city or county owned and operated hospital-based dental clinics;

176.32 (4) a dental clinic or dental group that is part of a dental group owned and operated
 176.33 by a nonprofit corporation in accordance with chapter 317A with more than 10,000 dental
 176.34 group patient encounters per year with patients who are uninsured or covered by medical
 176.35 assistance, general assistance medical care, or MinnesotaCare, if more than 50 percent

177.1 of the individual dental clinic's patient encounters per year are with patients who are
177.2 uninsured or covered by medical assistance or MinnesotaCare; and

177.3 (5) a dental clinic owned and operated by the University of Minnesota or the
177.4 Minnesota State Colleges and Universities system; and

177.5 (6) private practicing dentists if:

177.6 (i) the dentist's office is located within a health professional shortage area as defined
177.7 under Code of Federal Regulations, title 42, part 5, and United States Code, title 42,
177.8 section 254E;

177.9 (ii) more than 50 percent of the dentist's patient encounters per year are with patients
177.10 who are uninsured or covered by medical assistance or MinnesotaCare;

177.11 (iii) the dentist does not restrict access or services because of a patient's financial
177.12 limitations or public assistance status; and

177.13 (iv) the level of service provided by the dentist is critical to maintaining adequate
177.14 levels of patient access within the service area in which the dentist operates.

177.15 (c) The commissioner may designate a dentist or dental clinic as a critical access
177.16 dental provider if the dentist or dental clinic is willing to provide care to patients covered
177.17 by medical assistance, general assistance medical care, or MinnesotaCare at a level which
177.18 significantly increases access to dental care in the service area.

177.19 (d) A designated critical access clinic shall receive the reimbursement rate specified
177.20 in paragraph (a) for dental services provided off site at a private dental office if the
177.21 following requirements are met:

177.22 (1) the designated critical access dental clinic is located within a health professional
177.23 shortage area as defined under Code of Federal Regulations, title 42, part 5, and United
177.24 States Code, title 42, section 254E, and is located outside the seven-county metropolitan
177.25 area;

177.26 (2) the designated critical access dental clinic is not able to provide the service
177.27 and refers the patient to the off-site dentist;

177.28 (3) the service, if provided at the critical access dental clinic, would be reimbursed
177.29 at the critical access reimbursement rate;

177.30 (4) the dentist and allied dental professionals providing the services off site are
177.31 licensed and in good standing under chapter 150A;

177.32 (5) the dentist providing the services is enrolled as a medical assistance provider;

177.33 (6) the critical access dental clinic submits the claim for services provided off site
177.34 and receives the payment for the services; and

178.1 (7) the critical access dental clinic maintains dental records for each claim submitted
178.2 under this paragraph, including the name of the dentist, the off-site location, and the
178.3 license number of the dentist and allied dental professionals providing the services.

178.4 Sec. 19. Minnesota Statutes 2012, section 256B.76, is amended by adding a
178.5 subdivision to read:

178.6 **Subd. 7. Payment for certain primary care services and immunization**
178.7 **administration.** Payment for certain primary care services and immunization
178.8 administration services rendered on or after January 1, 2013, through December 31, 2014,
178.9 shall be made in accordance with section 1902(a)(13) of the Social Security Act.

178.10 Sec. 20. Minnesota Statutes 2012, section 256B.764, is amended to read:

178.11 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

178.12 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
178.13 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,
178.14 when these services are provided by a community clinic as defined in section 145.9268,
178.15 subdivision 1.

178.16 (b) Effective for services rendered on or after July 1, 2013, payment rates for
178.17 family planning services shall be increased by 20 percent over the rates in effect June
178.18 30, 2013, when these services are provided by a community clinic as defined in section
178.19 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care
178.20 and county-based purchasing plans to reflect this increase, and shall require plans to pass
178.21 on the full amount of the rate increase to eligible community clinics, in the form of higher
178.22 payment rates for family planning services.

178.23 **EFFECTIVE DATE.** This section is effective July 1, 2013.

178.24 Sec. 21. Minnesota Statutes 2012, section 256B.766, is amended to read:

178.25 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

178.26 (a) Effective for services provided on or after July 1, 2009, total payments for basic
178.27 care services, shall be reduced by three percent, except that for the period July 1, 2009,
178.28 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
178.29 assistance and general assistance medical care programs, prior to third-party liability and
178.30 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
178.31 therapy services, occupational therapy services, and speech-language pathology and
178.32 related services as basic care services. The reduction in this paragraph shall apply to

179.1 physical therapy services, occupational therapy services, and speech-language pathology
179.2 and related services provided on or after July 1, 2010.

179.3 (b) Payments made to managed care plans and county-based purchasing plans shall
179.4 be reduced for services provided on or after October 1, 2009, to reflect the reduction
179.5 effective July 1, 2009, and payments made to the plans shall be reduced effective October
179.6 1, 2010, to reflect the reduction effective July 1, 2010.

179.7 (c) Effective for services provided on or after September 1, 2011, through June 30,
179.8 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
179.9 from the rates in effect on August 31, 2011.

179.10 (d) Effective for services provided on or after September 1, 2011, through June
179.11 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
179.12 and durable medical equipment not subject to a volume purchase contract, prosthetics
179.13 and orthotics, renal dialysis services, laboratory services, public health nursing services,
179.14 physical therapy services, occupational therapy services, speech therapy services,
179.15 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
179.16 purchase contract, anesthesia services, and hospice services shall be reduced by three
179.17 percent from the rates in effect on August 31, 2011.

179.18 (e) This section does not apply to physician and professional services, inpatient
179.19 hospital services, family planning services, mental health services, dental services,
179.20 prescription drugs, medical transportation, federally qualified health centers, rural health
179.21 centers, Indian health services, and Medicare cost-sharing.

179.22 (f) For services provided on or after July 1, 2013, fee-for-service payments made
179.23 to pediatric hospitals as referenced in the Social Security Act, section 1886(d)(1)(B)(iii)
179.24 and nonstate government hospitals located in cities of the first class for the provision of
179.25 outpatient basic care services to persons under age 21 shall be increased by one percent,
179.26 subject to an aggregate spending limit under this paragraph of \$450,000 for the biennium
179.27 ending June 30, 2015.

179.28 Sec. 22. **PAYMENT FOR MULTIPLE SERVICES PROVIDED ON THE SAME**
179.29 **DAY.**

179.30 The commissioner of human services shall report by December 15, 2013, to the
179.31 chairs and ranking minority members of the legislative committees with jurisdiction over
179.32 health and human services policy and finance on the costs and savings to the medical
179.33 assistance program of allowing medical assistance payment, including supplemental
179.34 payments, for mental health services or dental services provided to a patient by a federally

180.1 qualified health center, federally qualified health care center look-alike, or a rural health
180.2 clinic on the same day as other covered health services furnished by the same provider.

180.3 **Sec. 23. DENTAL ADMINISTRATION AND REIMBURSEMENT REPORT.**

180.4 (a) The commissioner of human services shall study the feasibility of a single
180.5 administrator for all dental services provided under medical assistance and MinnesotaCare.
180.6 Dental services shall include services provided through the prepaid medical assistance
180.7 program and the fee-for-service system administered by the Department of Human
180.8 Services. The commissioner's study shall address and include recommendations on:

180.9 (1) possible administrative savings under a single administrator;

180.10 (2) current reimbursement levels and alternative reimbursement that could target
180.11 funding to assure greater access to dental services;

180.12 (3) flexible scheduling and the coordination of referrals to encourage greater
180.13 participation from private dental practitioners and clinics;

180.14 (4) approaches to reduce emergency room visits; and

180.15 (5) the use of a streamlined information system to provide information on patient
180.16 eligibility and restrictions on benefits.

180.17 (b) The commissioner shall also make recommendations on service delivery and
180.18 reimbursement methods, including the continuation or modification of critical access dental
180.19 provider payments under sections 256B.76, subdivision 4, and 256L.11, subdivision 7.

180.20 (c) In conducting the study, the commissioner shall consult with dental providers
180.21 currently providing services to enrollees of Minnesota health care programs, including
180.22 those receiving enhanced payments through critical access dental provider payments,
180.23 private practice dentists, safety net clinics, and the University of Minnesota Dental School.

180.24 (d) The commissioner shall submit a report and recommendations relating to dental
180.25 administration and reimbursement to the chairs and ranking minority members of the
180.26 legislative committees with jurisdiction over health and human services policy and finance
180.27 by December 15, 2013.

180.28 **Sec. 24. REQUEST FOR INFORMATION; EMERGENCY MEDICAL**
180.29 **ASSISTANCE.**

180.30 (a) The commissioner of human services shall issue a request for information (RFI)
180.31 to identify and develop options for a program to provide emergency medical assistance
180.32 recipients with coverage for medically necessary services not eligible for federal financial
180.33 participation. The RFI must focus on providing coverage for nonemergent services

181.1 for recipients who have two or more chronic conditions and have had two or more
181.2 hospitalizations covered by emergency medical assistance in a one-year period.

181.3 (b) The RFI must be issued by August 1, 2013, and require respondents to submit
181.4 information to the commissioner by November 1, 2013. The RFI must request information
181.5 on:

181.6 (1) services necessary to reduce emergency department and inpatient hospital use for
181.7 emergency medical assistance recipients;

181.8 (2) methods of service delivery that promote efficiency and cost-effectiveness, and
181.9 provide statewide access;

181.10 (3) funding options for the services to be covered under the program;

181.11 (4) coordination of service delivery and funding with services covered under
181.12 emergency medical assistance;

181.13 (5) options for program administration; and

181.14 (6) methods to evaluate the program, including evaluation of cost-effectiveness and
181.15 health outcomes for those emergency medical assistance recipients eligible for coverage
181.16 of additional services under the program.

181.17 (c) The commissioner shall make information submitted in response to the RFI
181.18 available on the agency Web site. The commissioner, based on the responses to the RFI,
181.19 shall submit recommendations on providing emergency medical assistance recipients
181.20 with coverage for nonemergent services, as described in paragraph (a), to the chairs and
181.21 ranking minority members of the legislative committees with jurisdiction over health and
181.22 human services policy and finance by January 15, 2014.

181.23 **ARTICLE 7**

181.24 **CONTINUING CARE**

181.25 Section 1. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

181.26 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
181.27 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
181.28 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
181.29 9555.6265, under this chapter for a physical location that will not be the primary residence
181.30 of the license holder for the entire period of licensure. If a license is issued during this
181.31 moratorium, and the license holder changes the license holder's primary residence away
181.32 from the physical location of the foster care license, the commissioner shall revoke the
181.33 license according to section 245A.07. Exceptions to the moratorium include:

181.34 (1) foster care settings that are required to be registered under chapter 144D;

182.1 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
182.2 and determined to be needed by the commissioner under paragraph (b);

182.3 (3) new foster care licenses determined to be needed by the commissioner under
182.4 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or
182.5 restructuring of state-operated services that limits the capacity of state-operated facilities;

182.6 (4) new foster care licenses determined to be needed by the commissioner under
182.7 paragraph (b) for persons requiring hospital level care; or

182.8 (5) new foster care licenses determined to be needed by the commissioner for the
182.9 transition of people from personal care assistance to the home and community-based
182.10 services.

182.11 (b) The commissioner shall determine the need for newly licensed foster care homes
182.12 as defined under this subdivision. As part of the determination, the commissioner shall
182.13 consider the availability of foster care capacity in the area in which the licensee seeks to
182.14 operate, and the recommendation of the local county board. The determination by the
182.15 commissioner must be final. A determination of need is not required for a change in
182.16 ownership at the same address.

182.17 ~~(e) The commissioner shall study the effects of the license moratorium under this~~
182.18 ~~subdivision and shall report back to the legislature by January 15, 2011. This study shall~~
182.19 ~~include, but is not limited to the following:~~

182.20 ~~(1) the overall capacity and utilization of foster care beds where the physical location~~
182.21 ~~is not the primary residence of the license holder prior to and after implementation~~
182.22 ~~of the moratorium;~~

182.23 ~~(2) the overall capacity and utilization of foster care beds where the physical~~
182.24 ~~location is the primary residence of the license holder prior to and after implementation~~
182.25 ~~of the moratorium; and~~

182.26 ~~(3) the number of licensed and occupied ICF/MR beds prior to and after~~
182.27 ~~implementation of the moratorium.~~

182.28 ~~(d)~~ (c) When a foster care recipient moves out of a foster home that is not the
182.29 primary residence of the license holder according to section 256B.49, subdivision 15,
182.30 paragraph (f), the county shall immediately inform the Department of Human Services
182.31 Licensing Division. The department shall decrease the statewide licensed capacity for
182.32 foster care settings where the physical location is not the primary residence of the license
182.33 holder, if the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the
182.34 savings required by reductions in licensed bed capacity under Laws 2011, First Special
182.35 Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide
182.36 long-term care residential services capacity within budgetary limits. Implementation of

183.1 the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner
183.2 shall delicense up to 128 beds by June 30, 2014, using the needs determination process.
183.3 Under this paragraph, the commissioner has the authority to reduce unused licensed
183.4 capacity of a current foster care program to accomplish the consolidation or closure of
183.5 settings. A decreased licensed capacity according to this paragraph is not subject to appeal
183.6 under this chapter.

183.7 ~~(e)~~ (d) Residential settings that would otherwise be subject to the decreased license
183.8 capacity established in paragraph ~~(d)~~ (c) shall be exempt under the following circumstances:

183.9 (1) until August 1, 2013, the license holder's beds occupied by residents whose
183.10 primary diagnosis is mental illness and the license holder is:

183.11 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
183.12 health services (ARMHS) as defined in section 256B.0623;

183.13 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
183.14 9520.0870;

183.15 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
183.16 9520.0870; or

183.17 (iv) a provider of intensive residential treatment services (IRTS) licensed under
183.18 Minnesota Rules, parts 9520.0500 to 9520.0670; or

183.19 (2) the license holder is certified under the requirements in subdivision 6a.

183.20 ~~(f)~~ (e) A resource need determination process, managed at the state level, using the
183.21 available reports required by section 144A.351, and other data and information shall
183.22 be used to determine where the reduced capacity required under paragraph ~~(d)~~ (c) will
183.23 be implemented. The commissioner shall consult with the stakeholders described in
183.24 section 144A.351, and employ a variety of methods to improve the state's capacity to
183.25 meet long-term care service needs within budgetary limits, including seeking proposals
183.26 from service providers or lead agencies to change service type, capacity, or location to
183.27 improve services, increase the independence of residents, and better meet needs identified
183.28 by the long-term care services reports and statewide data and information. By February
183.29 1 of ~~each~~ 2013 and August 1 of 2014 and each following year, the commissioner shall
183.30 provide information and data on the overall capacity of licensed long-term care services,
183.31 actions taken under this subdivision to manage statewide long-term care services and
183.32 supports resources, and any recommendations for change to the legislative committees
183.33 with jurisdiction over health and human services budget.

183.34 ~~(g)~~ (f) At the time of application and reapplication for licensure, the applicant and the
183.35 license holder that are subject to the moratorium or an exclusion established in paragraph
183.36 (a) are required to inform the commissioner whether the physical location where the foster

184.1 care will be provided is or will be the primary residence of the license holder for the entire
184.2 period of licensure. If the primary residence of the applicant or license holder changes, the
184.3 applicant or license holder must notify the commissioner immediately. The commissioner
184.4 shall print on the foster care license certificate whether or not the physical location is the
184.5 primary residence of the license holder.

184.6 ~~(h)~~ (g) License holders of foster care homes identified under paragraph ~~(g)~~ (f) that
184.7 are not the primary residence of the license holder and that also provide services in the
184.8 foster care home that are covered by a federally approved home and community-based
184.9 services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must
184.10 inform the human services licensing division that the license holder provides or intends to
184.11 provide these waiver-funded services. These license holders must be considered registered
184.12 under section 256B.092, subdivision 11, paragraph (c), and this registration status must
184.13 be identified on their license certificates.

184.14 Sec. 2. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
184.15 to read:

184.16 **Subd. 35. Commissioner must annually report certain prepaid medical**
184.17 **assistance plan data.** (a) The commissioner of human services and the commissioner
184.18 of education may share private or nonpublic data to allow the commissioners to analyze
184.19 the screening, diagnosis, and treatment of children with autism spectrum disorder and
184.20 other developmental conditions. The commissioners may share the individual-level data
184.21 necessary to:

184.22 (1) measure the prevalence of autism spectrum disorder and other developmental
184.23 conditions;

184.24 (2) analyze the effectiveness of existing policies and procedures in the early
184.25 identification of children with autism spectrum disorder and other developmental
184.26 conditions;

184.27 (3) assess the effectiveness of screening, diagnosis, and treatment to allow children
184.28 with autism spectrum disorder and other developmental conditions to meet developmental
184.29 and social-emotional milestones;

184.30 (4) identify and address disparities in screening, diagnosis, and treatment related
184.31 to the native language or race and ethnicity of the child;

184.32 (5) measure the effectiveness of public health care programs in addressing the medical
184.33 needs of children with autism spectrum disorder and other developmental conditions; and

184.34 (6) determine the capacity of educational systems and health care systems to meet
184.35 the needs of children with autism spectrum disorder and other developmental conditions.

185.1 (b) The commissioner of human services shall use the data shared with the
185.2 commissioner of education under this subdivision to improve public health care program
185.3 performance in early screening, diagnosis, and treatment for children once data are
185.4 available and shall report on the results and any summary data, as defined in section 13.02,
185.5 subdivision 19, on the department's public Web site by September 30 each year.

185.6 Sec. 3. Minnesota Statutes 2012, section 256.9657, subdivision 3a, is amended to read:

185.7 Subd. 3a. **ICF/MR ICF/DD license surcharge.** (a) Effective July 1, 2003, each
185.8 non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay
185.9 to the commissioner an annual surcharge according to the schedule in subdivision 4,
185.10 paragraph (d). The annual surcharge shall be \$1,040 per licensed bed. If the number of
185.11 licensed beds is reduced, the surcharge shall be based on the number of remaining licensed
185.12 beds the second month following the receipt of timely notice by the commissioner of
185.13 human services that beds have been delicensed. The facility must notify the commissioner
185.14 of health in writing when beds are delicensed. The commissioner of health must notify
185.15 the commissioner of human services within ten working days after receiving written
185.16 notification. If the notification is received by the commissioner of human services by
185.17 the 15th of the month, the invoice for the second following month must be reduced to
185.18 recognize the delicensing of beds. The commissioner may reduce, and may subsequently
185.19 restore, the surcharge under this subdivision based on the commissioner's determination of
185.20 a permissible surcharge.

185.21 (b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to \$3,679
185.22 per licensed bed.

185.23 **EFFECTIVE DATE.** This section is effective July 1, 2013.

185.24 Sec. 4. Minnesota Statutes 2012, section 256B.0911, subdivision 4d, is amended to read:

185.25 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a)
185.26 It is the policy of the state of Minnesota to ensure that individuals with disabilities or
185.27 chronic illness are served in the most integrated setting appropriate to their needs and have
185.28 the necessary information to make informed choices about home and community-based
185.29 service options.

185.30 (b) Individuals under 65 years of age who are admitted to a nursing facility from a
185.31 hospital must be screened prior to admission as outlined in subdivisions 4a through 4c.

185.32 (c) Individuals under 65 years of age who are admitted to nursing facilities with
185.33 only a telephone screening must receive a face-to-face assessment from the long-term

186.1 care consultation team member of the county in which the facility is located or from the
186.2 recipient's county case manager within 40 calendar days of admission.

186.3 (d) Individuals under 65 years of age who are admitted to a nursing facility
186.4 without preadmission screening according to the exemption described in subdivision 4b,
186.5 paragraph (a), clause (3), and who remain in the facility longer than 30 days must receive
186.6 a face-to-face assessment within 40 days of admission.

186.7 (e) At the face-to-face assessment, the long-term care consultation team member or
186.8 county case manager must perform the activities required under subdivision 3b.

186.9 (f) For individuals under 21 years of age, a screening interview which recommends
186.10 nursing facility admission must be face-to-face and approved by the commissioner before
186.11 the individual is admitted to the nursing facility.

186.12 (g) In the event that an individual under 65 years of age is admitted to a nursing
186.13 facility on an emergency basis, the county must be notified of the admission on the
186.14 next working day, and a face-to-face assessment as described in paragraph (c) must be
186.15 conducted within 40 calendar days of admission.

186.16 (h) At the face-to-face assessment, the long-term care consultation team member or
186.17 the case manager must present information about home and community-based options,
186.18 including consumer-directed options, so the individual can make informed choices. If the
186.19 individual chooses home and community-based services, the long-term care consultation
186.20 team member or case manager must complete a written relocation plan within 20 working
186.21 days of the visit. The plan shall describe the services needed to move out of the facility
186.22 and a time line for the move which is designed to ensure a smooth transition to the
186.23 individual's home and community.

186.24 (i) An individual under 65 years of age residing in a nursing facility shall receive a
186.25 face-to-face assessment at least every 12 months to review the person's service choices
186.26 and available alternatives unless the individual indicates, in writing, that annual visits are
186.27 not desired. In this case, the individual must receive a face-to-face assessment at least
186.28 once every 36 months for the same purposes.

186.29 (j) Notwithstanding the provisions of subdivision 6, the commissioner may pay
186.30 county agencies directly for face-to-face assessments for individuals under 65 years of age
186.31 who are being considered for placement or residing in a nursing facility. Until September
186.32 30, 2013, payments for individuals under 65 years of age shall be made as described
186.33 in this subdivision.

186.34 Sec. 5. Minnesota Statutes 2012, section 256B.0911, subdivision 6, is amended to read:

187.1 Subd. 6. **Payment for long-term care consultation services.** (a) Until September
187.2 30, 2013, payment for long-term care consultation face-to-face assessment shall be made
187.3 as described in this subdivision.

187.4 (b) The total payment for each county must be paid monthly by certified nursing
187.5 facilities in the county. The monthly amount to be paid by each nursing facility for each
187.6 fiscal year must be determined by dividing the county's annual allocation for long-term
187.7 care consultation services by 12 to determine the monthly payment and allocating the
187.8 monthly payment to each nursing facility based on the number of licensed beds in the
187.9 nursing facility. Payments to counties in which there is no certified nursing facility must be
187.10 made by increasing the payment rate of the two facilities located nearest to the county seat.

187.11 ~~(b)~~ (c) The commissioner shall include the total annual payment determined under
187.12 paragraph (a) for each nursing facility reimbursed under section 256B.431, 256B.434,
187.13 or 256B.441.

187.14 ~~(e)~~ (d) In the event of the layaway, delicensure and decertification, or removal from
187.15 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the
187.16 per diem payment amount in paragraph ~~(b)~~ (c) and may adjust the monthly payment
187.17 amount in paragraph (a). The effective date of an adjustment made under this paragraph
187.18 shall be on or after the first day of the month following the effective date of the layaway,
187.19 delicensure and decertification, or removal from layaway.

187.20 ~~(d)~~ (e) Payments for long-term care consultation services are available to the county
187.21 or counties to cover staff salaries and expenses to provide the services described in
187.22 subdivision 1a. The county shall employ, or contract with other agencies to employ,
187.23 within the limits of available funding, sufficient personnel to provide long-term care
187.24 consultation services while meeting the state's long-term care outcomes and objectives as
187.25 defined in subdivision 1. The county shall be accountable for meeting local objectives
187.26 as approved by the commissioner in the biennial home and community-based services
187.27 quality assurance plan on a form provided by the commissioner.

187.28 ~~(e)~~ (f) Notwithstanding section 256B.0641, overpayments attributable to payment
187.29 of the screening costs under the medical assistance program may not be recovered from
187.30 a facility.

187.31 ~~(f)~~ (g) The commissioner of human services shall amend the Minnesota medical
187.32 assistance plan to include reimbursement for the local consultation teams.

187.33 ~~(g)~~ (h) Until the alternative payment methodology in paragraph ~~(h)~~ (i) is implemented,
187.34 the county may bill, as case management services, assessments, support planning, and
187.35 follow-along provided to persons determined to be eligible for case management under

188.1 Minnesota health care programs. No individual or family member shall be charged for an
188.2 initial assessment or initial support plan development provided under subdivision 3a or 3b.

188.3 ~~(h)~~ (i) The commissioner shall develop an alternative payment methodology,
188.4 effective on October 1, 2013, for long-term care consultation services that includes
188.5 the funding available under this subdivision, and for assessments authorized under
188.6 sections 256B.092 and 256B.0659. In developing the new payment methodology, the
188.7 commissioner shall consider the maximization of other funding sources, including federal
188.8 administrative reimbursement through federal financial participation funding, for all
188.9 long-term care consultation and preadmission-screening activity. The alternative payment
188.10 methodology shall include the use of the appropriate time studies and the state financing
188.11 of nonfederal share as part of the state's medical assistance program.

188.12 Sec. 6. Minnesota Statutes 2012, section 256B.0916, is amended by adding a
188.13 subdivision to read:

188.14 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending
188.15 in excess of the allocation made by the commissioner. In the event a county or tribal
188.16 agency spends in excess of the allocation made by the commissioner for a given allocation
188.17 period, they must submit a corrective action plan to the commissioner. The plan must state
188.18 the actions the agency will take to correct their overspending for the year following the
188.19 period when the overspending occurred. Failure to correct overspending shall result in
188.20 recoupment of spending in excess of the allocation. Nothing in this subdivision shall be
188.21 construed as reducing the county's responsibility to offer and make available feasible
188.22 home and community-based options to eligible waiver recipients within the resources
188.23 allocated to them for that purpose.

188.24 Sec. 7. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

188.25 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
188.26 established a new service called residential support that is available on the community
188.27 alternative care, community alternatives for disabled individuals, developmental
188.28 disabilities, and brain injury waivers. Existing waiver service descriptions must be
188.29 modified to the extent necessary to ensure there is no duplication between other services.
188.30 Residential support services must be provided by vendors licensed as a community
188.31 residential setting as defined in section 245A.11, subdivision 8.

188.32 (b) Residential support services must meet the following criteria:

- 188.33 (1) providers of residential support services must own or control the residential site;
188.34 (2) the residential site must not be the primary residence of the license holder;

189.1 (3) the residential site must have a designated program supervisor responsible for
189.2 program oversight, development, and implementation of policies and procedures;

189.3 (4) the provider of residential support services must provide supervision, training,
189.4 and assistance as described in the person's coordinated service and support plan; and

189.5 (5) the provider of residential support services must meet the requirements of
189.6 licensure and additional requirements of the person's coordinated service and support plan.

189.7 (c) Providers of residential support services that meet the definition in paragraph
189.8 (a) must be registered using a process determined by the commissioner beginning July
189.9 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts
189.10 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts
189.11 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision
189.12 7, paragraph ~~(g)~~ (f), are considered registered under this section.

189.13 Sec. 8. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:

189.14 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall
189.15 establish statewide priorities for individuals on the waiting list for developmental
189.16 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must
189.17 include, but are not limited to, individuals who continue to have a need for waiver services
189.18 after they have maximized the use of state plan services and other funding resources,
189.19 including natural supports, prior to accessing waiver services, and who meet at least one
189.20 of the following criteria:

189.21 (1) have unstable living situations due to the age, incapacity, or sudden loss of
189.22 the primary caregivers;

189.23 (2) are moving from an institution due to bed closures;

189.24 (3) experience a sudden closure of their current living arrangement;

189.25 (4) require protection from confirmed abuse, neglect, or exploitation;

189.26 (5) experience a sudden change in need that can no longer be met through state plan
189.27 services or other funding resources alone; or

189.28 (6) meet other priorities established by the department.

189.29 (b) When allocating resources to lead agencies, the commissioner must take into
189.30 consideration the number of individuals waiting who meet statewide priorities and the
189.31 lead agencies' current use of waiver funds and existing service options. The commissioner
189.32 has the authority to transfer funds between counties, groups of counties, and tribes to
189.33 accommodate statewide priorities and resource needs while accounting for a necessary
189.34 base level reserve amount for each county, group of counties, and tribe.

190.1 ~~(e) The commissioner shall evaluate the impact of the use of statewide priorities and~~
190.2 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
190.3 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
190.4 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

190.5 **Sec. 9. [256B.0949] AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**

190.6 Subdivision 1. **Purpose.** This section creates a new benefit available under the
190.7 medical assistance state plan when federal approval consistent with the provisions in
190.8 subdivision 11 is obtained for a 1915(i) waiver pursuant to the Affordable Care Act, section
190.9 2402(c), amending United States Code, title 42, section 1396n(i)(1), or other option to
190.10 provide early intensive intervention to a child with an autism spectrum disorder diagnosis.
190.11 This benefit must provide coverage for diagnosis, multidisciplinary assessment, ongoing
190.12 progress evaluation, and medically necessary treatment of autism spectrum disorder.

190.13 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in
190.14 this subdivision have the meanings given.

190.15 (b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the
190.16 current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

190.17 (c) "Child" means a person under the age of seven, or for two years at any age under
190.18 age 18 if the person was not diagnosed with autism spectrum disorder before age five, or a
190.19 person under age 18 pursuant to subdivision 12.

190.20 (d) "Commissioner" means the commissioner of human services, unless otherwise
190.21 specified.

190.22 (e) "Early intensive intervention benefit" means autism treatment options based in
190.23 behavioral and developmental science, which may include modalities such as applied
190.24 behavior analysis, developmental treatment approaches, and naturalistic and parent
190.25 training models.

190.26 (f) "Generalizable goals" means results or gains that are observed during a variety
190.27 of activities with different people, such as providers, family members, other adults, and
190.28 children, and in different environments including, but not limited to, clinics, homes,
190.29 schools, and the community.

190.30 Subd. 3. **Initial eligibility.** This benefit is available to a child enrolled in medical
190.31 assistance who:

190.32 (1) has an autism spectrum disorder diagnosis;

190.33 (2) has had a diagnostic assessment described in subdivision 5, which recommends
190.34 early intensive intervention services;

191.1 (3) meets the criteria for medically necessary autism early intensive intervention
 191.2 services; and

191.3 (4) declines to enroll in the state services described in section 252.27.

191.4 Subd. 4. **Diagnosis.** (a) A diagnosis must:

191.5 (1) be based upon current DSM criteria including direct observations of the child
 191.6 and reports from parents or primary caregivers;

191.7 (2) be completed by a professional who has expertise and training in autism spectrum
 191.8 disorder and child development and who is a licensed physician, nurse practitioner, or
 191.9 a licensed mental health professional until the commissioner's assessment required in
 191.10 subdivision 8, clause (7), shows there are adequate professionals to avoid access problems
 191.11 or delays in diagnosis for young children if two professionals are required for a diagnosis
 191.12 pursuant to clause (3); and

191.13 (3) be completed by both a medical and mental health professional who have expertise
 191.14 and training in autism spectrum disorder and child development when the assessment in
 191.15 subdivision 8, clause (7), demonstrates that there are sufficient professionals available.

191.16 (b) Additional diagnostic assessment information including from special education
 191.17 evaluations and licensed school personnel, and from professionals licensed in the fields of
 191.18 medicine, speech and language, psychology, occupational therapy, and physical therapy
 191.19 may be considered.

191.20 Subd. 5. **Diagnostic assessment.** The following information and assessments must
 191.21 be performed, reviewed, and relied upon for the eligibility determination, treatment and
 191.22 services recommendations, and treatment plan development for the child:

191.23 (1) an assessment of the child's developmental skills, functional behavior, needs,
 191.24 and capacities based on direct observation of the child which must be administered by
 191.25 a licensed mental health professional and may also include observations from family
 191.26 members, licensed school personnel, child care providers, or other caregivers, as well as
 191.27 any medical or assessment information from other licensed professionals such as the
 191.28 child's physician, rehabilitation therapists, or mental health professionals; and

191.29 (2) an assessment of parental or caregiver capacity to participate in therapy including
 191.30 the type and level of parental or caregiver involvement and training recommended.

191.31 Subd. 6. **Treatment plan.** (a) Each child's treatment plan must be:

191.32 (1) based on the diagnostic assessment information specified in subdivisions 4 and 5;

191.33 (2) coordinated with medically necessary occupational, physical, and speech and

191.34 language therapies, special education, and other services the child and family are receiving;

191.35 (3) family-centered;

191.36 (4) culturally sensitive; and

192.1 (5) individualized based on the child's developmental status and the child's and
192.2 family's identified needs.

192.3 (b) The treatment plan must specify the:

192.4 (1) child's goals which are developmentally appropriate, functional, and
192.5 generalizable;

192.6 (2) treatment modality;

192.7 (3) treatment intensity;

192.8 (4) setting; and

192.9 (5) level and type of parental or caregiver involvement.

192.10 (c) The treatment must be supervised by a professional with expertise and training in
192.11 autism and child development who is a licensed physician, nurse practitioner, or mental
192.12 health professional.

192.13 (d) The treatment plan must be submitted to the commissioner for approval in a
192.14 manner determined by the commissioner for this purpose.

192.15 (e) Services authorized must be consistent with the child's approved treatment plan.

192.16 Subd. 7. **Ongoing eligibility.** (a) An independent progress evaluation conducted
192.17 by a licensed mental health professional with expertise and training in autism spectrum
192.18 disorder and child development must be completed after each six months of treatment,
192.19 or more frequently as determined by the commissioner, to determine if progress is being
192.20 made toward achieving generalizable gains and meeting functional goals contained in
192.21 the treatment plan.

192.22 (b) The progress evaluation must include:

192.23 (1) the treating provider's report;

192.24 (2) parental or caregiver input;

192.25 (3) an independent observation of the child which can be performed by the child's
192.26 licensed special education staff;

192.27 (4) any treatment plan modifications; and

192.28 (5) recommendations for continued treatment services.

192.29 (c) Progress evaluations must be submitted to the commissioner in a manner
192.30 determined by the commissioner for this purpose.

192.31 (d) A child who continues to achieve generalizable gains and treatment goals as
192.32 specified in the treatment plan is eligible to continue receiving this benefit.

192.33 (e) A child's treatment shall continue during the progress evaluation and during an
192.34 appeal if continuation of services pending appeal have been requested pursuant to section
192.35 256.045, subdivision 10.

193.1 Subd. 8. Refining the benefit with stakeholders. The commissioner must develop
193.2 the implementation details of the benefit in consultation with stakeholders and consider
193.3 recommendations from the Health Services Advisory Council, the Department of Human
193.4 Services Autism Spectrum Disorder Advisory Council, the Legislative Autism Spectrum
193.5 Disorder Task Force, and the Interagency Task Force of the Departments of Health,
193.6 Education, and Human Services. The commissioner must release these details for a 30-day
193.7 public comment period prior to submission to the federal government for approval. The
193.8 implementation details include, but are not limited to, the following components:

193.9 (1) a definition of the qualifications, standards, and roles of the treatment team,
193.10 including recommendations after stakeholder consultation on whether board-certified
193.11 behavior analysts and other types of professionals trained in autism spectrum disorder and
193.12 child development should be added as mental health or other professionals for treatment
193.13 supervision or other function under medical assistance;

193.14 (2) development of initial, uniform parameters for comprehensive multidisciplinary
193.15 diagnostic assessment information and progress evaluation standards;

193.16 (3) the design of an effective and consistent process for assessing parent and
193.17 caregiver capacity to participate in the child's early intervention treatment and methods of
193.18 involving the parents in the treatment of the child;

193.19 (4) formulation of a collaborative process in which professionals have opportunities
193.20 to collectively inform the comprehensive, multidisciplinary diagnostic assessment and
193.21 progress evaluation processes and standards to support quality improvement of early
193.22 intensive intervention services;

193.23 (5) coordination of this benefit and its interaction with other services provided by the
193.24 Departments of Human Services, Health, and Education;

193.25 (6) evaluation, on an ongoing basis, of research regarding the program and treatment
193.26 modalities provided to children under this benefit; and

193.27 (7) determination of the availability of licensed medical and mental health
193.28 professionals with expertise and training in autism spectrum disorder throughout the state
193.29 in order to assess whether there are sufficient professionals to require involvement of
193.30 both a medical and mental health professional to provide access and prevent delay in the
193.31 diagnosis and treatment of young children so as to implement subdivision 4, paragraph
193.32 (a), and to ensure treatment is effective, timely, and accessible.

193.33 Subd. 9. Revision of treatment options. (a) The commissioner may revise covered
193.34 treatment options as needed based on outcome data and other evidence.

193.35 (b) Before the changes become effective, the commissioner must provide public
193.36 notice of the changes, the reasons for the change, and a 30-day public comment period

194.1 to those who request notice through an electronic list accessible to the public on the
194.2 department's Web site.

194.3 Subd. 10. **Coordination between agencies.** The commissioners of human services
194.4 and education must develop the capacity to coordinate services and information including
194.5 diagnostic, functional, developmental, medical, and educational assessments; service
194.6 delivery; and progress evaluations across health and education sectors.

194.7 Subd. 11. **Federal approval of the autism benefit.** The provisions of subdivision 9
194.8 shall apply to state plan services under Title XIX of the Social Security Act when federal
194.9 approval is granted under a 1915(i) waiver or other authority which allows children
194.10 eligible for medical assistance through the TEFRA option under section 256B.055,
194.11 subdivision 12, to qualify and includes children eligible for medical assistance in families
194.12 over 150 percent of the federal poverty guidelines.

194.13 Subd. 12. **Local school districts option to continue treatment.** (a) A local school
194.14 district may contract with the commissioner of human services to pay the state share of
194.15 the benefits described under this section to continue this treatment as part of the special
194.16 education services offered to all students in the district diagnosed with an autism spectrum
194.17 disorder.

194.18 (b) A local school district may utilize third-party billing to seek reimbursement
194.19 for the district for any services paid by the district under this section for which private
194.20 insurance coverage was available to the child.

194.21 **EFFECTIVE DATE.** The autism benefit under subdivisions 1 to 7, 9, and 12, is
194.22 effective upon federal approval for the benefit under a 1915(i) waiver or other federal
194.23 authority needed to meet the requirements of subdivision 11, but no earlier than March 1,
194.24 2014. Subdivisions 8, 10, and 11 are effective July 1, 2013.

194.25 Sec. 10. Minnesota Statutes 2012, section 256B.095, is amended to read:

194.26 **256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.**

194.27 (a) Effective July 1, 1998, a quality assurance system for persons with developmental
194.28 disabilities, which includes an alternative quality assurance licensing system for programs,
194.29 is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice,
194.30 Steele, Wabasha, and Winona Counties for the purpose of improving the quality of
194.31 services provided to persons with developmental disabilities. A county, at its option, may
194.32 choose to have all programs for persons with developmental disabilities located within
194.33 the county licensed under chapter 245A using standards determined under the alternative

195.1 quality assurance licensing system or may continue regulation of these programs under the
195.2 licensing system operated by the commissioner. ~~The project expires on June 30, 2014.~~

195.3 (b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to
195.4 participate in the quality assurance system established under paragraph (a). The
195.5 commission established under section 256B.0951 may, at its option, allow additional
195.6 counties to participate in the system.

195.7 (c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a)
195.8 may establish a quality assurance system under this section. A new system established
195.9 under this section shall have the same rights and duties as the system established
195.10 under paragraph (a). A new system shall be governed by a commission under section
195.11 256B.0951. The commissioner shall appoint the initial commission members based
195.12 on recommendations from advocates, families, service providers, and counties in the
195.13 geographic area included in the new system. Counties that choose to participate in a
195.14 new system shall have the duties assigned under section 256B.0952. The new system
195.15 shall establish a quality assurance process under section 256B.0953. The provisions of
195.16 section 256B.0954 shall apply to a new system established under this paragraph. The
195.17 commissioner shall delegate authority to a new system established under this paragraph
195.18 according to section 256B.0955.

195.19 (d) Effective July 1, 2007, the quality assurance system may be expanded to include
195.20 programs for persons with disabilities and older adults.

195.21 (e) Effective July 1, 2013, a provider of service located in a county listed in
195.22 paragraph (a) that is a non-opted-in county may opt-in to the quality assurance system
195.23 provided the county where services are provided indicates its agreement with a county
195.24 with a delegation agreement with the Department of Human Services.

195.25 **EFFECTIVE DATE.** This section is effective July 1, 2013.

195.26 Sec. 11. Minnesota Statutes 2012, section 256B.0951, subdivision 1, is amended to read:

195.27 Subdivision 1. **Membership.** The Quality Assurance Commission is established.
195.28 The commission consists of at least 14 but not more than 21 members as follows: at
195.29 least three but not more than five members representing advocacy organizations; at
195.30 least three but not more than five members representing consumers, families, and their
195.31 legal representatives; at least three but not more than five members representing service
195.32 providers; at least three but not more than five members representing counties; and the
195.33 commissioner of human services or the commissioner's designee. The first commission
195.34 shall establish membership guidelines for the transition and recruitment of membership for
195.35 the commission's ongoing existence. Members of the commission who do not receive a

196.1 salary or wages from an employer for time spent on commission duties may receive a per
196.2 diem payment when performing commission duties and functions. All members may be
196.3 reimbursed for expenses related to commission activities. ~~Notwithstanding the provisions~~
196.4 ~~of section 15.059, subdivision 5, the commission expires on June 30, 2014.~~

196.5 Sec. 12. Minnesota Statutes 2012, section 256B.0951, subdivision 4, is amended to read:

196.6 Subd. 4. **Commission's authority to recommend variances of licensing**
196.7 **standards.** The commission may recommend to the commissioners of human services
196.8 and health variances from the standards governing licensure of programs for persons with
196.9 ~~developmental~~ disabilities in order to improve the quality of services by implementing
196.10 an alternative ~~developmental~~ disabilities licensing system if the commission determines
196.11 that the alternative licensing system does not adversely affect the health or safety of
196.12 persons being served by the licensed program nor compromise the qualifications of staff
196.13 to provide services.

196.14 Sec. 13. Minnesota Statutes 2012, section 256B.0952, subdivision 1, is amended to read:

196.15 Subdivision 1. **Notification.** Counties or providers shall give notice to the
196.16 commission and commissioners of human services and health of intent to join the
196.17 alternative quality assurance licensing system. A county or provider choosing to participate
196.18 in the alternative quality assurance licensing system commits to participate for three years.

196.19 Sec. 14. Minnesota Statutes 2012, section 256B.0952, subdivision 5, is amended to read:

196.20 Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised
196.21 of county staff; providers; consumers, families, and their legal representatives; members
196.22 of advocacy organizations; and other involved community members. Team members
196.23 must satisfactorily complete the training program approved by the commission and must
196.24 demonstrate performance-based competency. Team members are not considered to be
196.25 county employees for purposes of workers' compensation, unemployment insurance, or
196.26 state retirement laws solely on the basis of participation on a quality assurance team. ~~The~~
196.27 ~~county may pay~~ A per diem may be paid to team members for time spent on alternative
196.28 quality assurance process matters. All team members may be reimbursed for expenses
196.29 related to their participation in the alternative process.

196.30 Sec. 15. Minnesota Statutes 2012, section 256B.097, subdivision 1, is amended to read:

196.31 Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to
196.32 Minnesotans with disabilities and to meet the requirements of the federally approved home

197.1 and community-based waivers under section 1915c of the Social Security Act, a State
197.2 Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving
197.3 disability services is enacted. This system is a partnership between the Department of
197.4 Human Services and the State Quality Council established under subdivision 3.

197.5 (b) This system is a result of the recommendations from the Department of Human
197.6 Services' licensing and alternative quality assurance study mandated under Laws 2005,
197.7 First Special Session chapter 4, article 7, section 57, and presented to the legislature
197.8 in February 2007.

197.9 (c) The disability services eligible under this section include:

197.10 (1) the home and community-based services waiver programs for persons with
197.11 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
197.12 including brain injuries and services for those who qualify for nursing facility level of care
197.13 or hospital facility level of care and any other services licensed under chapter 245D;

197.14 (2) home care services under section 256B.0651;

197.15 (3) family support grants under section 252.32;

197.16 (4) consumer support grants under section 256.476;

197.17 (5) semi-independent living services under section 252.275; and

197.18 (6) services provided through an intermediate care facility for the developmentally
197.19 disabled.

197.20 (d) For purposes of this section, the following definitions apply:

197.21 (1) "commissioner" means the commissioner of human services;

197.22 (2) "council" means the State Quality Council under subdivision 3;

197.23 (3) "Quality Assurance Commission" means the commission under section
197.24 256B.0951; and

197.25 (4) "system" means the State Quality Assurance, Quality Improvement and
197.26 Licensing System under this section.

197.27 Sec. 16. Minnesota Statutes 2012, section 256B.097, subdivision 3, is amended to read:

197.28 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
197.29 Council which must define regional quality councils, and carry out a community-based,
197.30 person-directed quality review component, and a comprehensive system for effective
197.31 incident reporting, investigation, analysis, and follow-up.

197.32 (b) By August 1, 2011, the commissioner of human services shall appoint the
197.33 members of the initial State Quality Council. Members shall include representatives
197.34 from the following groups:

197.35 (1) disability service recipients and their family members;

198.1 (2) during the first ~~two~~ four years of the State Quality Council, there must be at least
198.2 three members from the Region 10 stakeholders. As regional quality councils are formed
198.3 under subdivision 4, each regional quality council shall appoint one member;

198.4 (3) disability service providers;

198.5 (4) disability advocacy groups; and

198.6 (5) county human services agencies and staff from the Department of Human
198.7 Services and Ombudsman for Mental Health and Developmental Disabilities.

198.8 (c) Members of the council who do not receive a salary or wages from an employer
198.9 for time spent on council duties may receive a per diem payment when performing council
198.10 duties and functions.

198.11 (d) The State Quality Council shall:

198.12 (1) assist the Department of Human Services in fulfilling federally mandated
198.13 obligations by monitoring disability service quality and quality assurance and
198.14 improvement practices in Minnesota;

198.15 (2) establish state quality improvement priorities with methods for achieving results
198.16 and provide an annual report to the legislative committees with jurisdiction over policy
198.17 and funding of disability services on the outcomes, improvement priorities, and activities
198.18 undertaken by the commission during the previous state fiscal year;

198.19 (3) identify issues pertaining to financial and personal risk that impede Minnesotans
198.20 with disabilities from optimizing choice of community-based services; and

198.21 (4) recommend to the chairs and ranking minority members of the legislative
198.22 committees with jurisdiction over human services and civil law by January 15, ~~2013~~
198.23 2014, statutory and rule changes related to the findings under clause (3) that promote
198.24 individualized service and housing choices balanced with appropriate individualized
198.25 protection.

198.26 (e) The State Quality Council, in partnership with the commissioner, shall:

198.27 (1) approve and direct implementation of the community-based, person-directed
198.28 system established in this section;

198.29 (2) recommend an appropriate method of funding this system, and determine the
198.30 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

198.31 (3) approve measurable outcomes in the areas of health and safety, consumer
198.32 evaluation, education and training, providers, and systems;

198.33 (4) establish variable licensure periods not to exceed three years based on outcomes
198.34 achieved; and

198.35 (5) in cooperation with the Quality Assurance Commission, design a transition plan
198.36 for licensed providers from Region 10 into the alternative licensing system ~~by July 1, 2013~~.

199.1 (f) The State Quality Council shall notify the commissioner of human services that a
199.2 facility, program, or service has been reviewed by quality assurance team members under
199.3 subdivision 4, paragraph (b), clause (13), and qualifies for a license.

199.4 (g) The State Quality Council, in partnership with the commissioner, shall establish
199.5 an ongoing review process for the system. The review shall take into account the
199.6 comprehensive nature of the system which is designed to evaluate the broad spectrum of
199.7 licensed and unlicensed entities that provide services to persons with disabilities. The
199.8 review shall address efficiencies and effectiveness of the system.

199.9 (h) The State Quality Council may recommend to the commissioner certain
199.10 variances from the standards governing licensure of programs for persons with disabilities
199.11 in order to improve the quality of services so long as the recommended variances do
199.12 not adversely affect the health or safety of persons being served or compromise the
199.13 qualifications of staff to provide services.

199.14 (i) The safety standards, rights, or procedural protections referenced under
199.15 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
199.16 recommendations to the commissioner or to the legislature in the report required under
199.17 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
199.18 procedural protections referenced under subdivision 2, paragraph (c).

199.19 (j) The State Quality Council may hire staff to perform the duties assigned in this
199.20 subdivision.

199.21 Sec. 17. Minnesota Statutes 2012, section 256B.431, subdivision 44, is amended to read:

199.22 Subd. 44. **Property rate ~~increase~~ increases for a facility in Bloomington effective**
199.23 **~~November 1, 2010~~ certain nursing facilities.** (a) Notwithstanding any other law to the
199.24 contrary, money available for moratorium projects under section 144A.073, subdivision
199.25 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception
199.26 project for a nursing facility in Bloomington licensed for 137 beds as of November 1,
199.27 2010, up to a total property rate adjustment of \$19.33.

199.28 (b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110
199.29 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow
199.30 \$1,129,463 of a completed construction project to increase the property payment rate.
199.31 Notwithstanding any other law to the contrary, money available under section 144A.073,
199.32 subdivision 11, after the completion of the moratorium exception approval process in 2013
199.33 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the
199.34 medical assistance budget for the increase in the replacement-cost-new limit.

200.1 (c) Effective July 1, 2013, or later, any boarding care facility in Hennepin
 200.2 County licensed for 100 beds shall be allowed to receive a property rate adjustment
 200.3 for a construction project that takes action to come into compliance with Minnesota
 200.4 Department of Labor and Industry elevator upgrade requirements, with costs below the
 200.5 minimum threshold under subdivision 16. Only costs related to the construction project
 200.6 that brings the facility into compliance with the elevator requirements shall be allowed.
 200.7 Notwithstanding any other law to the contrary, money available under section 144A.073,
 200.8 subdivision 11, after the completion of the moratorium exception approval process in
 200.9 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to
 200.10 the medical assistance program.

200.11 **EFFECTIVE DATE.** Paragraph (b) is effective retroactively from June 1, 2012.

200.12 Sec. 18. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:

200.13 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
 200.14 have their payment rates determined under this section rather than section 256B.431, the
 200.15 commissioner shall establish a rate under this subdivision. The nursing facility must enter
 200.16 into a written contract with the commissioner.

200.17 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
 200.18 contract under this section is the payment rate the facility would have received under
 200.19 section 256B.431.

200.20 (c) A nursing facility's case mix payment rates for the second and subsequent years
 200.21 of a facility's contract under this section are the previous rate year's contract payment
 200.22 rates plus an inflation adjustment and, for facilities reimbursed under this section or
 200.23 section 256B.431, an adjustment to include the cost of any increase in Health Department
 200.24 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
 200.25 inflation adjustment must be based on the change in the Consumer Price Index-All Items
 200.26 (United States City average) (CPI-U) forecasted by the commissioner of management and
 200.27 budget's national economic consultant, as forecasted in the fourth quarter of the calendar
 200.28 year preceding the rate year. The inflation adjustment must be based on the 12-month
 200.29 period from the midpoint of the previous rate year to the midpoint of the rate year for
 200.30 which the rate is being determined. For the rate years beginning on July 1, 1999, July 1,
 200.31 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006,
 200.32 July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall
 200.33 apply only to the property-related payment rate. For the rate years beginning on October
 200.34 1, 2011, ~~and~~ October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and
 200.35 October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning

201.1 in 2005, adjustment to the property payment rate under this section and section 256B.431
201.2 shall be effective on October 1. In determining the amount of the property-related payment
201.3 rate adjustment under this paragraph, the commissioner shall determine the proportion of
201.4 the facility's rates that are property-related based on the facility's most recent cost report.

201.5 (d) The commissioner shall develop additional incentive-based payments of up to
201.6 five percent above a facility's operating payment rate for achieving outcomes specified
201.7 in a contract. The commissioner may solicit contract amendments and implement those
201.8 which, on a competitive basis, best meet the state's policy objectives. The commissioner
201.9 shall limit the amount of any incentive payment and the number of contract amendments
201.10 under this paragraph to operate the incentive payments within funds appropriated for this
201.11 purpose. The contract amendments may specify various levels of payment for various
201.12 levels of performance. Incentive payments to facilities under this paragraph may be in the
201.13 form of time-limited rate adjustments or onetime supplemental payments. In establishing
201.14 the specified outcomes and related criteria, the commissioner shall consider the following
201.15 state policy objectives:

201.16 (1) successful diversion or discharge of residents to the residents' prior home or other
201.17 community-based alternatives;

201.18 (2) adoption of new technology to improve quality or efficiency;

201.19 (3) improved quality as measured in the Nursing Home Report Card;

201.20 (4) reduced acute care costs; and

201.21 (5) any additional outcomes proposed by a nursing facility that the commissioner
201.22 finds desirable.

201.23 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
201.24 take action to come into compliance with existing or pending requirements of the life
201.25 safety code provisions or federal regulations governing sprinkler systems must receive
201.26 reimbursement for the costs associated with compliance if all of the following conditions
201.27 are met:

201.28 (1) the expenses associated with compliance occurred on or after January 1, 2005,
201.29 and before December 31, 2008;

201.30 (2) the costs were not otherwise reimbursed under subdivision 4f or section
201.31 144A.071 or 144A.073; and

201.32 (3) the total allowable costs reported under this paragraph are less than the minimum
201.33 threshold established under section 256B.431, subdivision 15, paragraph (e), and
201.34 subdivision 16.

201.35 The commissioner shall use money appropriated for this purpose to provide to qualifying
201.36 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,

202.1 2008. Nursing facilities that have spent money or anticipate the need to spend money
202.2 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
202.3 system or (2) replacing all or portions of an existing sprinkler system may submit to the
202.4 commissioner by June 30, 2007, on a form provided by the commissioner the actual
202.5 costs of a completed project or the estimated costs, based on a project bid, of a planned
202.6 project. The commissioner shall calculate a rate adjustment equal to the allowable
202.7 costs of the project divided by the resident days reported for the report year ending
202.8 September 30, 2006. If the costs from all projects exceed the appropriation for this
202.9 purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the
202.10 qualifying facilities by reducing the rate adjustment determined for each facility by an
202.11 equal percentage. Facilities that used estimated costs when requesting the rate adjustment
202.12 shall report to the commissioner by January 31, 2009, on the use of this money on a
202.13 form provided by the commissioner. If the nursing facility fails to provide the report, the
202.14 commissioner shall recoup the money paid to the facility for this purpose. If the facility
202.15 reports expenditures allowable under this subdivision that are less than the amount received
202.16 in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

202.17 Sec. 19. Minnesota Statutes 2012, section 256B.434, is amended by adding a
202.18 subdivision to read:

202.19 Subd. 19a. Nursing facility rate adjustments beginning October 1, 2013. (a)
202.20 For the rate year beginning October 1, 2013, the commissioner shall make available to
202.21 each nursing facility reimbursed under this section a three percent operating payment
202.22 rate increase.

202.23 (b) Seventy-five percent of the money resulting from the rate adjustment under
202.24 paragraph (a) must be used for increases in compensation-related costs for employees
202.25 directly employed by the nursing facility on or after the effective date of the rate
202.26 adjustment, except:

202.27 (1) the administrator;

202.28 (2) persons employed in the central office of a corporation that has an ownership
202.29 interest in the nursing facility or exercises control over the nursing facility; and

202.30 (3) persons paid by the nursing facility under a management contract.

202.31 (c) The commissioner shall allow as compensation-related costs all costs for:

202.32 (1) wages and salaries;

202.33 (2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers'
202.34 compensation;

203.1 (3) the employer's share of health and dental insurance, life insurance, disability
203.2 insurance, long-term care insurance, uniform allowance, and pensions; and

203.3 (4) other benefits provided and workforce needs including the recruiting and training
203.4 of employees, subject to the approval of the commissioner.

203.5 (d) The portion of the rate adjustment under paragraph (a) that is not subject to the
203.6 requirements of paragraph (b) shall be provided to nursing facilities effective October 1.
203.7 Nursing facilities may apply for the portion of the rate adjustment under paragraph (a)
203.8 that is subject to the requirements in paragraph (b). The application must be submitted
203.9 to the commissioner within six months of the effective date of the rate adjustment, and
203.10 the nursing facility must provide additional information required by the commissioner
203.11 within nine months of the effective date of the rate adjustment. The commissioner must
203.12 respond to all applications within three weeks of receipt. The commissioner may waive
203.13 the deadlines in this paragraph under extraordinary circumstances, to be determined at the
203.14 sole discretion of the commissioner. The application must contain:

203.15 (1) an estimate of the amounts of money that must be used as specified in paragraph
203.16 (b);

203.17 (2) a detailed distribution plan specifying the allowable compensation-related and
203.18 wage increases the nursing facility will implement to use the funds available in clause (1);

203.19 (3) a description of how the nursing facility will notify eligible employees of
203.20 the contents of the approved application, which must provide for giving each eligible
203.21 employee a copy of the approved application, excluding the information required in clause
203.22 (1), or posting a copy of the approved application, excluding the information required in
203.23 clause (1), for a period of at least six weeks in an area of the nursing facility to which all
203.24 eligible employees have access; and

203.25 (4) instructions for employees who believe they have not received the
203.26 compensation-related or wage increases specified in clause (2), as approved by the
203.27 commissioner, and which must include a mailing address, e-mail address, and the
203.28 telephone number that may be used by the employee to contact the commissioner or the
203.29 commissioner's representative.

203.30 (e) For the October 1, 2013, rate increase, the commissioner shall ensure that cost
203.31 increases in distribution plans under paragraph (d), clause (2), that may be included in
203.32 approved applications, comply with the following requirements:

203.33 (1) a portion of the costs resulting from tenure-related wage or salary increases
203.34 may be considered to be allowable wage increases, according to formulas that the
203.35 commissioner shall provide, where employee retention is above the average statewide
203.36 rate of retention of direct care employees;

204.1 (2) the annualized amount of increases in costs for the employer's share of health
204.2 and dental insurance, life insurance, disability insurance, and workers' compensation
204.3 shall be allowable compensation-related increases if they are effective on or after April
204.4 1, 2013, and prior to April 1, 2014; and

204.5 (3) for nursing facilities in which employees are represented by an exclusive
204.6 bargaining representative, the commissioner shall approve the application only upon
204.7 receipt of a letter of acceptance of the distribution plan, in regard to members of the
204.8 bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2013.
204.9 Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of
204.10 this provision as having been met in regard to the members of the bargaining unit.

204.11 (f) The commissioner shall review applications received under paragraph (e) and
204.12 shall provide the portion of the rate adjustment under paragraph (b) if the requirements
204.13 of this statute have been met. The rate adjustment shall be effective October 1.
204.14 Notwithstanding paragraph (a), if the approved application distributes less money than is
204.15 available, the amount of the rate adjustment shall be reduced so that the amount of money
204.16 made available is equal to the amount to be distributed.

204.17 (g) The increase in this subdivision shall be applied as a total percentage to
204.18 operating rates effective September 30, 2013, except that they shall not increase any
204.19 performance-based incentive payments under section 256B.434, subdivision 4, paragraph
204.20 (d), awarded prior to the effective date of the rate adjustment. Facilities receiving equitable
204.21 cost-sharing for publicly owned nursing facilities program rate adjustments under section
204.22 256B.441, subdivision 55a, must have rate increases under this paragraph computed based
204.23 on rates in effect before the increases given under section 256B.441, subdivision 55a.

204.24 Sec. 20. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

204.25 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
204.26 services shall calculate the amount of the planned closure rate adjustment available under
204.27 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

204.28 (1) the amount available is the net reduction of nursing facility beds multiplied
204.29 by \$2,080;

204.30 (2) the total number of beds in the nursing facility or facilities receiving the planned
204.31 closure rate adjustment must be identified;

204.32 (3) capacity days are determined by multiplying the number determined under
204.33 clause (2) by 365; and

204.34 (4) the planned closure rate adjustment is the amount available in clause (1), divided
204.35 by capacity days determined under clause (3).

205.1 (b) A planned closure rate adjustment under this section is effective on the first day
205.2 of the month following completion of closure of the facility designated for closure in
205.3 the application and becomes part of the nursing facility's ~~total operating~~ external fixed
205.4 payment rate.

205.5 (c) Applicants may use the planned closure rate adjustment to allow for a property
205.6 payment for a new nursing facility or an addition to an existing nursing facility or as
205.7 an ~~operating payment~~ external fixed rate adjustment. Applications approved under this
205.8 subdivision are exempt from other requirements for moratorium exceptions under section
205.9 144A.073, subdivisions 2 and 3.

205.10 (d) Upon the request of a closing facility, the commissioner must allow the facility a
205.11 closure rate adjustment as provided under section 144A.161, subdivision 10.

205.12 (e) A facility that has received a planned closure rate adjustment may reassign it
205.13 to another facility that is under the same ownership at any time within three years of its
205.14 effective date. The amount of the adjustment shall be computed according to paragraph (a).

205.15 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
205.16 the commissioner shall recalculate planned closure rate adjustments for facilities that
205.17 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
205.18 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
205.19 from the date the per bed dollar amount is increased.

205.20 (g) For planned closures approved after June 30, 2009, the commissioner of human
205.21 services shall calculate the amount of the planned closure rate adjustment available under
205.22 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

205.23 (h) ~~Beginning~~ Between July 16, 2011, and June 30, 2013, the commissioner shall ~~no~~
205.24 ~~longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

205.25 Sec. 21. Minnesota Statutes 2012, section 256B.441, subdivision 13, is amended to read:

205.26 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
205.27 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
205.28 section 144.122; until September 30, 2013, long-term care consultation fees under
205.29 section 256B.0911, subdivision 6; family advisory council fee under section 144A.33;
205.30 scholarships under section 256B.431, subdivision 36; planned closure rate adjustments
205.31 under section 256B.437; or single bed room incentives under section 256B.431,
205.32 subdivision 42; property taxes and property insurance; and PERA.

205.33 Sec. 22. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:

206.1 Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner
206.2 shall calculate a payment rate for external fixed costs.

206.3 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
206.4 shall be equal to \$8.86. For a facility licensed as both a nursing home and a boarding care
206.5 home, the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the
206.6 result of its number of nursing home beds divided by its total number of licensed beds.

206.7 (b) The portion related to the licensure fee under section 144.122, paragraph (d),
206.8 shall be the amount of the fee divided by actual resident days.

206.9 (c) The portion related to scholarships shall be determined under section 256B.431,
206.10 subdivision 36.

206.11 (d) Until September 30, 2013, the portion related to long-term care consultation shall
206.12 be determined according to section 256B.0911, subdivision 6.

206.13 (e) The portion related to development and education of resident and family advisory
206.14 councils under section 144A.33 shall be \$5 divided by 365.

206.15 (f) The portion related to planned closure rate adjustments shall be as determined
206.16 under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436.
206.17 Planned closure rate adjustments that take effect before October 1, 2014, shall no longer
206.18 be included in the payment rate for external fixed costs beginning October 1, 2016.
206.19 Planned closure rate adjustments that take effect on or after October 1, 2014, shall no
206.20 longer be included in the payment rate for external fixed costs beginning on October 1 of
206.21 the first year not less than two years after their effective date.

206.22 (g) The portions related to property insurance, real estate taxes, special assessments,
206.23 and payments made in lieu of real estate taxes directly identified or allocated to the nursing
206.24 facility shall be the actual amounts divided by actual resident days.

206.25 (h) The portion related to the Public Employees Retirement Association shall be
206.26 actual costs divided by resident days.

206.27 (i) The single bed room incentives shall be as determined under section 256B.431,
206.28 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
206.29 no longer be included in the payment rate for external fixed costs beginning October 1,
206.30 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
206.31 longer be included in the payment rate for external fixed costs beginning on October 1 of
206.32 the first year not less than two years after their effective date.

206.33 (j) The payment rate for external fixed costs shall be the sum of the amounts in
206.34 paragraphs (a) to (i).

206.35 Sec. 23. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:

207.1 Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall
207.2 establish statewide priorities for individuals on the waiting list for community alternative
207.3 care, community alternatives for disabled individuals, and brain injury waiver services,
207.4 as of January 1, 2010. The statewide priorities must include, but are not limited to,
207.5 individuals who continue to have a need for waiver services after they have maximized the
207.6 use of state plan services and other funding resources, including natural supports, prior to
207.7 accessing waiver services, and who meet at least one of the following criteria:

207.8 (1) have unstable living situations due to the age, incapacity, or sudden loss of
207.9 the primary caregivers;

207.10 (2) are moving from an institution due to bed closures;

207.11 (3) experience a sudden closure of their current living arrangement;

207.12 (4) require protection from confirmed abuse, neglect, or exploitation;

207.13 (5) experience a sudden change in need that can no longer be met through state plan
207.14 services or other funding resources alone; or

207.15 (6) meet other priorities established by the department.

207.16 (b) When allocating resources to lead agencies, the commissioner must take into
207.17 consideration the number of individuals waiting who meet statewide priorities and the
207.18 lead agencies' current use of waiver funds and existing service options. The commissioner
207.19 has the authority to transfer funds between counties, groups of counties, and tribes to
207.20 accommodate statewide priorities and resource needs while accounting for a necessary
207.21 base level reserve amount for each county, group of counties, and tribe.

207.22 ~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and~~
207.23 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
207.24 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
207.25 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

207.26 Sec. 24. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

207.27 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments
207.28 shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.
207.29 With the permission of the recipient or the recipient's designated legal representative,
207.30 the recipient's current provider of services may submit a written report outlining their
207.31 recommendations regarding the recipient's care needs prepared by a direct service
207.32 employee with at least 20 hours of service to that client. The person conducting the
207.33 assessment or reassessment must notify the provider of the date by which this information
207.34 is to be submitted. This information shall be provided to the person conducting the

208.1 assessment and the person or the person's legal representative and must be considered
208.2 prior to the finalization of the assessment or reassessment.

208.3 (b) There must be a determination that the client requires a hospital level of care or a
208.4 nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph
208.5 (d), at initial and subsequent assessments to initiate and maintain participation in the
208.6 waiver program.

208.7 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
208.8 appropriate to determine nursing facility level of care for purposes of medical assistance
208.9 payment for nursing facility services, only face-to-face assessments conducted according
208.10 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
208.11 determination or a nursing facility level of care determination must be accepted for
208.12 purposes of initial and ongoing access to waiver services payment.

208.13 (d) Recipients who are found eligible for home and community-based services under
208.14 this section before their 65th birthday may remain eligible for these services after their
208.15 65th birthday if they continue to meet all other eligibility factors.

208.16 (e) The commissioner shall develop criteria to identify recipients whose level of
208.17 functioning is reasonably expected to improve and reassess these recipients to establish
208.18 a baseline assessment. Recipients who meet these criteria must have a comprehensive
208.19 transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be
208.20 reassessed every six months until there has been no significant change in the recipient's
208.21 functioning for at least 12 months. Upon federal approval, if the recipient is able to have
208.22 the recipient's needs met through alternative services in a less restrictive setting, the
208.23 case manager shall help the recipient develop a plan to transition to an appropriate less
208.24 restrictive setting. After there has been no significant change in the recipient's functioning
208.25 for at least 12 months, reassessments of the recipient's strengths, informal support systems,
208.26 and need for services shall be conducted at least every 12 months and at other times
208.27 when there has been a significant change in the recipient's functioning. Counties, case
208.28 managers, and service providers are responsible for conducting these reassessments and
208.29 shall complete the reassessments out of existing funds.

208.30 **EFFECTIVE DATE.** This section is effective January 1, 2014.

208.31 Sec. 25. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:

208.32 Subd. 15. **Coordinated service and support plan; comprehensive transitional**
208.33 **service plan; maintenance service plan.** (a) Each recipient of home and community-based
208.34 waived services shall be provided a copy of the written coordinated service and support
208.35 plan which meets the requirements in section 256B.092, subdivision 1b.

209.1 (b) In developing the comprehensive transitional service plan, the individual
209.2 receiving services, the case manager, and the guardian, if applicable, will identify the
209.3 transitional service plan fundamental service outcome and anticipated timeline to achieve
209.4 this outcome. Within the first 20 days following a recipient's request for an assessment or
209.5 reassessment, the transitional service planning team must be identified. A team leader must
209.6 be identified who will be responsible for assigning responsibility and communicating with
209.7 team members to ensure implementation of the transition plan and ongoing assessment and
209.8 communication process. The team leader should be an individual, such as the case manager
209.9 or guardian, who has the opportunity to follow the recipient to the next level of service.

209.10 Within ten days following an assessment, a comprehensive transitional service plan
209.11 must be developed incorporating elements of a comprehensive functional assessment and
209.12 including short-term measurable outcomes and timelines for achievement of and reporting
209.13 on these outcomes. Functional milestones must also be identified and reported according
209.14 to the timelines agreed upon by the transitional service planning team. In addition, the
209.15 comprehensive transitional service plan must identify additional supports that may assist
209.16 in the achievement of the fundamental service outcome such as the development of greater
209.17 natural community support, increased collaboration among agencies, and technological
209.18 supports.

209.19 The timelines for reporting on functional milestones will prompt a reassessment of
209.20 services provided, the units of services, rates, and appropriate service providers. It is
209.21 the responsibility of the transitional service planning team leader to review functional
209.22 milestone reporting to determine if the milestones are consistent with observable skills
209.23 and that milestone achievement prompts any needed changes to the comprehensive
209.24 transitional service plan.

209.25 For those whose fundamental transitional service outcome involves the need to
209.26 procure housing, a plan for the recipient to seek the resources necessary to secure the least
209.27 restrictive housing possible should be incorporated into the plan, including employment
209.28 and public supports such as housing access and shelter needy funding.

209.29 (c) Counties and other agencies responsible for funding community placement and
209.30 ongoing community supportive services are responsible for the implementation of the
209.31 comprehensive transitional service plans. Oversight responsibilities include both ensuring
209.32 effective transitional service delivery and efficient utilization of funding resources.

209.33 (d) Following one year of transitional services, the transitional services planning team
209.34 will make a determination as to whether or not the individual receiving services requires
209.35 the current level of continuous and consistent support in order to maintain the recipient's
209.36 current level of functioning. Recipients who are determined to have not had a significant

210.1 change in functioning for 12 months must move from a transitional to a maintenance
210.2 service plan. Recipients on a maintenance service plan must be reassessed to determine if
210.3 the recipient would benefit from a transitional service plan at least every 12 months and at
210.4 other times when there has been a significant change in the recipient's functioning. This
210.5 assessment should consider any changes to technological or natural community supports.

210.6 (e) When a county is evaluating denials, reductions, or terminations of home and
210.7 community-based services under section 256B.49 for an individual, the case manager
210.8 shall offer to meet with the individual or the individual's guardian in order to discuss
210.9 the prioritization of service needs within the coordinated service and support plan,
210.10 comprehensive transitional service plan, or maintenance service plan. The reduction in
210.11 the authorized services for an individual due to changes in funding for waived services
210.12 may not exceed the amount needed to ensure medically necessary services to meet the
210.13 individual's health, safety, and welfare.

210.14 (f) At the time of reassessment, local agency case managers shall assess each recipient
210.15 of community alternatives for disabled individuals or brain injury waived services
210.16 currently residing in a licensed adult foster home that is not the primary residence of the
210.17 license holder, or in which the license holder is not the primary caregiver, to determine if
210.18 that recipient could appropriately be served in a community-living setting. If appropriate
210.19 for the recipient, the case manager shall offer the recipient, through a person-centered
210.20 planning process, the option to receive alternative housing and service options. In the
210.21 event that the recipient chooses to transfer from the adult foster home, the vacated bed
210.22 shall not be filled with another recipient of waiver services and group residential housing
210.23 and the licensed capacity shall be reduced accordingly, unless the savings required by the
210.24 licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7,
210.25 sections 1 and 40, paragraph (f), for foster care settings where the physical location is not
210.26 the primary residence of the license holder are met through voluntary changes described
210.27 in section 245A.03, subdivision 7, paragraph ~~(f)~~(e), or as provided under paragraph (a),
210.28 clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers,
210.29 the county agency, with the assistance of the department, shall facilitate a consolidation of
210.30 settings or closure. This reassessment process shall be completed by July 1, 2013.

210.31 Sec. 26. Minnesota Statutes 2012, section 256B.49, is amended by adding a
210.32 subdivision to read:

210.33 Subd. 25. Excess allocations. County and tribal agencies will be responsible for
210.34 authorizations in excess of the allocation made by the commissioner. In the event a county
210.35 or tribal agency authorizes in excess of the allocation made by the commissioner for a

211.1 given allocation period, they must submit a corrective action plan to the commissioner.
211.2 The plan must state the actions the agency will take to correct their over-authorization for
211.3 the year following the period when the over-authorization occurred. Failure to correct
211.4 over-authorizations shall result in recoupment of authorizations in excess of the allocation.
211.5 Nothing in this subdivision shall be construed as reducing the county's responsibility to
211.6 offer and make available feasible home and community-based options to eligible waiver
211.7 recipients within the resources allocated to them for that purpose.

211.8 Sec. 27. Minnesota Statutes 2012, section 256B.492, is amended to read:

211.9 **256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE**
211.10 **WITH DISABILITIES.**

211.11 (a) Individuals receiving services under a home and community-based waiver under
211.12 section 256B.092 or 256B.49 may receive services in the following settings:

211.13 (1) an individual's own home or family home;

211.14 (2) a licensed adult foster care setting of up to five people; and

211.15 (3) community living settings as defined in section 256B.49, subdivision 23, where
211.16 individuals with disabilities may reside in all of the units in a building of four or fewer
211.17 units, and no more than the greater of four or 25 percent of the units in a multifamily
211.18 building of more than four units, unless required by the Housing Opportunities for Persons
211.19 with AIDS program.

211.20 (b) The settings in paragraph (a) must not:

211.21 (1) be located in a building that is a publicly or privately operated facility that
211.22 provides institutional treatment or custodial care;

211.23 (2) be located in a building on the grounds of or adjacent to a public or private
211.24 institution;

211.25 (3) be a housing complex designed expressly around an individual's diagnosis or
211.26 disability, unless required by the Housing Opportunities for Persons with AIDS program;

211.27 (4) be segregated based on a disability, either physically or because of setting
211.28 characteristics, from the larger community; and

211.29 (5) have the qualities of an institution which include, but are not limited to:
211.30 regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions
211.31 agreed to and documented in the person's individual service plan shall not result in a
211.32 residence having the qualities of an institution as long as the restrictions for the person are
211.33 not imposed upon others in the same residence and are the least restrictive alternative,
211.34 imposed for the shortest possible time to meet the person's needs.

212.1 (c) The provisions of paragraphs (a) and (b) do not apply to any setting in which
212.2 individuals receive services under a home and community-based waiver as of July 1,
212.3 2012, and the setting does not meet the criteria of this section.

212.4 (d) Notwithstanding paragraph (c), a program in Hennepin County established as
212.5 part of a Hennepin County demonstration project is qualified for the exception allowed
212.6 under paragraph (c).

212.7 (e) The commissioner shall submit an amendment to the waiver plan no later than
212.8 December 31, 2012.

212.9 Sec. 28. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:

212.10 Subd. 2. **Planned closure process needs determination.** The commissioner shall
212.11 announce and implement a program for planned closure of adult foster care homes. Planned
212.12 closure shall be the preferred method for achieving necessary budgetary savings required by
212.13 the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph ~~(d)~~
212.14 (c). If additional closures are required to achieve the necessary savings, the commissioner
212.15 shall use the process and priorities in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c).

212.16 Sec. 29. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
212.17 subdivision to read:

212.18 Subd. 14. **Rate increase effective June 1, 2013.** For rate periods beginning on or
212.19 after June 1, 2013, the commissioner shall increase the total operating payment rate for
212.20 each facility reimbursed under this section by \$7.81 per day. The increase shall not be
212.21 subject to any annual percentage increase.

212.22 **EFFECTIVE DATE.** This section is effective June 1, 2013.

212.23 Sec. 30. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
212.24 subdivision to read:

212.25 Subd. 15. **ICF/DD rate increases effective July 1, 2013.** (a) Notwithstanding
212.26 subdivision 12, for each facility reimbursed under this section, for the rate period
212.27 beginning July 1, 2013, the commissioner shall increase operating payments equal to two
212.28 percent of the operating payment rates in effect on June 30, 2013.

212.29 (b) For each facility, the commissioner shall apply the rate increase based on
212.30 occupied beds, using the percentage specified in this subdivision multiplied by the total
212.31 payment rate, including the variable rate, but excluding the property-related payment
212.32 rate in effect on the preceding date. The total rate increase shall include the adjustment
212.33 provided in section 256B.501, subdivision 12.

213.1 Sec. 31. Minnesota Statutes 2012, section 256B.69, is amended by adding a
 213.2 subdivision to read:

213.3 Subd. 32a. **Initiatives to improve early screening, diagnosis, and treatment of**
 213.4 **children with autism spectrum disorder and other developmental conditions.** (a) The
 213.5 commissioner shall require managed care plans and county-based purchasing plans, as
 213.6 a condition of contract, to implement strategies that facilitate access for young children
 213.7 between the ages of one and three years to periodic developmental and social-emotional
 213.8 screenings, as recommended by the Minnesota Interagency Developmental Screening
 213.9 Task Force, and that those children who do not meet milestones are provided access to
 213.10 appropriate evaluation and assessment, including treatment recommendations, expected to
 213.11 improve the child's functioning, with the goal of meeting milestones by age five.

213.12 (b) The managed care plans must report the following data annually:

213.13 (1) the number of children who received a diagnostic assessment;

213.14 (2) the total number of children ages one to six with a diagnosis of autism spectrum
 213.15 disorder who received treatments;

213.16 (3) the number of children identified under clause (2) reported by each 12-month
 213.17 age group beginning with age one and ending with age six;

213.18 (4) the types of treatments provided to children identified under clause (2) listed by
 213.19 billing code, including the number of units billed for each child;

213.20 (5) barriers to providing screening, diagnosis, and treatment of young children
 213.21 between the ages of one and three years and any strategies implemented to address
 213.22 those barriers; and

213.23 (6) recommendations on how to measure and report on the effectiveness of the
 213.24 strategies implemented to facilitate access for young children to provide developmental
 213.25 and social-emotional screening, diagnosis, and treatment.

213.26 Sec. 32. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
 213.27 3, as amended by Laws 2012, chapter 247, article 4, section 43, is amended to read:

213.28 **Subd. 3. Forecasted Programs**

213.29 The amounts that may be spent from this
 213.30 appropriation for each purpose are as follows:

213.31 **(a) MFIP/DWP Grants**

213.32	Appropriations by Fund		
213.33	General	84,680,000	91,978,000
213.34	Federal TANF	84,425,000	75,417,000

214.1	(b) MFIP Child Care Assistance Grants	55,456,000	30,923,000
214.2	(c) General Assistance Grants	49,192,000	46,938,000
214.3	General Assistance Standard. The		
214.4	commissioner shall set the monthly standard		
214.5	of assistance for general assistance units		
214.6	consisting of an adult recipient who is		
214.7	childless and unmarried or living apart		
214.8	from parents or a legal guardian at \$203.		
214.9	The commissioner may reduce this amount		
214.10	according to Laws 1997, chapter 85, article		
214.11	3, section 54.		
214.12	Emergency General Assistance. The		
214.13	amount appropriated for emergency general		
214.14	assistance funds is limited to no more than		
214.15	\$6,689,812 in fiscal year 2012 and \$6,729,812		
214.16	in fiscal year 2013. Funds to counties shall		
214.17	be allocated by the commissioner using the		
214.18	allocation method specified in Minnesota		
214.19	Statutes, section 256D.06.		
214.20	(d) Minnesota Supplemental Aid Grants	38,095,000	39,120,000
214.21	(e) Group Residential Housing Grants	121,080,000	129,238,000
214.22	(f) MinnesotaCare Grants	295,046,000	317,272,000
214.23	This appropriation is from the health care		
214.24	access fund.		
214.25	(g) Medical Assistance Grants	4,501,582,000	4,437,282,000
214.26	Managed Care Incentive Payments. The		
214.27	commissioner shall not make managed care		
214.28	incentive payments for expanding preventive		
214.29	services during fiscal years beginning July 1,		
214.30	2011, and July 1, 2012.		
214.31	Reduction of Rates for Congregate		
214.32	Living for Individuals with Lower Needs.		
214.33	Beginning October 1, 2011, lead agencies		

215.1 must reduce rates in effect on January 1, 2011,
215.2 by ten percent for individuals with lower
215.3 needs living in foster care settings where the
215.4 license holder does not share the residence
215.5 with recipients on the CADI and DD waivers
215.6 and customized living settings for CADI.
215.7 Lead agencies shall consult with providers to
215.8 review individual service plans and identify
215.9 changes or modifications to reduce the
215.10 utilization of services while maintaining the
215.11 health and safety of the individual receiving
215.12 services. Lead agencies must adjust contracts
215.13 within 60 days of the effective date. If
215.14 federal waiver approval is obtained under
215.15 the long-term care realignment waiver
215.16 application submitted on February 13,
215.17 2012, and federal financial participation is
215.18 authorized for the alternative care program,
215.19 the commissioner shall adjust this payment
215.20 rate reduction from ten to five percent for
215.21 services rendered on or after July 1, 2012, or
215.22 the first day of the month following federal
215.23 approval, whichever is later. Effective
215.24 August 1, 2013, this provision does not apply
215.25 to individuals whose primary diagnosis is
215.26 mental illness and who are living in foster
215.27 care settings where the license holder is
215.28 also (1) a provider of assertive community
215.29 treatment (ACT) or adult rehabilitative
215.30 mental health services (ARMHS) as defined
215.31 in Minnesota Statutes, section 256B.0623;
215.32 (2) a mental health center or mental health
215.33 clinic certified under Minnesota Rules, parts
215.34 9520.0750 to 9520.0870; or (3) a provider
215.35 of intensive residential treatment services

216.1 (IRTS) licensed under Minnesota Rules,
216.2 parts 9520.0500 to 9520.0670.

216.3 **Reduction of Lead Agency Waiver**

216.4 **Allocations to Implement Rate Reductions**

216.5 **for Congregate Living for Individuals**

216.6 **with Lower Needs.** Beginning October 1,

216.7 2011, the commissioner shall reduce lead

216.8 agency waiver allocations to implement the

216.9 reduction of rates for individuals with lower

216.10 needs living in foster care settings where the

216.11 license holder does not share the residence

216.12 with recipients on the CADI and DD waivers

216.13 and customized living settings for CADI.

216.14 **Reduce customized living and 24-hour**

216.15 **customized living component rates.**

216.16 Effective July 1, 2011, the commissioner

216.17 shall reduce elderly waiver customized living

216.18 and 24-hour customized living component

216.19 service spending by five percent through

216.20 reductions in component rates and service

216.21 rate limits. The commissioner shall adjust

216.22 the elderly waiver capitation payment

216.23 rates for managed care organizations paid

216.24 under Minnesota Statutes, section 256B.69,

216.25 subdivisions 6a and 23, to reflect reductions

216.26 in component spending for customized living

216.27 services and 24-hour customized living

216.28 services under Minnesota Statutes, section

216.29 256B.0915, subdivisions 3e and 3h, for the

216.30 contract period beginning January 1, 2012.

216.31 To implement the reduction specified in

216.32 this provision, capitation rates paid by the

216.33 commissioner to managed care organizations

216.34 under Minnesota Statutes, section 256B.69,

216.35 shall reflect a ten percent reduction for the

216.36 specified services for the period January 1,

217.1 2012, to June 30, 2012, and a five percent
217.2 reduction for those services on or after July
217.3 1, 2012.

217.4 **Limit Growth in the Developmental**
217.5 **Disability Waiver.** The commissioner
217.6 shall limit growth in the developmental
217.7 disability waiver to six diversion allocations
217.8 per month beginning July 1, 2011, through
217.9 June 30, 2013, and 15 diversion allocations
217.10 per month beginning July 1, 2013, through
217.11 June 30, 2015. Waiver allocations shall
217.12 be targeted to individuals who meet the
217.13 priorities for accessing waiver services
217.14 identified in Minnesota Statutes, 256B.092,
217.15 subdivision 12. The limits do not include
217.16 conversions from intermediate care facilities
217.17 for persons with developmental disabilities.
217.18 Notwithstanding any contrary provisions in
217.19 this article, this paragraph expires June 30,
217.20 2015.

217.21 **Limit Growth in the Community**
217.22 **Alternatives for Disabled Individuals**
217.23 **Waiver.** The commissioner shall limit
217.24 growth in the community alternatives for
217.25 disabled individuals waiver to 60 allocations
217.26 per month beginning July 1, 2011, through
217.27 June 30, 2013, and 85 allocations per
217.28 month beginning July 1, 2013, through
217.29 June 30, 2015. Waiver allocations must
217.30 be targeted to individuals who meet the
217.31 priorities for accessing waiver services
217.32 identified in Minnesota Statutes, section
217.33 256B.49, subdivision 11a. The limits include
217.34 conversions and diversions, unless the
217.35 commissioner has approved a plan to convert
217.36 funding due to the closure or downsizing

218.1 of a residential facility or nursing facility
 218.2 to serve directly affected individuals on
 218.3 the community alternatives for disabled
 218.4 individuals waiver. Notwithstanding any
 218.5 contrary provisions in this article, this
 218.6 paragraph expires June 30, 2015.

218.7 **Personal Care Assistance Relative**

218.8 **Care.** The commissioner shall adjust the
 218.9 capitation payment rates for managed care
 218.10 organizations paid under Minnesota Statutes,
 218.11 section 256B.69, to reflect the rate reductions
 218.12 for personal care assistance provided by
 218.13 a relative pursuant to Minnesota Statutes,
 218.14 section 256B.0659, subdivision 11. This rate
 218.15 reduction is effective July 1, 2013.

218.16	(h) Alternative Care Grants	46,421,000	46,035,000
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218.17 **Alternative Care Transfer.** Any money
 218.18 allocated to the alternative care program that
 218.19 is not spent for the purposes indicated does
 218.20 not cancel but shall be transferred to the
 218.21 medical assistance account.

218.22	(i) Chemical Dependency Entitlement Grants	94,675,000	93,298,000
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218.23 **EFFECTIVE DATE.** This section is effective August 1, 2013.

218.24 Sec. 33. **RECOMMENDATIONS FOR CONCENTRATION LIMITS ON HOME**
 218.25 **AND COMMUNITY-BASED SETTINGS.**

218.26 The commissioner of human services shall consult with the Minnesota Olmstead
 218.27 subcabinet, advocates, providers, and city representatives to develop recommendations
 218.28 on concentration limits on home and community-based settings, as defined in
 218.29 Minnesota Statutes, section 256B.492, as well as any other exceptions to the definition.
 218.30 The recommendations must be consistent with Minnesota's Olmstead plan. The
 218.31 recommendations and proposed legislation must be submitted to the chairs and ranking
 218.32 minority members of the legislative committees with jurisdiction over health and human
 218.33 services policy and finance by February 1, 2014.

219.1 Sec. 34. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY**
219.2 **1, 2013.**

219.3 (a) The commissioner of human services shall increase reimbursement rates, grants,
219.4 allocations, individual limits, and rate limits, as applicable, by two percent for the rate
219.5 period beginning July 1, 2013, for services rendered on or after those dates. County or
219.6 tribal contracts for services specified in this section must be amended to pass through
219.7 these rate increases within 60 days of the effective date.

219.8 (b) The rate changes described in this section must be provided to:

219.9 (1) home and community-based waived services for persons with developmental
219.10 disabilities or related conditions, including consumer-directed community supports, under
219.11 Minnesota Statutes, section 256B.501;

219.12 (2) waived services under community alternatives for disabled individuals,
219.13 including consumer-directed community supports, under Minnesota Statutes, section
219.14 256B.49;

219.15 (3) community alternative care waived services, including consumer-directed
219.16 community supports, under Minnesota Statutes, section 256B.49;

219.17 (4) traumatic brain injury waived services, including consumer-directed
219.18 community supports, under Minnesota Statutes, section 256B.49;

219.19 (5) home and community-based waived services for the elderly under Minnesota
219.20 Statutes, section 256B.0915;

219.21 (6) nursing services and home health services under Minnesota Statutes, section
219.22 256B.0625, subdivision 6a;

219.23 (7) personal care services and qualified professional supervision of personal care
219.24 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

219.25 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
219.26 subdivision 7;

219.27 (9) day training and habilitation services for adults with developmental disabilities
219.28 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
219.29 additional cost of rate adjustments on day training and habilitation services, provided as a
219.30 social service, under Minnesota Statutes, section 256M.60;

219.31 (10) alternative care services under Minnesota Statutes, section 256B.0913;

219.32 (11) living skills training programs for persons with intractable epilepsy who need
219.33 assistance in the transition to independent living under Laws 1988, chapter 689;

219.34 (12) semi-independent living services (SILS) under Minnesota Statutes, section
219.35 252.275, including SILS funding under county social services grants formerly funded
219.36 under Minnesota Statutes, chapter 256I;

220.1 (13) consumer support grants under Minnesota Statutes, section 256.476;

220.2 (14) family support grants under Minnesota Statutes, section 252.32;

220.3 (15) housing access grants under Minnesota Statutes, section 256B.0658;

220.4 (16) self-advocacy grants under Laws 2009, chapter 101; and

220.5 (17) technology grants under Laws 2009, chapter 79.

220.6 (c) A managed care plan receiving state payments for the services in this section
 220.7 must include these increases in their payments to providers. To implement the rate increase
 220.8 in this section, capitation rates paid by the commissioner to managed care organizations
 220.9 under Minnesota Statutes, section 256B.69, shall reflect a two percent increase for the
 220.10 specified services for the period beginning July 1, 2013.

220.11 (d) Counties shall increase the budget for each recipient of consumer-directed
 220.12 community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

220.13 **Sec. 35. TRAINING OF AUTISM SERVICE PROVIDERS.**

220.14 The commissioners of health and human services shall ensure that the departments'
 220.15 autism-related service providers receive training in culturally appropriate approaches to
 220.16 servicing the Somali, Latino, Hmong, and Indigenous American Indian communities, and
 220.17 other cultural groups experiencing a disproportionate incidence of autism.

220.18 **Sec. 36. DIRECTION TO COMMISSIONER.**

220.19 By January 1, 2014, the commissioner of human services shall apply to the federal
 220.20 Centers for Medicare and Medicaid Services for a waiver or other authority to provide
 220.21 applied behavioral analysis services to children with autism spectrum disorder and related
 220.22 conditions under the medical assistance program.

220.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

220.24 **Sec. 37. RECOMMENDATIONS ON RAISING THE ASSET LIMITS FOR**
 220.25 **SENIORS AND PERSONS WITH DISABILITIES.**

220.26 The commissioner of human services shall consult with interested stakeholders to
 220.27 develop recommendations to increase the asset limit a reasonable amount considering
 220.28 changes since the limit was established for (1) individuals who are not homeowners and (2)
 220.29 homeowners eligible for medical assistance due to disability or age who are not residing in
 220.30 a nursing facility, intermediate care facility for persons with developmental disabilities,
 220.31 or other institution whose costs for room and board are covered by medical assistance or
 220.32 state funds. The recommendations must be provided to the legislative committees with
 220.33 jurisdiction over health and human services policy and finance by February 1, 2014.

221.1 **Sec. 38. NURSING HOME LEVEL OF CARE REPORT.**

221.2 (a) The commissioner of human services shall report on the impact of the nursing
221.3 facility level of care to be implemented January 1, 2014, including the following:

221.4 (1) the number of individuals who lose eligibility for home and community-based
221.5 services waivers under Minnesota Statutes, sections 256B.0915 and 256B.49, and
221.6 alternative care under Minnesota Statutes, section 256B.0913;

221.7 (2) the number of individuals who lose eligibility for medical assistance; and

221.8 (3) for individuals reported under clauses (1) and (2), and to the extent possible:

221.9 (i) their living situation before and after nursing facility level of care implementation;

221.10 and

221.11 (ii) the programs or services they received before and after nursing facility level of
221.12 care implementation, including, but not limited to, personal care assistant services and
221.13 essential community supports.

221.14 (b) The commissioner of human services shall report to the chairs of the legislative
221.15 committees with jurisdiction over health and human services policy and finance with the
221.16 information required under paragraph (a). A preliminary report shall be submitted on
221.17 October 1, 2014, and a final report shall be submitted February 15, 2015.

221.18 **Sec. 39. HOME AND COMMUNITY-BASED SERVICES REPORT CARD.**

221.19 (a) The commissioner of human services shall work with existing advisory groups
221.20 to develop recommendations for a home and community-based services report card.

221.21 The advisory committee shall consider the requirements from the Minnesota Consumer
221.22 Information Guide under Minnesota Statutes, section 144G.06, as a base for development
221.23 of a home and community-based services report card to compare the housing options
221.24 available to consumers. Other items to be considered by the advisory committee in
221.25 developing recommendations include:

221.26 (1) defining the goal of the report card;

221.27 (2) measuring outcomes, consumer information, and options for pay for performance;

221.28 (3) developing separate measures for programs for the elderly population and for
221.29 persons with disabilities;

221.30 (4) identifying sources of information that are standardized and contain sufficient
221.31 data;

221.32 (5) identifying the financial support needed to create and publicize the housing
221.33 information guide, and ongoing funding for data collection and staffing to monitor,
221.34 report, and analyze data;

- 222.1 (6) recognizing that home and community-based services settings exist with
222.2 significant variations as to size, settings, and services available;
222.3 (7) ensuring that consumer choice and consumer information is retained and valued;
222.4 and
222.5 (8) considering the applicability of these measures on providers based on payer
222.6 source, size, and population served.
222.7 (b) The workgroup shall discuss whether additional funding, resources, or research
222.8 is needed. The workgroup shall report recommendations to the legislative committees
222.9 with jurisdiction over health and human services policy and finance by August 1, 2014.
222.10 The report card shall be available on July 1, 2015.

222.11 Sec. 40. **REPEALER.**

- 222.12 (a) Minnesota Statutes 2012, sections 256B.14, subdivision 3a; and 256B.5012,
222.13 subdivision 13; and Laws 2011, First Special Session chapter 9, article 7, section 54, as
222.14 amended by Laws 2012, chapter 247, article 4, section 42, and Laws 2012, chapter 298,
222.15 section 3, are repealed.
222.16 (b) Minnesota Statutes 2012, section 256B.096, subdivisions 1, 2, 3, and 4, are
222.17 repealed.

222.18 **ARTICLE 8**

222.19 **WAIVER PROVIDER STANDARDS**

- 222.20 Section 1. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:
222.21 Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity
222.22 licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under
222.23 section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47,
222.24 an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts
222.25 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or
222.26 a hospice provider licensed under sections 144A.75 to 144A.755.

- 222.27 Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:

- 222.28 Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this
222.29 subdivision, "health care facility" means a facility:

- 222.30 (1) licensed by the commissioner of health as a hospital, boarding care home or
222.31 supervised living facility under sections 144.50 to 144.58, or a nursing home under
222.32 chapter 144A;

223.1 (2) registered by the commissioner of health as a housing with services establishment
223.2 as defined in section 144D.01; or

223.3 (3) licensed by the commissioner of human services as a residential facility under
223.4 chapter 245A to provide adult foster care, adult mental health treatment, chemical
223.5 dependency treatment to adults, or residential services to persons with developmental
223.6 disabilities.

223.7 (b) Prior to admission to a health care facility, a person required to register under
223.8 this section shall disclose to:

223.9 (1) the health care facility employee processing the admission the person's status
223.10 as a registered predatory offender under this section; and

223.11 (2) the person's corrections agent, or if the person does not have an assigned
223.12 corrections agent, the law enforcement authority with whom the person is currently
223.13 required to register, that inpatient admission will occur.

223.14 (c) A law enforcement authority or corrections agent who receives notice under
223.15 paragraph (b) or who knows that a person required to register under this section is
223.16 planning to be admitted and receive, or has been admitted and is receiving health care
223.17 at a health care facility shall notify the administrator of the facility and deliver a fact
223.18 sheet to the administrator containing the following information: (1) name and physical
223.19 description of the offender; (2) the offender's conviction history, including the dates of
223.20 conviction; (3) the risk level classification assigned to the offender under section 244.052,
223.21 if any; and (4) the profile of likely victims.

223.22 (d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care
223.23 facility receives a fact sheet under paragraph (c) that includes a risk level classification for
223.24 the offender, and if the facility admits the offender, the facility shall distribute the fact
223.25 sheet to all residents at the facility. If the facility determines that distribution to a resident
223.26 is not appropriate given the resident's medical, emotional, or mental status, the facility
223.27 shall distribute the fact sheet to the patient's next of kin or emergency contact.

223.28 **Sec. 3. [245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY**
223.29 **MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**

223.30 **Subdivision 1. Rules.** The commissioner of human services shall, within 24 months
223.31 of enactment of this section, adopt rules governing the use of positive support strategies,
223.32 safety interventions, and emergency use of manual restraint in facilities and services
223.33 licensed under chapter 245D.

223.34 **Subd. 2. Data collection.** (a) The commissioner shall, with stakeholder input,
223.35 develop data collection elements specific to incidents on the use of controlled procedures

224.1 with persons receiving services from providers regulated under Minnesota Rules, parts
224.2 9525.2700 to 9525.2810, and incidents involving persons receiving services from
224.3 providers identified to be licensed under chapter 245D effective January 1, 2014. Providers
224.4 shall report the data in a format and at a frequency provided by the commissioner of
224.5 human services.

224.6 (b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts
224.7 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures
224.8 in a format and at a frequency provided by the commissioner.

224.9 Sec. 4. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:

224.10 Subd. 10. **Nonresidential program.** "Nonresidential program" means care,
224.11 supervision, rehabilitation, training or habilitation of a person provided outside the
224.12 person's own home and provided for fewer than 24 hours a day, including adult day
224.13 care programs; and chemical dependency or chemical abuse programs that are located
224.14 in a nursing home or hospital and receive public funds for providing chemical abuse or
224.15 chemical dependency treatment services under chapter 254B. Nonresidential programs
224.16 include home and community-based services ~~and semi-independent living services~~ for
224.17 persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in
224.18 or outside of a person's own home under chapter 245D.

224.19 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:

224.20 Subd. 14. **Residential program.** "Residential program" means a program
224.21 that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training,
224.22 education, habilitation, or treatment outside a person's own home, including a program
224.23 in an intermediate care facility for four or more persons with developmental disabilities;
224.24 and chemical dependency or chemical abuse programs that are located in a hospital
224.25 or nursing home and receive public funds for providing chemical abuse or chemical
224.26 dependency treatment services under chapter 254B. Residential programs include home
224.27 and community-based services for persons with ~~developmental~~ disabilities or persons age
224.28 65 and older that are provided in or outside of a person's own home under chapter 245D.

224.29 Sec. 6. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

224.30 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial
224.31 license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340,
224.32 or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under
224.33 this chapter for a physical location that will not be the primary residence of the license

225.1 holder for the entire period of licensure. If a license is issued during this moratorium, and
225.2 the license holder changes the license holder's primary residence away from the physical
225.3 location of the foster care license, the commissioner shall revoke the license according
225.4 to section 245A.07. The commissioner shall not issue an initial license for a community
225.5 residential setting licensed under chapter 245D. Exceptions to the moratorium include:

225.6 (1) foster care settings that are required to be registered under chapter 144D;

225.7 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
225.8 community residential setting licenses replacing adult foster care licenses in existence on
225.9 December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

225.10 (3) new foster care licenses or community residential setting licenses determined to
225.11 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
225.12 ICF/MR, or regional treatment center, or restructuring of state-operated services that
225.13 limits the capacity of state-operated facilities;

225.14 (4) new foster care licenses or community residential setting licenses determined
225.15 to be needed by the commissioner under paragraph (b) for persons requiring hospital
225.16 level care; or

225.17 (5) new foster care licenses or community residential setting licenses determined to
225.18 be needed by the commissioner for the transition of people from personal care assistance
225.19 to the home and community-based services.

225.20 (b) The commissioner shall determine the need for newly licensed foster care
225.21 homes or community residential settings as defined under this subdivision. As part of the
225.22 determination, the commissioner shall consider the availability of foster care capacity in
225.23 the area in which the licensee seeks to operate, and the recommendation of the local
225.24 county board. The determination by the commissioner must be final. A determination of
225.25 need is not required for a change in ownership at the same address.

225.26 (c) The commissioner shall study the effects of the license moratorium under this
225.27 subdivision and shall report back to the legislature by January 15, 2011. This study shall
225.28 include, but is not limited to the following:

225.29 (1) the overall capacity and utilization of foster care beds where the physical location
225.30 is not the primary residence of the license holder prior to and after implementation
225.31 of the moratorium;

225.32 (2) the overall capacity and utilization of foster care beds where the physical
225.33 location is the primary residence of the license holder prior to and after implementation
225.34 of the moratorium; and

225.35 (3) the number of licensed and occupied ICF/MR beds prior to and after
225.36 implementation of the moratorium.

226.1 (d) When a ~~foster care recipient~~ resident served by the program moves out of a
226.2 foster home that is not the primary residence of the license holder according to section
226.3 256B.49, subdivision 15, paragraph (f), or the community residential setting, the county
226.4 shall immediately inform the Department of Human Services Licensing Division.

226.5 The department shall decrease the statewide licensed capacity for foster care settings
226.6 where the physical location is not the primary residence of the license holder, or for
226.7 community residential settings, if the voluntary changes described in paragraph (f) are
226.8 not sufficient to meet the savings required by reductions in licensed bed capacity under
226.9 Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f),
226.10 and maintain statewide long-term care residential services capacity within budgetary
226.11 limits. Implementation of the statewide licensed capacity reduction shall begin on July
226.12 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the
226.13 needs determination process. Under this paragraph, the commissioner has the authority
226.14 to reduce unused licensed capacity of a current foster care program, or the community
226.15 residential settings, to accomplish the consolidation or closure of settings. A decreased
226.16 licensed capacity according to this paragraph is not subject to appeal under this chapter.

226.17 (e) Residential settings that would otherwise be subject to the decreased license
226.18 capacity established in paragraph (d) shall be exempt under the following circumstances:

226.19 (1) until August 1, 2013, the license holder's beds occupied by residents whose
226.20 primary diagnosis is mental illness and the license holder is:

226.21 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
226.22 health services (ARMHS) as defined in section 256B.0623;

226.23 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
226.24 9520.0870;

226.25 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
226.26 9520.0870; or

226.27 (iv) a provider of intensive residential treatment services (IRTS) licensed under
226.28 Minnesota Rules, parts 9520.0500 to 9520.0670; or

226.29 (2) the license holder is certified under the requirements in subdivision 6a or section
226.30 245D.33.

226.31 (f) A resource need determination process, managed at the state level, using the
226.32 available reports required by section 144A.351, and other data and information shall
226.33 be used to determine where the reduced capacity required under paragraph (d) will be
226.34 implemented. The commissioner shall consult with the stakeholders described in section
226.35 144A.351, and employ a variety of methods to improve the state's capacity to meet
226.36 long-term care service needs within budgetary limits, including seeking proposals from

227.1 service providers or lead agencies to change service type, capacity, or location to improve
227.2 services, increase the independence of residents, and better meet needs identified by the
227.3 long-term care services reports and statewide data and information. By February 1 of each
227.4 year, the commissioner shall provide information and data on the overall capacity of
227.5 licensed long-term care services, actions taken under this subdivision to manage statewide
227.6 long-term care services and supports resources, and any recommendations for change to
227.7 the legislative committees with jurisdiction over health and human services budget.

227.8 (g) At the time of application and reapplication for licensure, the applicant and the
227.9 license holder that are subject to the moratorium or an exclusion established in paragraph
227.10 (a) are required to inform the commissioner whether the physical location where the foster
227.11 care will be provided is or will be the primary residence of the license holder for the entire
227.12 period of licensure. If the primary residence of the applicant or license holder changes, the
227.13 applicant or license holder must notify the commissioner immediately. The commissioner
227.14 shall print on the foster care license certificate whether or not the physical location is the
227.15 primary residence of the license holder.

227.16 (h) License holders of foster care homes identified under paragraph (g) that are not
227.17 the primary residence of the license holder and that also provide services in the foster care
227.18 home that are covered by a federally approved home and community-based services
227.19 waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the
227.20 human services licensing division that the license holder provides or intends to provide
227.21 these waiver-funded services. ~~These license holders must be considered registered under~~
227.22 ~~section 256B.092, subdivision 11, paragraph (c), and this registration status must be~~
227.23 ~~identified on their license certificates.~~

227.24 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

227.25 Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall
227.26 prohibit a program that is excluded from licensure under subdivision 2, paragraph
227.27 (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any
227.28 application received from such an excluded provider is processed in the same manner as
227.29 all other applications for child care center licensure.

227.30 Sec. 8. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:

227.31 Subd. 3. **Implementation.** (a) The commissioner shall implement the
227.32 responsibilities of this chapter according to the timelines in paragraphs (b) and (c)
227.33 only within the limits of available appropriations or other administrative cost recovery
227.34 methodology.

228.1 (b) The licensure of home and community-based services according to this section
228.2 shall be implemented January 1, 2014. License applications shall be received and
228.3 processed on a phased-in schedule as determined by the commissioner beginning July
228.4 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that
228.5 the application is complete according to section 245A.04.

228.6 (c) Within the limits of available appropriations or other administrative cost recovery
228.7 methodology, implementation of compliance monitoring must be phased in after January
228.8 1, 2014.

228.9 (1) Applicants who do not currently hold a license issued under ~~this chapter~~ 245B
228.10 must receive an initial compliance monitoring visit after 12 months of the effective date of
228.11 the initial license for the purpose of providing technical assistance on how to achieve and
228.12 maintain compliance with the applicable law or rules governing the provision of home and
228.13 community-based services under chapter 245D. If during the review the commissioner
228.14 finds that the license holder has failed to achieve compliance with an applicable law or
228.15 rule and this failure does not imminently endanger the health, safety, or rights of the
228.16 persons served by the program, the commissioner may issue a licensing review report with
228.17 recommendations for achieving and maintaining compliance.

228.18 (2) Applicants who do currently hold a license issued under this chapter must receive
228.19 a compliance monitoring visit after 24 months of the effective date of the initial license.

228.20 (d) Nothing in this subdivision shall be construed to limit the commissioner's
228.21 authority to suspend or revoke a license or issue a fine at any time under section 245A.07,
228.22 or ~~make issue~~ correction orders and make a license conditional for failure to comply with
228.23 applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity
228.24 of the violation of law or rule and the effect of the violation on the health, safety, or
228.25 rights of persons served by the program.

228.26 Sec. 9. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

228.27 Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license
228.28 under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is
228.29 based on a disqualification for which reconsideration was requested and which was not
228.30 set aside under section 245C.22, the scope of the contested case hearing shall include the
228.31 disqualification and the licensing sanction or denial of a license, unless otherwise specified
228.32 in this subdivision. When the licensing sanction or denial of a license is based on a
228.33 determination of maltreatment under section 626.556 or 626.557, or a disqualification for
228.34 serious or recurring maltreatment which was not set aside, the scope of the contested case
228.35 hearing shall include the maltreatment determination, disqualification, and the licensing

229.1 sanction or denial of a license, unless otherwise specified in this subdivision. In such
229.2 cases, a fair hearing under section 256.045 shall not be conducted as provided for in
229.3 sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

229.4 (b) Except for family child care and child foster care, reconsideration of a
229.5 maltreatment determination under sections 626.556, subdivision 10i, and 626.557,
229.6 subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall
229.7 not be conducted when:

229.8 (1) a denial of a license under section 245A.05, or a licensing sanction under section
229.9 245A.07, is based on a determination that the license holder is responsible for maltreatment
229.10 or the disqualification of a license holder is based on serious or recurring maltreatment;

229.11 (2) the denial of a license or licensing sanction is issued at the same time as the
229.12 maltreatment determination or disqualification; and

229.13 (3) the license holder appeals the maltreatment determination or disqualification,
229.14 and denial of a license or licensing sanction. In these cases, a fair hearing shall not be
229.15 conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision
229.16 9d. The scope of the contested case hearing must include the maltreatment determination,
229.17 disqualification, and denial of a license or licensing sanction.

229.18 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
229.19 determination or disqualification, but does not appeal the denial of a license or a licensing
229.20 sanction, reconsideration of the maltreatment determination shall be conducted under
229.21 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
229.22 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
229.23 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
229.24 626.557, subdivision 9d.

229.25 (c) In consolidated contested case hearings regarding sanctions issued in family child
229.26 care, child foster care, family adult day services, ~~and~~ adult foster care, and community
229.27 residential settings, the county attorney shall defend the commissioner's orders in
229.28 accordance with section 245A.16, subdivision 4.

229.29 (d) The commissioner's final order under subdivision 5 is the final agency action
229.30 on the issue of maltreatment and disqualification, including for purposes of subsequent
229.31 background studies under chapter 245C and is the only administrative appeal of the final
229.32 agency determination, specifically, including a challenge to the accuracy and completeness
229.33 of data under section 13.04.

229.34 (e) When consolidated hearings under this subdivision involve a licensing sanction
229.35 based on a previous maltreatment determination for which the commissioner has issued
229.36 a final order in an appeal of that determination under section 256.045, or the individual

230.1 failed to exercise the right to appeal the previous maltreatment determination under
230.2 section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is
230.3 conclusive on the issue of maltreatment. In such cases, the scope of the administrative
230.4 law judge's review shall be limited to the disqualification and the licensing sanction or
230.5 denial of a license. In the case of a denial of a license or a licensing sanction issued to
230.6 a facility based on a maltreatment determination regarding an individual who is not the
230.7 license holder or a household member, the scope of the administrative law judge's review
230.8 includes the maltreatment determination.

230.9 (f) The hearings of all parties may be consolidated into a single contested case
230.10 hearing upon consent of all parties and the administrative law judge, if:

230.11 (1) a maltreatment determination or disqualification, which was not set aside under
230.12 section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing
230.13 sanction under section 245A.07;

230.14 (2) the disqualified subject is an individual other than the license holder and upon
230.15 whom a background study must be conducted under section 245C.03; and

230.16 (3) the individual has a hearing right under section 245C.27.

230.17 (g) When a denial of a license under section 245A.05 or a licensing sanction under
230.18 section 245A.07 is based on a disqualification for which reconsideration was requested
230.19 and was not set aside under section 245C.22, and the individual otherwise has no hearing
230.20 right under section 245C.27, the scope of the administrative law judge's review shall
230.21 include the denial or sanction and a determination whether the disqualification should
230.22 be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In
230.23 determining whether the disqualification should be set aside, the administrative law judge
230.24 shall consider the factors under section 245C.22, subdivision 4, to determine whether the
230.25 individual poses a risk of harm to any person receiving services from the license holder.

230.26 (h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction
230.27 under section 245A.07 is based on the termination of a variance under section 245C.30,
230.28 subdivision 4, the scope of the administrative law judge's review shall include the sanction
230.29 and a determination whether the disqualification should be set aside, unless section
230.30 245C.24 prohibits the set-aside of the disqualification. In determining whether the
230.31 disqualification should be set aside, the administrative law judge shall consider the factors
230.32 under section 245C.22, subdivision 4, to determine whether the individual poses a risk of
230.33 harm to any person receiving services from the license holder.

230.34 Sec. 10. Minnesota Statutes 2012, section 245A.10, is amended to read:

230.35 **245A.10 FEES.**

231.1 Subdivision 1. **Application or license fee required, programs exempt from fee.**

231.2 (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation
231.3 of applications and inspection of programs which are licensed under this chapter.

231.4 (b) Except as provided under subdivision 2, no application or license fee shall be
231.5 charged for child foster care, adult foster care, ~~or~~ family and group family child care, or
231.6 a community residential setting.

231.7 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
231.8 purposes of family and group family child care licensing under this chapter, a county
231.9 agency may charge a fee to an applicant or license holder to recover the actual cost of
231.10 background studies, but in any case not to exceed \$100 annually. A county agency may
231.11 also charge a license fee to an applicant or license holder not to exceed \$50 for a one-year
231.12 license or \$100 for a two-year license.

231.13 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
231.14 applicant for authorization to recover the actual cost of background studies completed
231.15 under section 119B.125, but in any case not to exceed \$100 annually.

231.16 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

231.17 (1) in cases of financial hardship;

231.18 (2) if the county has a shortage of providers in the county's area;

231.19 (3) for new providers; or

231.20 (4) for providers who have attained at least 16 hours of training before seeking
231.21 initial licensure.

231.22 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
231.23 an installment basis for up to one year. If the provider is receiving child care assistance
231.24 payments from the state, the provider may have the fees under paragraph (a) or (b)
231.25 deducted from the child care assistance payments for up to one year and the state shall
231.26 reimburse the county for the county fees collected in this manner.

231.27 (e) For purposes of adult foster care and child foster care licensing, and licensing
231.28 the physical plant of a community residential setting, under this chapter, a county agency
231.29 may charge a fee to a corporate applicant or corporate license holder to recover the actual
231.30 cost of licensing inspections, not to exceed \$500 annually.

231.31 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the
231.32 following circumstances:

231.33 (1) in cases of financial hardship;

231.34 (2) if the county has a shortage of providers in the county's area; or

231.35 (3) for new providers.

232.1 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
232.2 under subdivision 1, an applicant for an initial license or certification issued by the
232.3 commissioner shall submit a \$500 application fee with each new application required
232.4 under this subdivision. An applicant for an initial day services facility license under
232.5 chapter 245D shall submit a \$250 application fee with each new application. The
232.6 application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license
232.7 or certification fee that expires on December 31. The commissioner shall not process an
232.8 application until the application fee is paid.

232.9 (b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license
232.10 to provide services at a specific location.

232.11 ~~(1) For a license to provide residential-based habilitation services to persons with~~
232.12 ~~developmental disabilities under chapter 245B, an applicant shall submit an application~~
232.13 ~~for each county in which the services will be provided. Upon licensure, the license~~
232.14 ~~holder may provide services to persons in that county plus no more than three persons~~
232.15 ~~at any one time in each of up to ten additional counties. A license holder in one county~~
232.16 ~~may not provide services under the home and community-based waiver for persons with~~
232.17 ~~developmental disabilities to more than three people in a second county without holding~~
232.18 ~~a separate license for that second county. Applicants or licensees providing services~~
232.19 ~~under this clause to not more than three persons remain subject to the inspection fees~~
232.20 ~~established in section 245A.10, subdivision 2, for each location. The license issued by~~
232.21 ~~the commissioner must state the name of each additional county where services are being~~
232.22 ~~provided to persons with developmental disabilities. A license holder must notify the~~
232.23 ~~commissioner before making any changes that would alter the license information listed~~
232.24 ~~under section 245A.04, subdivision 7, paragraph (a), including any additional counties~~
232.25 ~~where persons with developmental disabilities are being served. For a license to provide~~
232.26 home and community-based services to persons with disabilities or age 65 and older under
232.27 chapter 245D, an applicant shall submit an application to provide services statewide.

232.28 ~~(2) For a license to provide supported employment, crisis respite, or~~
232.29 ~~semi-independent living services to persons with developmental disabilities under chapter~~
232.30 ~~245B, an applicant shall submit a single application to provide services statewide.~~

232.31 ~~(3) For a license to provide independent living assistance for youth under section~~
232.32 ~~245A.22, an applicant shall submit a single application to provide services statewide.~~

232.33 ~~(4)~~ (3) For a license for a private agency to provide foster care or adoption services
232.34 under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single
232.35 application to provide services statewide.

233.1 (c) The initial application fee charged under this subdivision does not include the
 233.2 temporary license surcharge under section 16E.22.

233.3 **Subd. 4. License or certification fee for certain programs.** (a) Child care centers
 233.4 shall pay an annual nonrefundable license fee based on the following schedule:

233.5 Licensed Capacity	Child Care Center License Fee
233.6 1 to 24 persons	\$200
233.7 25 to 49 persons	\$300
233.8 50 to 74 persons	\$400
233.9 75 to 99 persons	\$500
233.10 100 to 124 persons	\$600
233.11 125 to 149 persons	\$700
233.12 150 to 174 persons	\$800
233.13 175 to 199 persons	\$900
233.14 200 to 224 persons	\$1,000
233.15 225 or more persons	\$1,100

233.16 ~~(b) A day training and habilitation program serving persons with developmental~~
 233.17 ~~disabilities or related conditions shall pay an annual nonrefundable license fee based on~~
 233.18 ~~the following schedule:~~

233.19 Licensed Capacity	License Fee
233.20 1 to 24 persons	\$800
233.21 25 to 49 persons	\$1,000
233.22 50 to 74 persons	\$1,200
233.23 75 to 99 persons	\$1,400
233.24 100 to 124 persons	\$1,600
233.25 125 to 149 persons	\$1,800
233.26 150 or more persons	\$2,000

233.27 ~~Except as provided in paragraph (c), when a day training and habilitation program~~
 233.28 ~~serves more than 50 percent of the same persons in two or more locations in a community,~~
 233.29 ~~the day training and habilitation program shall pay a license fee based on the licensed~~
 233.30 ~~capacity of the largest facility and the other facility or facilities shall be charged a license~~
 233.31 ~~fee based on a licensed capacity of a residential program serving one to 24 persons.~~

233.32 ~~(e) When a day training and habilitation program serving persons with developmental~~
 233.33 ~~disabilities or related conditions seeks a single license allowed under section 245B.07,~~
 233.34 ~~subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed~~
 233.35 ~~capacity for each location.~~

233.36 ~~(d) A program licensed to provide supported employment services to persons~~
 233.37 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 233.38 ~~license fee of \$650.~~

234.1 ~~(e) A program licensed to provide crisis respite services to persons with~~
 234.2 ~~developmental disabilities under chapter 245B shall pay an annual nonrefundable license~~
 234.3 ~~fee of \$700.~~

234.4 ~~(f) A program licensed to provide semi-independent living services to persons~~
 234.5 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 234.6 ~~license fee of \$700.~~

234.7 ~~(g) A program licensed to provide residential-based habilitation services under the~~
 234.8 ~~home and community-based waiver for persons with developmental disabilities shall pay~~
 234.9 ~~an annual license fee that includes a base rate of \$690 plus \$60 times the number of clients~~
 234.10 ~~served on the first day of July of the current license year.~~

234.11 ~~(h) A residential program certified by the Department of Health as an intermediate~~
 234.12 ~~care facility for persons with developmental disabilities (ICF/MR) and a noncertified~~
 234.13 ~~residential program licensed to provide health or rehabilitative services for persons~~
 234.14 ~~with developmental disabilities shall pay an annual nonrefundable license fee based on~~
 234.15 ~~the following schedule:~~

Licensed Capacity	License Fee
1 to 24 persons	\$535
25 to 49 persons	\$735
50 or more persons	\$935

234.20 (b) A program licensed to provide one or more of the home and community-based
 234.21 services and supports identified under chapter 245D to persons with disabilities or age
 234.22 65 and older, shall pay an annual nonrefundable license fee that includes a base rate of
 234.23 \$2,250, plus \$92 times the number of persons served, on average, greater than 40 hours per
 234.24 week for the month of June of the current license year for programs serving ten or more
 234.25 persons. The fee is limited to a maximum of 200 persons, regardless of the actual number
 234.26 of persons served. Programs serving nine or fewer persons pay only half of the base rate.

234.27 (c) A facility licensed under chapter 245D to provide day services shall pay an
 234.28 annual nonrefundable license fee of \$100.

234.29 ~~(i) (d) A chemical dependency treatment program licensed under Minnesota Rules,~~
 234.30 ~~parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an~~
 234.31 ~~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

235.1 ~~(j)~~ (e) A chemical dependency program licensed under Minnesota Rules, parts
 235.2 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual
 235.3 nonrefundable license fee based on the following schedule:

235.4	Licensed Capacity	License Fee
235.5	1 to 24 persons	\$760
235.6	25 to 49 persons	\$960
235.7	50 or more persons	\$1,160

235.8 ~~(k)~~ (f) Except for child foster care, a residential facility licensed under Minnesota
 235.9 Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee
 235.10 based on the following schedule:

235.11	Licensed Capacity	License Fee
235.12	1 to 24 persons	\$1,000
235.13	25 to 49 persons	\$1,100
235.14	50 to 74 persons	\$1,200
235.15	75 to 99 persons	\$1,300
235.16	100 or more persons	\$1,400

235.17 ~~(l)~~ (g) A residential facility licensed under Minnesota Rules, parts 9520.0500 to
 235.18 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license
 235.19 fee based on the following schedule:

235.20	Licensed Capacity	License Fee
235.21	1 to 24 persons	\$2,525
235.22	25 or more persons	\$2,725

235.23 ~~(m)~~ (h) A residential facility licensed under Minnesota Rules, parts 9570.2000 to
 235.24 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
 235.25 license fee based on the following schedule:

235.26	Licensed Capacity	License Fee
235.27	1 to 24 persons	\$450
235.28	25 to 49 persons	\$650
235.29	50 to 74 persons	\$850
235.30	75 to 99 persons	\$1,050
235.31	100 or more persons	\$1,250

235.32 ~~(n)~~ (i) A program licensed to provide independent living assistance for youth under
 235.33 section 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

235.34 ~~(o)~~ (j) A private agency licensed to provide foster care and adoption services under
 235.35 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable
 235.36 license fee of \$875.

236.1 ~~(p)~~ (k) A program licensed as an adult day care center licensed under Minnesota
 236.2 Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based
 236.3 on the following schedule:

236.4	Licensed Capacity	License Fee
236.5	1 to 24 persons	\$500
236.6	25 to 49 persons	\$700
236.7	50 to 74 persons	\$900
236.8	75 to 99 persons	\$1,100
236.9	100 or more persons	\$1,300

236.10 ~~(q)~~ (l) A program licensed to provide treatment services to persons with sexual
 236.11 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
 236.12 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

236.13 ~~(r)~~ (m) A mental health center or mental health clinic requesting certification for
 236.14 purposes of insurance and subscriber contract reimbursement under Minnesota Rules,
 236.15 parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the
 236.16 mental health center or mental health clinic provides services at a primary location with
 236.17 satellite facilities, the satellite facilities shall be certified with the primary location without
 236.18 an additional charge.

236.19 Subd. 6. **License not issued until license or certification fee is paid.** The
 236.20 commissioner shall not issue a license or certification until the license or certification fee
 236.21 is paid. The commissioner shall send a bill for the license or certification fee to the billing
 236.22 address identified by the license holder. If the license holder does not submit the license or
 236.23 certification fee payment by the due date, the commissioner shall send the license holder
 236.24 a past due notice. If the license holder fails to pay the license or certification fee by the
 236.25 due date on the past due notice, the commissioner shall send a final notice to the license
 236.26 holder informing the license holder that the program license will expire on December 31
 236.27 unless the license fee is paid before December 31. If a license expires, the program is no
 236.28 longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2,
 236.29 must not operate after the expiration date. After a license expires, if the former license
 236.30 holder wishes to provide licensed services, the former license holder must submit a new
 236.31 license application and application fee under subdivision 3.

236.32 Subd. 7. **Human services licensing fees to recover expenditures.** Notwithstanding
 236.33 section 16A.1285, subdivision 2, related to activities for which the commissioner charges
 236.34 a fee, the commissioner must plan to fully recover direct expenditures for licensing
 236.35 activities under this chapter over a five-year period. The commissioner may have
 236.36 anticipated expenditures in excess of anticipated revenues in a biennium by using surplus
 236.37 revenues accumulated in previous bienniums.

237.1 Subd. 8. **Deposit of license fees.** A human services licensing account is created in
237.2 the state government special revenue fund. Fees collected under subdivisions 3 and 4 must
237.3 be deposited in the human services licensing account and are annually appropriated to the
237.4 commissioner for licensing activities authorized under this chapter.

237.5 **EFFECTIVE DATE.** This section is effective July 1, 2013.

237.6 Sec. 11. Minnesota Statutes 2012, section 245A.11, subdivision 2a, is amended to read:

237.7 Subd. 2a. **Adult foster care and community residential setting license capacity.**

237.8 (a) The commissioner shall issue adult foster care and community residential setting
237.9 licenses with a maximum licensed capacity of four beds, including nonstaff roomers and
237.10 boarders, except that the commissioner may issue a license with a capacity of five beds,
237.11 including roomers and boarders, according to paragraphs (b) to (f).

237.12 (b) ~~An adult foster care~~ The license holder may have a maximum license capacity
237.13 of five if all persons in care are age 55 or over and do not have a serious and persistent
237.14 mental illness or a developmental disability.

237.15 (c) The commissioner may grant variances to paragraph (b) to allow a ~~foster care~~
237.16 ~~provider~~ facility with a licensed capacity of five persons to admit an individual under the
237.17 age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of
237.18 the variance is recommended by the county in which the licensed ~~foster care provider~~
237.19 facility is located.

237.20 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
237.21 bed for emergency crisis services for a person with serious and persistent mental illness
237.22 or a developmental disability, regardless of age, if the variance complies with section
237.23 245A.04, subdivision 9, and approval of the variance is recommended by the county in
237.24 which the licensed ~~foster care provider~~ facility is located.

237.25 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of a
237.26 fifth bed for respite services, as defined in section 245A.02, for persons with disabilities,
237.27 regardless of age, if the variance complies with sections 245A.03, subdivision 7, and
237.28 245A.04, subdivision 9, and approval of the variance is recommended by the county in
237.29 which the licensed ~~foster care provider~~ facility is ~~licensed~~ located. Respite care may be
237.30 provided under the following conditions:

237.31 (1) staffing ratios cannot be reduced below the approved level for the individuals
237.32 being served in the home on a permanent basis;

237.33 (2) no more than two different individuals can be accepted for respite services in
237.34 any calendar month and the total respite days may not exceed 120 days per program in
237.35 any calendar year;

238.1 (3) the person receiving respite services must have his or her own bedroom, which
 238.2 could be used for alternative purposes when not used as a respite bedroom, and cannot be
 238.3 the room of another person who lives in the ~~foster care home~~ facility; and

238.4 (4) individuals living in the ~~foster care home~~ facility must be notified when the
 238.5 variance is approved. The provider must give 60 days' notice in writing to the residents
 238.6 and their legal representatives prior to accepting the first respite placement. Notice must
 238.7 be given to residents at least two days prior to service initiation, or as soon as the license
 238.8 holder is able if they receive notice of the need for respite less than two days prior to
 238.9 initiation, each time a respite client will be served, unless the requirement for this notice is
 238.10 waived by the resident or legal guardian.

238.11 (f) The commissioner may issue an adult foster care or community residential setting
 238.12 license with a capacity of five adults if the fifth bed does not increase the overall statewide
 238.13 capacity of licensed adult foster care or community residential setting beds in homes that
 238.14 are not the primary residence of the license holder, as identified in a plan submitted to the
 238.15 commissioner by the county, when the capacity is recommended by the county licensing
 238.16 agency of the county in which the facility is located and if the recommendation verifies that:

238.17 (1) the facility meets the physical environment requirements in the adult foster
 238.18 care licensing rule;

238.19 (2) the five-bed living arrangement is specified for each resident in the resident's:

238.20 (i) individualized plan of care;

238.21 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

238.22 (iii) individual resident placement agreement under Minnesota Rules, part

238.23 9555.5105, subpart 19, if required;

238.24 (3) the license holder obtains written and signed informed consent from each
 238.25 resident or resident's legal representative documenting the resident's informed choice
 238.26 to remain living in the home and that the resident's refusal to consent would not have
 238.27 resulted in service termination; and

238.28 (4) the facility was licensed for adult foster care before March 1, 2011.

238.29 (g) The commissioner shall not issue a new adult foster care license under paragraph
 238.30 (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care
 238.31 license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five
 238.32 adults if the license holder continues to comply with the requirements in paragraph (f).

238.33 Sec. 12. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

238.34 Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The
 238.35 commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts

239.1 requiring a caregiver to be present in an adult foster care home during normal sleeping
239.2 hours to allow for alternative methods of overnight supervision. The commissioner may
239.3 grant the variance if the local county licensing agency recommends the variance and the
239.4 county recommendation includes documentation verifying that:

239.5 (1) the county has approved the license holder's plan for alternative methods of
239.6 providing overnight supervision and determined the plan protects the residents' health,
239.7 safety, and rights;

239.8 (2) the license holder has obtained written and signed informed consent from
239.9 each resident or each resident's legal representative documenting the resident's or legal
239.10 representative's agreement with the alternative method of overnight supervision; and

239.11 (3) the alternative method of providing overnight supervision, which may include
239.12 the use of technology, is specified for each resident in the resident's: (i) individualized
239.13 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if
239.14 required; or (iii) individual resident placement agreement under Minnesota Rules, part
239.15 9555.5105, subpart 19, if required.

239.16 (b) To be eligible for a variance under paragraph (a), the adult foster care license
239.17 holder must not have had a conditional license issued under section 245A.06, or any
239.18 other licensing sanction issued under section 245A.07 during the prior 24 months based
239.19 on failure to provide adequate supervision, health care services, or resident safety in
239.20 the adult foster care home.

239.21 (c) A license holder requesting a variance under this subdivision to utilize
239.22 technology as a component of a plan for alternative overnight supervision may request
239.23 the commissioner's review in the absence of a county recommendation. Upon receipt of
239.24 such a request from a license holder, the commissioner shall review the variance request
239.25 with the county.

239.26 (d) A variance granted by the commissioner according to this subdivision before
239.27 January 1, 2014, to a license holder for an adult foster care home must transfer with the
239.28 license when the license converts to a community residential setting license under chapter
239.29 245D. The terms and conditions of the variance remain in effect as approved at the time
239.30 the variance was granted.

239.31 Sec. 13. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:

239.32 Subd. 7a. **Alternate overnight supervision technology; adult foster care license**
239.33 **and community residential setting licenses.** (a) The commissioner may grant an
239.34 applicant or license holder an adult foster care or community residential setting license
239.35 for a residence that does not have a caregiver in the residence during normal sleeping

240.1 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section
240.2 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder
240.3 when an incident occurs that may jeopardize the health, safety, or rights of a foster
240.4 care recipient. The applicant or license holder must comply with all other requirements
240.5 under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under
240.6 chapter 245D, and the requirements under this subdivision. The license printed by the
240.7 commissioner must state in bold and large font:

240.8 (1) that the facility is under electronic monitoring; and

240.9 (2) the telephone number of the county's common entry point for making reports of
240.10 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

240.11 (b) Applications for a license under this section must be submitted directly to
240.12 the Department of Human Services licensing division. The licensing division must
240.13 immediately notify the ~~host county and lead county contract agency and the host county~~
240.14 licensing agency. The licensing division must collaborate with the county licensing
240.15 agency in the review of the application and the licensing of the program.

240.16 (c) Before a license is issued by the commissioner, and for the duration of the
240.17 license, the applicant or license holder must establish, maintain, and document the
240.18 implementation of written policies and procedures addressing the requirements in
240.19 paragraphs (d) through (f).

240.20 (d) The applicant or license holder must have policies and procedures that:

240.21 (1) establish characteristics of target populations that will be admitted into the home,
240.22 and characteristics of populations that will not be accepted into the home;

240.23 (2) explain the discharge process when a ~~foster care recipient~~ resident served by the
240.24 program requires overnight supervision or other services that cannot be provided by the
240.25 license holder due to the limited hours that the license holder is on site;

240.26 (3) describe the types of events to which the program will respond with a physical
240.27 presence when those events occur in the home during time when staff are not on site, and
240.28 how the license holder's response plan meets the requirements in paragraph (e), clause
240.29 (1) or (2);

240.30 (4) establish a process for documenting a review of the implementation and
240.31 effectiveness of the response protocol for the response required under paragraph (e),
240.32 clause (1) or (2). The documentation must include:

240.33 (i) a description of the triggering incident;

240.34 (ii) the date and time of the triggering incident;

240.35 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);

240.36 (iv) whether the response met the resident's needs;

241.1 (v) whether the existing policies and response protocols were followed; and

241.2 (vi) whether the existing policies and protocols are adequate or need modification.

241.3 When no physical presence response is completed for a three-month period, the
241.4 license holder's written policies and procedures must require a physical presence response
241.5 drill to be conducted for which the effectiveness of the response protocol under paragraph
241.6 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

241.7 (5) establish that emergency and nonemergency phone numbers are posted in a
241.8 prominent location in a common area of the home where they can be easily observed by a
241.9 person responding to an incident who is not otherwise affiliated with the home.

241.10 (e) The license holder must document and include in the license application which
241.11 response alternative under clause (1) or (2) is in place for responding to situations that
241.12 present a serious risk to the health, safety, or rights of ~~people receiving foster care services~~
241.13 in the home residents served by the program:

241.14 (1) response alternative (1) requires only the technology to provide an electronic
241.15 notification or alert to the license holder that an event is underway that requires a response.
241.16 Under this alternative, no more than ten minutes will pass before the license holder will be
241.17 physically present on site to respond to the situation; or

241.18 (2) response alternative (2) requires the electronic notification and alert system under
241.19 alternative (1), but more than ten minutes may pass before the license holder is present on
241.20 site to respond to the situation. Under alternative (2), all of the following conditions are met:

241.21 (i) the license holder has a written description of the interactive technological
241.22 applications that will assist the license holder in communicating with and assessing the
241.23 needs related to the care, health, and safety of the foster care recipients. This interactive
241.24 technology must permit the license holder to remotely assess the well being of the ~~foster~~
241.25 ~~care recipient~~ resident served by the program without requiring the initiation of the
241.26 foster care recipient. Requiring the foster care recipient to initiate a telephone call does
241.27 not meet this requirement;

241.28 (ii) the license holder documents how the remote license holder is qualified and
241.29 capable of meeting the needs of the foster care recipients and assessing foster care
241.30 recipients' needs under item (i) during the absence of the license holder on site;

241.31 (iii) the license holder maintains written procedures to dispatch emergency response
241.32 personnel to the site in the event of an identified emergency; and

241.33 (iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual~~
241.34 ~~service plan~~ coordinated service and support plan under ~~section~~ sections 256B.0913,
241.35 subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49,
241.36 subdivision 15, if required, or individual resident placement agreement under Minnesota

242.1 Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time,
242.2 which may be greater than ten minutes, for the license holder to be on site for that foster
242.3 ~~care recipient~~ resident.

242.4 (f) Each ~~foster care recipient's~~ resident's placement agreement, individual service
242.5 agreement, and plan must clearly state that the adult foster care or community residential
242.6 setting license category is a program without the presence of a caregiver in the residence
242.7 during normal sleeping hours; the protocols in place for responding to situations that
242.8 present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents
242.9 served by the program under paragraph (e), clause (1) or (2); and a signed informed
242.10 consent from each ~~foster care recipient~~ resident served by the program or the person's
242.11 legal representative documenting the person's or legal representative's agreement with
242.12 placement in the program. If electronic monitoring technology is used in the home, the
242.13 informed consent form must also explain the following:

242.14 (1) how any electronic monitoring is incorporated into the alternative supervision
242.15 system;

242.16 (2) the backup system for any electronic monitoring in times of electrical outages or
242.17 other equipment malfunctions;

242.18 (3) how the caregivers or direct support staff are trained on the use of the technology;

242.19 (4) the event types and license holder response times established under paragraph (e);

242.20 (5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy
242.21 related to electronic monitoring and related to any electronically recorded data generated
242.22 by the monitoring system. A ~~foster care recipient~~ resident served by the program may
242.23 not be removed from a program under this subdivision for failure to consent to electronic
242.24 monitoring. The consent form must explain where and how the electronically recorded
242.25 data is stored, with whom it will be shared, and how long it is retained; and

242.26 (6) the risks and benefits of the alternative overnight supervision system.

242.27 The written explanations under clauses (1) to (6) may be accomplished through
242.28 cross-references to other policies and procedures as long as they are explained to the
242.29 person giving consent, and the person giving consent is offered a copy.

242.30 (g) Nothing in this section requires the applicant or license holder to develop or
242.31 maintain separate or duplicative policies, procedures, documentation, consent forms, or
242.32 individual plans that may be required for other licensing standards, if the requirements of
242.33 this section are incorporated into those documents.

242.34 (h) The commissioner may grant variances to the requirements of this section
242.35 according to section 245A.04, subdivision 9.

243.1 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning
243.2 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
243.3 contractors affiliated with the license holder.

243.4 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
243.5 remotely determine what action the license holder needs to take to protect the well-being
243.6 of the foster care recipient.

243.7 (k) The commissioner shall evaluate license applications using the requirements
243.8 in paragraphs (d) to (f). The commissioner shall provide detailed application forms,
243.9 including a checklist of criteria needed for approval.

243.10 (l) To be eligible for a license under paragraph (a), the adult foster care or community
243.11 residential setting license holder must not have had a conditional license issued under
243.12 section 245A.06 or any licensing sanction under section 245A.07 during the prior 24
243.13 months based on failure to provide adequate supervision, health care services, or resident
243.14 safety in the adult foster care home or community residential setting.

243.15 (m) The commissioner shall review an application for an alternative overnight
243.16 supervision license within 60 days of receipt of the application. When the commissioner
243.17 receives an application that is incomplete because the applicant failed to submit required
243.18 documents or that is substantially deficient because the documents submitted do not meet
243.19 licensing requirements, the commissioner shall provide the applicant written notice
243.20 that the application is incomplete or substantially deficient. In the written notice to the
243.21 applicant, the commissioner shall identify documents that are missing or deficient and
243.22 give the applicant 45 days to resubmit a second application that is substantially complete.
243.23 An applicant's failure to submit a substantially complete application after receiving
243.24 notice from the commissioner is a basis for license denial under section 245A.05. The
243.25 commissioner shall complete subsequent review within 30 days.

243.26 (n) Once the application is considered complete under paragraph (m), the
243.27 commissioner will approve or deny an application for an alternative overnight supervision
243.28 license within 60 days.

243.29 (o) For the purposes of this subdivision, "supervision" means:

243.30 (1) oversight by a caregiver or direct support staff as specified in the individual
243.31 resident's place agreement or coordinated service and support plan and awareness of the
243.32 resident's needs and activities; and

243.33 (2) the presence of a caregiver or direct support staff in a residence during normal
243.34 sleeping hours, unless a determination has been made and documented in the individual's
243.35 coordinated service and support plan that the individual does not require the presence of a
243.36 caregiver or direct support staff during normal sleeping hours.

244.1 Sec. 14. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:

244.2 Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care
244.3 or community residential setting license holder who creates, collects, records, maintains,
244.4 stores, or discloses any individually identifiable recipient data, whether in an electronic
244.5 or any other format, must comply with the privacy and security provisions of applicable
244.6 privacy laws and regulations, including:

244.7 (1) the federal Health Insurance Portability and Accountability Act of 1996
244.8 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
244.9 title 45, part 160, and subparts A and E of part 164; and

244.10 (2) the Minnesota Government Data Practices Act as codified in chapter 13.

244.11 (b) For purposes of licensure, the license holder shall be monitored for compliance
244.12 with the following data privacy and security provisions:

244.13 (1) the license holder must control access to data on ~~foster care recipients~~ residents
244.14 served by the program according to the definitions of public and private data on individuals
244.15 under section 13.02; classification of the data on individuals as private under section
244.16 13.46, subdivision 2; and control over the collection, storage, use, access, protection,
244.17 and contracting related to data according to section 13.05, in which the license holder is
244.18 assigned the duties of a government entity;

244.19 (2) the license holder must provide each ~~foster care recipient~~ resident served by
244.20 the program with a notice that meets the requirements under section 13.04, in which
244.21 the license holder is assigned the duties of the government entity, and that meets the
244.22 requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall
244.23 describe the purpose for collection of the data, and to whom and why it may be disclosed
244.24 pursuant to law. The notice must inform the ~~recipient~~ individual that the license holder
244.25 uses electronic monitoring and, if applicable, that recording technology is used;

244.26 (3) the license holder must not install monitoring cameras in bathrooms;

244.27 (4) electronic monitoring cameras must not be concealed from the ~~foster care~~
244.28 ~~recipients~~ residents served by the program; and

244.29 (5) electronic video and audio recordings of ~~foster care recipients~~ residents served
244.30 by the program shall be stored by the license holder for five days unless: (i) a ~~foster care~~
244.31 ~~recipient~~ resident served by the program or legal representative requests that the recording
244.32 be held longer based on a specific report of alleged maltreatment; or (ii) the recording
244.33 captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or
244.34 a crime under chapter 609. When requested by a ~~recipient~~ resident served by the program
244.35 or when a recording captures an incident or event of alleged maltreatment or a crime, the
244.36 license holder must maintain the recording in a secured area for no longer than 30 days

245.1 to give the investigating agency an opportunity to make a copy of the recording. The
245.2 investigating agency will maintain the electronic video or audio recordings as required in
245.3 section 626.557, subdivision 12b.

245.4 (c) The commissioner shall develop, and make available to license holders and
245.5 county licensing workers, a checklist of the data privacy provisions to be monitored
245.6 for purposes of licensure.

245.7 Sec. 15. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:

245.8 Subd. 8. **Community residential setting license.** (a) The commissioner shall
245.9 establish provider standards for residential support services that integrate service standards
245.10 and the residential setting under one license. The commissioner shall propose statutory
245.11 language and an implementation plan for licensing requirements for residential support
245.12 services to the legislature by January 15, 2012, as a component of the quality outcome
245.13 standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

245.14 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
245.15 for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105
245.16 to 9555.6265, ~~or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340;~~
245.17 and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b)~~ section
245.18 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

245.19 Sec. 16. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:

245.20 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
245.21 private agencies that have been designated or licensed by the commissioner to perform
245.22 licensing functions and activities under section 245A.04 and background studies for family
245.23 child care under chapter 245C; to recommend denial of applicants under section 245A.05;
245.24 to issue correction orders, to issue variances, and recommend a conditional license under
245.25 section 245A.06, or to recommend suspending or revoking a license or issuing a fine under
245.26 section 245A.07, shall comply with rules and directives of the commissioner governing
245.27 those functions and with this section. The following variances are excluded from the
245.28 delegation of variance authority and may be issued only by the commissioner:

245.29 (1) dual licensure of family child care and child foster care, dual licensure of child
245.30 and adult foster care, and adult foster care and family child care;

245.31 (2) adult foster care maximum capacity;

245.32 (3) adult foster care minimum age requirement;

245.33 (4) child foster care maximum age requirement;

246.1 (5) variances regarding disqualified individuals except that county agencies may
246.2 issue variances under section 245C.30 regarding disqualified individuals when the county
246.3 is responsible for conducting a consolidated reconsideration according to sections 245C.25
246.4 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
246.5 and a disqualification based on serious or recurring maltreatment; ~~and~~

246.6 (6) the required presence of a caregiver in the adult foster care residence during
246.7 normal sleeping hours; and

246.8 (7) variances for community residential setting licenses under chapter 245D.

246.9 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency
246.10 must not grant a license holder a variance to exceed the maximum allowable family child
246.11 care license capacity of 14 children.

246.12 (b) County agencies must report information about disqualification reconsiderations
246.13 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances
246.14 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
246.15 prescribed by the commissioner.

246.16 (c) For family day care programs, the commissioner may authorize licensing reviews
246.17 every two years after a licensee has had at least one annual review.

246.18 (d) For family adult day services programs, the commissioner may authorize
246.19 licensing reviews every two years after a licensee has had at least one annual review.

246.20 (e) A license issued under this section may be issued for up to two years.

246.21 Sec. 17. Minnesota Statutes 2012, section 245D.02, is amended to read:

246.22 **245D.02 DEFINITIONS.**

246.23 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given
246.24 them in this section.

246.25 Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given
246.26 in section 245A.02, subdivision 2b.

246.27 Subd. 2a. **Authorized representative.** "Authorized representative" means a parent,
246.28 family member, advocate, or other adult authorized by the person or the person's legal
246.29 representative, to serve as a representative in connection with the provision of services
246.30 licensed under this chapter. This authorization must be in writing or by another method
246.31 that clearly indicates the person's free choice. The authorized representative must have no
246.32 financial interest in the provision of any services included in the person's service delivery
246.33 plan and must be capable of providing the support necessary to assist the person in the use
246.34 of home and community-based services licensed under this chapter.

247.1 Subd. 3. **Case manager.** "Case manager" means the individual designated
247.2 to provide waiver case management services, care coordination, or long-term care
247.3 consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,
247.4 or successor provisions.

247.5 Subd. 3a. **Certification.** "Certification" means the commissioner's written
247.6 authorization for a license holder to provide specialized services based on certification
247.7 standards in section 245D.33. The term certification and its derivatives have the same
247.8 meaning and may be substituted for the term licensure and its derivatives in this chapter
247.9 and chapter 245A.

247.10 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the
247.11 Department of Human Services or the commissioner's designated representative.

247.12 Subd. 4a. **Community residential setting.** "Community residential setting" means
247.13 a residential program as identified in section 245A.11, subdivision 8, where residential
247.14 supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause
247.15 (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant
247.16 of the facility licensed according to this chapter, and the license holder does not reside
247.17 in the facility.

247.18 Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support
247.19 plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision
247.20 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.

247.21 Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated
247.22 service and support plan addendum" means the documentation that this chapter requires
247.23 of the license holder for each person receiving services.

247.24 Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster
247.25 residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340,
247.26 or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to
247.27 9555.6265, where the license holder does not live in the home.

247.28 Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence"
247.29 or "culturally competent" means the ability and the will to respond to the unique needs of
247.30 a person that arise from the person's culture and the ability to use the person's culture as a
247.31 resource or tool to assist with the intervention and help meet the person's needs.

247.32 Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed
247.33 according to this chapter at which persons receive day services licensed under this chapter
247.34 from the license holder's direct support staff for a cumulative total of more than 30 days
247.35 within any 12-month period and the license holder is the owner, lessor, or tenant of the
247.36 facility.

248.1 Subd. 5. **Department.** "Department" means the Department of Human Services.

248.2 Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
248.3 subdivision 11, and is used interchangeably with the term "direct support service."

248.4 Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means
248.5 employees of the license holder who have direct contact with persons served by the
248.6 program and includes temporary staff or subcontractors, regardless of employer, providing
248.7 program services for hire under the control of the license holder who have direct contact
248.8 with persons served by the program.

248.9 Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

248.10 Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary
248.11 daily operation of the program including, but not limited to, fires, severe weather, natural
248.12 disasters, power failures, or other events that threaten the immediate health and safety of
248.13 a person receiving services and that require calling 911, emergency evacuation, moving
248.14 to an emergency shelter, or temporary closure or relocation of the program to another
248.15 facility or service site for more than 24 hours.

248.16 Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual
248.17 restraint" means using a manual restraint when a person poses an imminent risk of
248.18 physical harm to self or others and is the least restrictive intervention that would achieve
248.19 safety. Property damage, verbal aggression, or a person's refusal to receive or participate
248.20 in treatment or programming on their own, do not constitute an emergency.

248.21 Subd. 8b. **Expanded support team.** "Expanded support team" means the members
248.22 of the support team defined in subdivision 46, and a licensed health or mental health
248.23 professional or other licensed, certified, or qualified professionals or consultants working
248.24 with the person and included in the team at the request of the person or the person's legal
248.25 representative.

248.26 Subd. 8c. **Family foster care.** "Family foster care" means a child foster family
248.27 setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult
248.28 foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265,
248.29 where the license holder lives in the home.

248.30 Subd. 9. **Health services.** "Health services" means any service or treatment
248.31 consistent with the physical and mental health needs of the person, such as medication
248.32 administration and monitoring, medical, dental, nutritional, health monitoring, wellness
248.33 education, and exercise.

248.34 Subd. 10. **Home and community-based services.** "Home and community-based
248.35 services" means the services ~~subject to the provisions of this chapter~~ identified in section
248.36 245D.03, subdivision 1, and as defined in:

249.1 (1) the federal federally approved waiver plans governed by United States Code,
 249.2 title 42, sections 1396 et seq., or the state's alternative care program according to section
 249.3 256B.0913, including the waivers for persons with disabilities under section 256B.49,
 249.4 subdivision 11, including the brain injury (BI) waiver; plan; the community alternative
 249.5 care (CAC) waiver; plan; the community alternatives for disabled individuals (CADI)
 249.6 waiver; plan; the developmental disability (DD) waiver; plan under section 256B.092,
 249.7 subdivision 5; the elderly waiver (EW), and plan under section 256B.0915, subdivision 1;
 249.8 or successor plans respective to each waiver; or

249.9 (2) the alternative care (AC) program under section 256B.0913.

249.10 Subd. 11. **Incident.** "Incident" means an occurrence ~~that affects the~~ which involves
 249.11 a person and requires the program to make a response that is not a part of the program's
 249.12 ordinary provision of services to a that person, and includes any of the following:

249.13 (1) serious injury of a person as determined by section 245.91, subdivision 6;

249.14 (2) a person's death;

249.15 (3) any medical emergency, unexpected serious illness, or significant unexpected
 249.16 change in an illness or medical condition, or the mental health status of a person that
 249.17 requires calling the program to call 911 or a mental health crisis intervention team,
 249.18 physician treatment, or hospitalization;

249.19 (4) any mental health crisis that requires the program to call 911 or a mental health
 249.20 crisis intervention team;

249.21 (5) an act or situation involving a person that requires the program to call 911,
 249.22 law enforcement, or the fire department;

249.23 ~~(4)~~ (6) a person's unauthorized or unexplained absence from a program;

249.24 ~~(5)~~ (7) physical aggression conduct by a person receiving services against another
 249.25 person receiving services that causes physical pain, injury, or persistent emotional distress,
 249.26 including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting,
 249.27 pushing, and spitting;

249.28 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with
 249.29 a person's opportunities to participate in or receive service or support;

249.30 (ii) places the person in actual and reasonable fear of harm;

249.31 (iii) places the person in actual and reasonable fear of damage to property of the
 249.32 person; or

249.33 (iv) substantially disrupts the orderly operation of the program;

249.34 ~~(6)~~ (8) any sexual activity between persons receiving services involving force or
 249.35 coercion as defined under section 609.341, subdivisions 3 and 14; or

249.36 (9) any emergency use of manual restraint as identified in section 245D.061; or

250.1 (7) (10) a report of alleged or suspected child or vulnerable adult maltreatment
250.2 under section 626.556 or 626.557.

250.3 Subd. 11a. **Intermediate care facility for persons with developmental disabilities**
250.4 **or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or
250.5 "ICF/DD" means a residential program licensed to serve four or more persons with
250.6 developmental disabilities under section 252.28 and chapter 245A and licensed as a
250.7 supervised living facility under chapter 144, which together are certified by the Department
250.8 of Health as an intermediate care facility for persons with developmental disabilities.

250.9 Subd. 11b. **Least restrictive alternative.** "Least restrictive alternative" means
250.10 the alternative method for providing supports and services that is the least intrusive and
250.11 most normalized given the level of supervision and protection required for the person.
250.12 This level of supervision and protection allows risk taking to the extent that there is no
250.13 reasonable likelihood that serious harm will happen to the person or others.

250.14 Subd. 12. **Legal representative.** "Legal representative" means the parent of a
250.15 person who is under 18 years of age, a court-appointed guardian, or other representative
250.16 with legal authority to make decisions about services for a person. Other representatives
250.17 with legal authority to make decisions include but are not limited to a health care agent or
250.18 an attorney-in-fact authorized through a health care directive or power of attorney.

250.19 Subd. 13. **License.** "License" has the meaning given in section 245A.02,
250.20 subdivision 8.

250.21 Subd. 14. **Licensed health professional.** "Licensed health professional" means a
250.22 person licensed in Minnesota to practice those professions described in section 214.01,
250.23 subdivision 2.

250.24 Subd. 15. **License holder.** "License holder" has the meaning given in section
250.25 245A.02, subdivision 9.

250.26 Subd. 16. **Medication.** "Medication" means a prescription drug or over-the-counter
250.27 drug. For purposes of this chapter, "medication" includes dietary supplements.

250.28 ~~Subd. 17. **Medication administration.** "Medication administration" means~~
250.29 ~~performing the following set of tasks to ensure a person takes both prescription and~~
250.30 ~~over-the-counter medications and treatments according to orders issued by appropriately~~
250.31 ~~licensed professionals, and includes the following:~~

250.32 (1) checking the person's medication record;

250.33 (2) preparing the medication for administration;

250.34 (3) administering the medication to the person;

250.35 (4) documenting the administration of the medication or the reason for not
250.36 administering the medication; and

251.1 ~~(5) reporting to the prescriber or a nurse any concerns about the medication,~~
251.2 ~~including side effects, adverse reactions, effectiveness, or the person's refusal to take the~~
251.3 ~~medication or the person's self-administration of the medication.~~

251.4 ~~Subd. 18. **Medication assistance.** "Medication assistance" means providing verbal~~
251.5 ~~or visual reminders to take regularly scheduled medication, which includes either of~~
251.6 ~~the following:~~

251.7 ~~(1) bringing to the person and opening a container of previously set up medications~~
251.8 ~~and emptying the container into the person's hand or opening and giving the medications~~
251.9 ~~in the original container to the person, or bringing to the person liquids or food to~~
251.10 ~~accompany the medication; or~~

251.11 ~~(2) providing verbal or visual reminders to perform regularly scheduled treatments~~
251.12 ~~and exercises.~~

251.13 ~~Subd. 19. **Medication management.** "Medication management" means the~~
251.14 ~~provision of any of the following:~~

251.15 ~~(1) medication-related services to a person;~~

251.16 ~~(2) medication setup;~~

251.17 ~~(3) medication administration;~~

251.18 ~~(4) medication storage and security;~~

251.19 ~~(5) medication documentation and charting;~~

251.20 ~~(6) verification and monitoring of effectiveness of systems to ensure safe medication~~
251.21 ~~handling and administration;~~

251.22 ~~(7) coordination of medication refills;~~

251.23 ~~(8) handling changes to prescriptions and implementation of those changes;~~

251.24 ~~(9) communicating with the pharmacy; or~~

251.25 ~~(10) coordination and communication with prescriber.~~

251.26 ~~For the purposes of this chapter, medication management does not mean "medication~~
251.27 ~~therapy management services" as identified in section 256B.0625, subdivision 13h.~~

251.28 ~~Subd. 20. **Mental health crisis intervention team.** "Mental health crisis~~
251.29 ~~intervention team" means a mental health crisis response providers provider as identified~~
251.30 ~~in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944,~~
251.31 ~~subdivision 1, paragraph (d), for children.~~

251.32 ~~Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that~~
251.33 ~~enables individuals with disabilities to interact with nondisabled persons to the fullest~~
251.34 ~~extent possible.~~

252.1 Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that
252.2 is not required by federal law to bear the statement "Caution: Federal law prohibits
252.3 dispensing without prescription."

252.4 Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by
252.5 the person that can be observed, measured, and determined reliable and valid.

252.6 Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision
252.7 11.

252.8 Subd. 23. **Person with a disability.** "Person with a disability" means a person
252.9 determined to have a disability by the commissioner's state medical review team as
252.10 identified in section 256B.055, subdivision 7, the Social Security Administration, or
252.11 the person is determined to have a developmental disability as defined in Minnesota
252.12 Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section
252.13 252.27, subdivision 1a.

252.14 Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter
252.15 147.

252.16 Subd. 24. **Prescriber.** ~~"Prescriber" means a licensed practitioner as defined in~~
252.17 ~~section 151.01, subdivision 23, person who is authorized under section sections 148.235;~~
252.18 151.01, subdivision 23; or 151.37 to prescribe drugs. For the purposes of this chapter, the
252.19 term "prescriber" is used interchangeably with "physician."

252.20 Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section
252.21 151.01, subdivision ~~17~~ 16.

252.22 Subd. 26. **Program.** "Program" means either the nonresidential or residential
252.23 program as defined in section 245A.02, subdivisions 10 and 14.

252.24 Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any
252.25 medication prescribed to treat the symptoms of mental illness that affect thought processes,
252.26 mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic
252.27 (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and
252.28 stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder.
252.29 Other miscellaneous medications are considered to be a psychotropic medication when
252.30 they are specifically prescribed to treat a mental illness or to control or alter behavior.

252.31 Subd. 28. **Restraint.** "Restraint" means physical or mechanical limiting of the free
252.32 and normal movement of body or limbs.

252.33 Subd. 29. **Seclusion.** ~~"Seclusion" means separating a person from others in a way~~
252.34 ~~that prevents social contact and prevents the person from leaving the situation if he or she~~
252.35 chooses the placement of a person alone in a room from which exit is prohibited by a staff

253.1 person or a mechanism such as a lock, a device, or an object positioned to hold the door
253.2 closed or otherwise prevent the person from leaving the room.

253.3 Subd. 29a. **Self-determination.** "Self-determination" means the person makes
253.4 decisions independently, plans for the person's own future, determines how money is spent
253.5 for the person's supports, and takes responsibility for making these decisions. If a person
253.6 has a legal representative, the legal representative's decision-making authority is limited to
253.7 the scope of authority granted by the court or allowed in the document authorizing the
253.8 legal representative to act.

253.9 Subd. 29b. **Semi-independent living services.** "Semi-independent living services"
253.10 has the meaning given in section 252.275.

253.11 Subd. 30. **Service.** "Service" means care, training, supervision, counseling,
253.12 consultation, or medication assistance assigned to the license holder in the coordinated
253.13 service and support plan.

253.14 ~~Subd. 31. **Service plan.** "Service plan" means the individual service plan or~~
253.15 ~~individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,~~
253.16 ~~or successor provisions, and includes any support plans or service needs identified as~~
253.17 ~~a result of long-term care consultation, or a support team meeting that includes the~~
253.18 ~~participation of the person, the person's legal representative, and case manager, or assigned~~
253.19 ~~to a license holder through an authorized service agreement.~~

253.20 Subd. 32. **Service site.** "Service site" means the location where the service is
253.21 provided to the person, including, but not limited to, a facility licensed according to
253.22 chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's
253.23 own home; or a community-based location.

253.24 ~~Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a~~
253.25 ~~person served by the facility, agency, or program.~~

253.26 Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning
253.27 given in Minnesota Rules, part 4665.0100, subpart 10.

253.28 Subd. 33b. **Supervision.** (a) "Supervision" means:

253.29 (1) oversight by direct support staff as specified in the person's coordinated service
253.30 and support plan or coordinated service and support plan addendum and awareness of
253.31 the person's needs and activities;

253.32 (2) responding to situations that present a serious risk to the health, safety, or rights
253.33 of the person while services are being provided; and

253.34 (3) the presence of direct support staff at a service site while services are being
253.35 provided, unless a determination has been made and documented in the person's coordinated

254.1 service and support plan or coordinated service and support plan addendum that the person
 254.2 does not require the presence of direct support staff while services are being provided.

254.3 (b) For the purposes of this definition, "while services are being provided," means
 254.4 any period of time during which the license holder will seek reimbursement for services.

254.5 Subd. 34. **Support team.** "Support team" means the service planning team
 254.6 identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in
 254.7 Minnesota Rules, part 9525.0004, subpart 14.

254.8 Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an
 254.9 ongoing activity to a room, either locked or unlocked, or otherwise separating a person
 254.10 from others in a way that prevents social contact and prevents the person from leaving
 254.11 the situation if the person chooses. For the purpose of chapter 245D, "time out" does
 254.12 not mean voluntary removal or self-removal for the purpose of calming, prevention of
 254.13 escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out"
 254.14 does not include a person voluntarily moving from an ongoing activity to an unlocked
 254.15 room or otherwise separating from a situation or social contact with others if the person
 254.16 chooses. For the purposes of this definition, "voluntarily" means without being forced,
 254.17 compelled, or coerced.

254.18 ~~Subd. 35. **Unit of government.** "Unit of government" means every city, county,~~
 254.19 ~~town, school district, other political subdivisions of the state, and any agency of the state~~
 254.20 ~~or the United States, and includes any instrumentality of a unit of government.~~

254.21 Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than
 254.22 medications, ordered or prescribed by a licensed health or mental health professional,
 254.23 provided to a person to cure, rehabilitate, or ease symptoms.

254.24 Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the
 254.25 license holder, provides direct services without pay to a person served by the license holder.

254.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

254.27 Sec. 18. Minnesota Statutes 2012, section 245D.03, is amended to read:

254.28 **245D.03 APPLICABILITY AND EFFECT.**

254.29 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of
 254.30 home and community-based services to persons with disabilities and persons age 65 and
 254.31 older pursuant to this chapter. The licensing standards in this chapter govern the provision
 254.32 of ~~the following~~ basic support services; and intensive support services.

254.33 ~~(1) housing access coordination as defined under the current BI, CADI, and DD~~
 254.34 ~~waiver plans or successor plans;~~

255.1 ~~(2) respite services as defined under the current CADI, BI, CAC, DD, and EW~~
 255.2 ~~waiver plans or successor plans when the provider is an individual who is not an employee~~
 255.3 ~~of a residential or nonresidential program licensed by the Department of Human Services~~
 255.4 ~~or the Department of Health that is otherwise providing the respite service;~~

255.5 ~~(3) behavioral programming as defined under the current BI and CADI waiver~~
 255.6 ~~plans or successor plans;~~

255.7 ~~(4) specialist services as defined under the current DD waiver plan or successor plans;~~

255.8 ~~(5) companion services as defined under the current BI, CADI, and EW waiver~~
 255.9 ~~plans or successor plans, excluding companion services provided under the Corporation~~
 255.10 ~~for National and Community Services Senior Companion Program established under the~~
 255.11 ~~Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

255.12 ~~(6) personal support as defined under the current DD waiver plan or successor plans;~~

255.13 ~~(7) 24-hour emergency assistance, on-call and personal emergency response as~~
 255.14 ~~defined under the current CADI and DD waiver plans or successor plans;~~

255.15 ~~(8) night supervision services as defined under the current BI waiver plan or~~
 255.16 ~~successor plans;~~

255.17 ~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW~~
 255.18 ~~waiver plans or successor plans, excluding providers licensed by the Department of Health~~
 255.19 ~~under chapter 144A and those providers providing cleaning services only;~~

255.20 ~~(10) independent living skills training as defined under the current BI and CADI~~
 255.21 ~~waiver plans or successor plans;~~

255.22 ~~(11) prevocational services as defined under the current BI and CADI waiver plans~~
 255.23 ~~or successor plans;~~

255.24 ~~(12) structured day services as defined under the current BI waiver plan or successor~~
 255.25 ~~plans; or~~

255.26 ~~(13) supported employment as defined under the current BI and CADI waiver plans~~
 255.27 ~~or successor plans.~~

255.28 (b) Basic support services provide the level of assistance, supervision, and care that
 255.29 is necessary to ensure the health and safety of the person and do not include services that
 255.30 are specifically directed toward the training, treatment, habilitation, or rehabilitation of
 255.31 the person. Basic support services include:

255.32 (1) in-home and out-of-home respite care services as defined in section 245A.02,
 255.33 subdivision 15, and under the brain injury, community alternative care, community
 255.34 alternatives for disabled individuals, developmental disability, and elderly waiver plans;

255.35 (2) companion services as defined under the brain injury, community alternatives for
 255.36 disabled individuals, and elderly waiver plans, excluding companion services provided

256.1 under the Corporation for National and Community Services Senior Companion Program
256.2 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;
256.3 (3) personal support as defined under the developmental disability waiver plan;
256.4 (4) 24-hour emergency assistance, personal emergency response as defined under the
256.5 community alternatives for disabled individuals and developmental disability waiver plans;
256.6 (5) night supervision services as defined under the brain injury waiver plan; and
256.7 (6) homemaker services as defined under the community alternatives for disabled
256.8 individuals, brain injury, community alternative care, developmental disability, and elderly
256.9 waiver plans, excluding providers licensed by the Department of Health under chapter
256.10 144A and those providers providing cleaning services only.

256.11 (c) Intensive support services provide assistance, supervision, and care that is
256.12 necessary to ensure the health and safety of the person and services specifically directed
256.13 toward the training, habilitation, or rehabilitation of the person. Intensive support services
256.14 include:

256.15 (1) intervention services, including:

256.16 (i) behavioral support services as defined under the brain injury and community
256.17 alternatives for disabled individuals waiver plans;

256.18 (ii) in-home or out-of-home crisis respite services as defined under the developmental
256.19 disability waiver plan; and

256.20 (iii) specialist services as defined under the current developmental disability waiver
256.21 plan;

256.22 (2) in-home support services, including:

256.23 (i) in-home family support and supported living services as defined under the
256.24 developmental disability waiver plan;

256.25 (ii) independent living services training as defined under the brain injury and
256.26 community alternatives for disabled individuals waiver plans; and

256.27 (iii) semi-independent living services;

256.28 (3) residential supports and services, including:

256.29 (i) supported living services as defined under the developmental disability waiver
256.30 plan provided in a family or corporate child foster care residence, a family adult foster
256.31 care residence, a community residential setting, or a supervised living facility;

256.32 (ii) foster care services as defined in the brain injury, community alternative care,
256.33 and community alternatives for disabled individuals waiver plans provided in a family or
256.34 corporate child foster care residence, a family adult foster care residence, or a community
256.35 residential setting; and

257.1 (iii) residential services provided in a supervised living facility that is certified by
257.2 the Department of Health as an ICF/DD;

257.3 (4) day services, including:

257.4 (i) structured day services as defined under the brain injury waiver plan;

257.5 (ii) day training and habilitation services under sections 252.40 to 252.46, and as
257.6 defined under the developmental disability waiver plan; and

257.7 (iii) prevocational services as defined under the brain injury and community
257.8 alternatives for disabled individuals waiver plans; and

257.9 (5) supported employment as defined under the brain injury, developmental
257.10 disability, and community alternatives for disabled individuals waiver plans.

257.11 **Subd. 2. Relationship to other standards governing home and community-based**
257.12 **services.** (a) A license holder governed by this chapter is also subject to the licensure
257.13 requirements under chapter 245A.

257.14 ~~(b) A license holder concurrently providing child foster care services licensed~~
257.15 ~~according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed~~
257.16 ~~under this chapter is exempt from section 245D.04 as it applies to the person. A corporate~~
257.17 ~~or family child foster care site controlled by a license holder and providing services~~
257.18 ~~governed by this chapter is exempt from compliance with section 245D.04. This exemption~~
257.19 ~~applies to foster care homes where at least one resident is receiving residential supports~~
257.20 ~~and services licensed according to this chapter. This chapter does not apply to corporate or~~
257.21 ~~family child foster care homes that do not provide services licensed under this chapter.~~

257.22 (c) A family adult foster care site controlled by a license holder and providing
257.23 services governed by this chapter is exempt from compliance with Minnesota Rules, parts
257.24 9555.6185; 9555.6225, subpart 8; 9555.6235, item C; 9555.6245; 9555.6255, subpart
257.25 2; and 9555.6265. These exemptions apply to family adult foster care homes where at
257.26 least one resident is receiving residential supports and services licensed according to this
257.27 chapter. This chapter does not apply to family adult foster care homes that do not provide
257.28 services licensed under this chapter.

257.29 (d) A license holder providing services licensed according to this chapter in a
257.30 supervised living facility is exempt from compliance with sections 245D.04; 245D.05,
257.31 subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).

257.32 (e) A license holder providing residential services to persons in an ICF/DD is exempt
257.33 from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision
257.34 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09,
257.35 subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

258.1 ~~(e) (f) A license holder concurrently providing home care homemaker services~~
258.2 ~~registered licensed according to sections 144A.43 to 144A.49 to the same person receiving~~
258.3 ~~home management services licensed under this chapter and registered according to chapter~~
258.4 ~~144A is exempt from compliance with section 245D.04 as it applies to the person.~~

258.5 ~~(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt~~
258.6 ~~from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557,~~
258.7 ~~subdivision 14, paragraph (b).~~

258.8 ~~(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing~~
258.9 ~~structured day, prevocational, or supported employment services under this chapter~~
258.10 ~~and day training and habilitation or supported employment services licensed under~~
258.11 ~~chapter 245B within the same program is exempt from compliance with this chapter~~
258.12 ~~when the license holder notifies the commissioner in writing that the requirements under~~
258.13 ~~chapter 245B will be met for all persons receiving these services from the program. For~~
258.14 ~~the purposes of this paragraph, if the license holder has obtained approval from the~~
258.15 ~~commissioner for an alternative inspection status according to section 245B.031, that~~
258.16 ~~approval will apply to all persons receiving services in the program.~~

258.17 ~~(g) Nothing in this chapter prohibits a license holder from concurrently serving~~
258.18 ~~persons without disabilities or people who are or are not age 65 and older, provided this~~
258.19 ~~chapter's standards are met as well as other relevant standards.~~

258.20 ~~(h) The documentation required under sections 245D.07 and 245D.071 must meet~~
258.21 ~~the individual program plan requirements identified in section 256B.092 or successor~~
258.22 ~~provisions.~~

258.23 **Subd. 3. Variance.** If the conditions in section 245A.04, subdivision 9, are met,
258.24 the commissioner may grant a variance to any of the requirements in this chapter, except
258.25 sections 245D.04, and 245D.10, subdivision 4, paragraph (b) 245D.06, subdivision 4,
258.26 paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and
258.27 information rights of persons.

258.28 **Subd. 4. License holders with multiple 245D licenses.** (a) When a person changes
258.29 service from one license to a different license held by the same license holder, the license
258.30 holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).

258.31 (b) When a staff person begins providing direct service under one or more licenses
258.32 held by the same license holder, other than the license for which staff orientation was
258.33 initially provided according to section 245D.09, subdivision 4, the license holder is
258.34 exempt from those staff orientation requirements, except the staff person must review each
258.35 person's service plan and medication administration procedures in accordance with section
258.36 245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.

259.1 Subd. 5. **Program certification.** An applicant or a license holder may apply for
259.2 program certification as identified in section 245D.33.

259.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

259.4 Sec. 19. Minnesota Statutes 2012, section 245D.04, is amended to read:

259.5 **245D.04 SERVICE RECIPIENT RIGHTS.**

259.6 Subdivision 1. **License holder responsibility for individual rights of persons**
259.7 **served by the program.** The license holder must:

259.8 (1) provide each person or each person's legal representative with a written notice
259.9 that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of
259.10 those rights within five working days of service initiation and annually thereafter;

259.11 (2) make reasonable accommodations to provide this information in other formats
259.12 or languages as needed to facilitate understanding of the rights by the person and the
259.13 person's legal representative, if any;

259.14 (3) maintain documentation of the person's or the person's legal representative's
259.15 receipt of a copy and an explanation of the rights; and

259.16 (4) ensure the exercise and protection of the person's rights in the services provided
259.17 by the license holder and as authorized in the coordinated service and support plan.

259.18 Subd. 2. **Service-related rights.** A person's service-related rights include the right to:

259.19 (1) participate in the development and evaluation of the services provided to the
259.20 person;

259.21 (2) have services and supports identified in the coordinated service and support plan
259.22 and the coordinated service and support plan addendum provided in a manner that respects
259.23 and takes into consideration the person's preferences according to the requirements in
259.24 sections 245D.07 and 245D.071;

259.25 (3) refuse or terminate services and be informed of the consequences of refusing
259.26 or terminating services;

259.27 (4) know, in advance, limits to the services available from the license holder,
259.28 including the license holder's knowledge, skill, and ability to meet the person's service and
259.29 support needs based on the information required in section 245D.031, subdivision 2;

259.30 (5) know conditions and terms governing the provision of services, including the
259.31 license holder's admission criteria and policies and procedures related to temporary
259.32 service suspension and service termination;

259.33 (6) a coordinated transfer to ensure continuity of care when there will be a change
259.34 in the provider;

260.1 (7) know what the charges are for services, regardless of who will be paying for the
260.2 services, and be notified of changes in those charges;

260.3 (7) (8) know, in advance, whether services are covered by insurance, government
260.4 funding, or other sources, and be told of any charges the person or other private party
260.5 may have to pay; and

260.6 (8) (9) receive services from an individual who is competent and trained, who has
260.7 professional certification or licensure, as required, and who meets additional qualifications
260.8 identified in the person's coordinated service and support plan; or coordinated service and
260.9 support plan addendum.

260.10 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include
260.11 the right to:

260.12 (1) have personal, financial, service, health, and medical information kept private,
260.13 and be advised of disclosure of this information by the license holder;

260.14 (2) access records and recorded information about the person in accordance with
260.15 applicable state and federal law, regulation, or rule;

260.16 (3) be free from maltreatment;

260.17 (4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except
260.18 for emergency use of manual restraint to protect the person from imminent danger to self
260.19 or others according to the requirements in section 245D.06;

260.20 (5) receive services in a clean and safe environment when the license holder is the
260.21 owner, lessor, or tenant of the service site;

260.22 (6) be treated with courtesy and respect and receive respectful treatment of the
260.23 person's property;

260.24 (7) reasonable observance of cultural and ethnic practice and religion;

260.25 (8) be free from bias and harassment regarding race, gender, age, disability,
260.26 spirituality, and sexual orientation;

260.27 (9) be informed of and use the license holder's grievance policy and procedures,
260.28 including knowing how to contact persons responsible for addressing problems and to
260.29 appeal under section 256.045;

260.30 (10) know the name, telephone number, and the Web site, e-mail, and street
260.31 addresses of protection and advocacy services, including the appropriate state-appointed
260.32 ombudsman, and a brief description of how to file a complaint with these offices;

260.33 (11) assert these rights personally, or have them asserted by the person's family,
260.34 authorized representative, or legal representative, without retaliation;

260.35 (12) give or withhold written informed consent to participate in any research or
260.36 experimental treatment;

261.1 (13) associate with other persons of the person's choice;

261.2 (14) personal privacy; and

261.3 (15) engage in chosen activities.

261.4 (b) For a person residing in a residential site licensed according to chapter 245A,
261.5 or where the license holder is the owner, lessor, or tenant of the residential service site,
261.6 protection-related rights also include the right to:

261.7 (1) have daily, private access to and use of a non-coin-operated telephone for local
261.8 calls and long-distance calls made collect or paid for by the person;

261.9 (2) receive and send, without interference, uncensored, unopened mail or electronic
261.10 correspondence or communication; ~~and~~

261.11 (3) have use of and free access to common areas in the residence; and

261.12 (4) privacy for visits with the person's spouse, next of kin, legal counsel, religious
261.13 advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including
261.14 privacy in the person's bedroom.

261.15 (c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a),
261.16 clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure
261.17 the health, safety, and well-being of the person. Any restriction of those rights must be
261.18 documented in the person's coordinated service and support plan for the person and or
261.19 coordinated service and support plan addendum. The restriction must be implemented
261.20 in the least restrictive alternative manner necessary to protect the person and provide
261.21 support to reduce or eliminate the need for the restriction in the most integrated setting
261.22 and inclusive manner. The documentation must include the following information:

261.23 (1) the justification for the restriction based on an assessment of the person's
261.24 vulnerability related to exercising the right without restriction;

261.25 (2) the objective measures set as conditions for ending the restriction;

261.26 (3) a schedule for reviewing the need for the restriction based on the conditions for
261.27 ending the restriction to occur, ~~at a minimum, every three months for persons who do not~~
261.28 ~~have a legal representative and annually for persons who do have a legal representative~~
261.29 semiannually from the date of initial approval, at a minimum, or more frequently if
261.30 requested by the person, the person's legal representative, if any, and case manager; and

261.31 (4) signed and dated approval for the restriction from the person, or the person's
261.32 legal representative, if any. A restriction may be implemented only when the required
261.33 approval has been obtained. Approval may be withdrawn at any time. If approval is
261.34 withdrawn, the right must be immediately and fully restored.

261.35 **EFFECTIVE DATE.** This section is effective January 1, 2014.

262.1 Sec. 20. Minnesota Statutes 2012, section 245D.05, is amended to read:

262.2 **245D.05 HEALTH SERVICES.**

262.3 Subdivision 1. **Health needs.** (a) The license holder is responsible for ~~providing~~
 262.4 meeting health services service needs assigned in the coordinated service and support plan
 262.5 ~~and or the coordinated service and support plan addendum,~~ consistent with the person's
 262.6 health needs. The license holder is responsible for promptly notifying ~~the person or~~
 262.7 the person's legal representative, if any, and the case manager of changes in a person's
 262.8 physical and mental health needs affecting ~~assigned health services~~ service needs assigned
 262.9 to the license holder in the coordinated service and support plan or the coordinated service
 262.10 and support plan addendum, when discovered by the license holder, unless the license
 262.11 holder has reason to know the change has already been reported. The license holder
 262.12 must document when the notice is provided.

262.13 (b) ~~When assigned in the service plan,~~ If responsibility for meeting the person's
 262.14 health service needs has been assigned to the license holder in the coordinated service and
 262.15 support plan or the coordinated service and support plan addendum, the license holder is
 262.16 ~~required to~~ must maintain documentation on how the person's health needs will be met,
 262.17 including a description of the procedures the license holder will follow in order to:

262.18 (1) provide medication ~~administration, assistance or medication assistance, or~~
 262.19 ~~medication management~~ administration according to this chapter;

262.20 (2) monitor health conditions according to written instructions from ~~the person's~~
 262.21 ~~physician or~~ a licensed health professional;

262.22 (3) assist with or coordinate medical, dental, and other health service appointments; or

262.23 (4) use medical equipment, devices, or adaptive aides or technology safely and
 262.24 correctly according to written instructions from ~~the person's physician or~~ a licensed
 262.25 health professional.

262.26 Subd. 1a. **Medication setup.** For the purposes of this subdivision, "medication
 262.27 setup" means the arranging of medications according to instructions from the pharmacy,
 262.28 the prescriber, or a licensed nurse, for later administration when the license holder
 262.29 is assigned responsibility for medication assistance or medication administration in
 262.30 the coordinated service and support plan or the coordinated service and support plan
 262.31 addendum. A prescription label or the prescriber's written or electronically recorded order
 262.32 for the prescription is sufficient to constitute written instructions from the prescriber. The
 262.33 license holder must document in the person's medication administration record: dates
 262.34 of setup, name of medication, quantity of dose, times to be administered, and route of
 262.35 administration at time of setup; and, when the person will be away from home, to whom
 262.36 the medications were given.

263.1 Subd. 1b. **Medication assistance.** If responsibility for medication assistance
263.2 is assigned to the license holder in the coordinated service and support plan or the
263.3 coordinated service and support plan addendum, the license holder must ensure that
263.4 the requirements of subdivision 2, paragraph (b), have been met when staff provides
263.5 medication assistance to enable a person to self-administer medication or treatment when
263.6 the person is capable of directing the person's own care, or when the person's legal
263.7 representative is present and able to direct care for the person. For the purposes of this
263.8 subdivision, "medication assistance" means any of the following:

263.9 (1) bringing to the person and opening a container of previously set up medications,
263.10 emptying the container into the person's hand, or opening and giving the medications in
263.11 the original container to the person;

263.12 (2) bringing to the person liquids or food to accompany the medication; or

263.13 (3) providing reminders to take regularly scheduled medication or perform regularly
263.14 scheduled treatments and exercises.

263.15 Subd. 2. **Medication administration.** (a) If responsibility for medication
263.16 administration is assigned to the license holder in the coordinated service and support plan
263.17 or the coordinated service and support plan addendum, the license holder must implement
263.18 the following medication administration procedures to ensure a person takes medications
263.19 and treatments as prescribed:

263.20 (1) checking the person's medication record;

263.21 (2) preparing the medication as necessary;

263.22 (3) administering the medication or treatment to the person;

263.23 (4) documenting the administration of the medication or treatment or the reason for
263.24 not administering the medication or treatment; and

263.25 (5) reporting to the prescriber or a nurse any concerns about the medication or
263.26 treatment, including side effects, effectiveness, or a pattern of the person refusing to
263.27 take the medication or treatment as prescribed. Adverse reactions must be immediately
263.28 reported to the prescriber or a nurse.

263.29 (b)(1) The license holder must ensure that the following criteria requirements in
263.30 clauses (2) to (4) have been met before staff that is not a licensed health professional
263.31 administers administering medication or treatment;

263.32 (+) (2) The license holder must obtain written authorization has been obtained from
263.33 the person or the person's legal representative to administer medication or treatment
263.34 orders; and must obtain reauthorization annually as needed. If the person or the person's
263.35 legal representative refuses to authorize the license holder to administer medication, the

264.1 medication must not be administered. The refusal to authorize medication administration
 264.2 must be reported to the prescriber as expeditiously as possible.

264.3 ~~(2)~~ (3) The staff person ~~has completed~~ responsible for administering the medication
 264.4 or treatment must complete medication administration training according to section
 264.5 245D.09, subdivision 4, ~~paragraph 4a, paragraphs (a) and (c), clause (2); and, as applicable~~
 264.6 to the person, paragraph (d).

264.7 ~~(3) The medication or treatment will be administered under administration~~
 264.8 ~~procedures established for the person in consultation with a licensed health professional.~~
 264.9 ~~written instruction from the person's physician may constitute the medication~~
 264.10 ~~administration procedures. A prescription label or the prescriber's order for the~~
 264.11 ~~prescription is sufficient to constitute written instructions from the prescriber. A licensed~~
 264.12 ~~health professional may delegate medication administration procedures.~~

264.13 (4) For a license holder providing intensive support services, the medication or
 264.14 treatment must be administered according to the license holder's medication administration
 264.15 policy and procedures as required under section 245D.11, subdivision 2, clause (3).

264.16 ~~(b)~~ (c) The license holder must ensure the following information is documented in
 264.17 the person's medication administration record:

264.18 (1) the information on the current prescription label or the prescriber's current written
 264.19 or electronically recorded order or prescription that includes directions for the person's
 264.20 name, description of the medication or treatment to be provided, and the frequency and
 264.21 other information needed to safely and correctly ~~administering~~ administer the medication
 264.22 or treatment to ensure effectiveness;

264.23 (2) information on any ~~discomforts~~, risks, or other side effects that are reasonable to
 264.24 expect, and any contraindications to its use. This information must be readily available
 264.25 to all staff administering the medication;

264.26 (3) the possible consequences if the medication or treatment is not taken or
 264.27 administered as directed;

264.28 (4) instruction ~~from the prescriber~~ on when and to whom to report the following:

264.29 (i) if ~~the~~ a dose of medication or treatment is not administered or treatment is not
 264.30 performed as prescribed, whether by error by the staff or the person or by refusal by
 264.31 the person; and

264.32 (ii) the occurrence of possible adverse reactions to the medication or treatment;

264.33 (5) notation of any occurrence of a dose of medication not being administered or
 264.34 treatment not performed as prescribed, whether by error by the staff or the person or by
 264.35 refusal by the person, or of adverse reactions, and when and to whom the report was
 264.36 made; and

265.1 (6) notation of when a medication or treatment is started, administered, changed, or
265.2 discontinued.

265.3 ~~(e) The license holder must ensure that the information maintained in the medication
265.4 administration record is current and is regularly reviewed with the person or the person's
265.5 legal representative and the staff administering the medication to identify medication
265.6 administration issues or errors. At a minimum, the review must be conducted every three
265.7 months or more often if requested by the person or the person's legal representative.
265.8 Based on the review, the license holder must develop and implement a plan to correct
265.9 medication administration issues or errors. If issues or concerns are identified related to
265.10 the medication itself, the license holder must report those as required under subdivision 4.~~

265.11 ~~Subd. 3. **Medication assistance.** The license holder must ensure that the
265.12 requirements of subdivision 2, paragraph (a), have been met when staff provides assistance
265.13 to enable a person to self-administer medication when the person is capable of directing
265.14 the person's own care, or when the person's legal representative is present and able to
265.15 direct care for the person.~~

265.16 ~~Subd. 4. **Reviewing and reporting medication and treatment issues.** The
265.17 following medication administration issues must be reported to the person or the person's
265.18 legal representative and case manager as they occur or following timelines established
265.19 in the person's service plan or as requested in writing by the person or the person's legal
265.20 representative, or the case manager: (a) When assigned responsibility for medication
265.21 administration, the license holder must ensure that the information maintained in
265.22 the medication administration record is current and is regularly reviewed to identify
265.23 medication administration errors. At a minimum, the review must be conducted every
265.24 three months, or more frequently as directed in the coordinated service and support plan
265.25 or coordinated service and support plan addendum or as requested by the person or the
265.26 person's legal representative. Based on the review, the license holder must develop and
265.27 implement a plan to correct patterns of medication administration errors when identified.~~

265.28 ~~(b) If assigned responsibility for medication assistance or medication administration,
265.29 the license holder must report the following to the person's legal representative and case
265.30 manager as they occur or as otherwise directed in the coordinated service and support plan
265.31 or the coordinated service and support plan addendum:~~

265.32 (1) any reports made to the person's physician or prescriber required under
265.33 subdivision 2, paragraph ~~(b)~~ (c), clause (4);

265.34 (2) a person's refusal or failure to take or receive medication or treatment as
265.35 prescribed; or

265.36 (3) concerns about a person's self-administration of medication or treatment.

266.1 Subd. 5. **Injectable medications.** Injectable medications may be administered
266.2 according to a prescriber's order and written instructions when one of the following
266.3 conditions has been met:

266.4 (1) a registered nurse or licensed practical nurse will administer the subcutaneous or
266.5 intramuscular injection;

266.6 (2) a supervising registered nurse with a physician's order has delegated the
266.7 administration of subcutaneous injectable medication to an unlicensed staff member
266.8 and has provided the necessary training; or

266.9 (3) there is an agreement signed by the license holder, the prescriber, and the
266.10 person or the person's legal representative specifying what subcutaneous injections may
266.11 be given, when, how, and that the prescriber must retain responsibility for the license
266.12 holder's giving the injections. A copy of the agreement must be placed in the person's
266.13 service recipient record.

266.14 Only licensed health professionals are allowed to administer psychotropic
266.15 medications by injection.

266.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

266.17 Sec. 21. **[245D.051] PSYCHOTROPIC MEDICATION USE AND**
266.18 **MONITORING.**

266.19 **Subdivision 1. Conditions for psychotropic medication administration.** (a)
266.20 When a person is prescribed a psychotropic medication and the license holder is assigned
266.21 responsibility for administration of the medication in the person's coordinated service
266.22 and support plan or the coordinated service and support plan addendum, the license
266.23 holder must ensure that the requirements in paragraphs (b) to (d) and section 245D.05,
266.24 subdivision 2, are met.

266.25 (b) Use of the medication must be included in the person's coordinated service and
266.26 support plan or in the coordinated service and support plan addendum and based on a
266.27 prescriber's current written or electronically recorded prescription.

266.28 (c) The license holder must develop, implement, and maintain the following
266.29 documentation in the person's coordinated service and support plan addendum according
266.30 to the requirements in sections 245D.07 and 245D.071:

266.31 (1) a description of the target symptoms that the psychotropic medication is to
266.32 alleviate; and

266.33 (2) documentation methods the license holder will use to monitor and measure
266.34 changes in the target symptoms that are to be alleviated by the psychotropic medication if
266.35 required by the prescriber. The license holder must collect and report on medication and

267.1 symptom-related data as instructed by the prescriber. The license holder must provide
267.2 the monitoring data to the expanded support team for review every three months, or as
267.3 otherwise requested by the person or the person's legal representative.

267.4 For the purposes of this section, "target symptom" refers to any perceptible
267.5 diagnostic criteria for a person's diagnosed mental disorder as defined by the Diagnostic
267.6 and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or
267.7 successive editions that has been identified for alleviation.

267.8 (d) If a person is prescribed a psychotropic medication, monitoring the use of the
267.9 psychotropic medication must be assigned to the license holder in the coordinated service
267.10 and support plan or the coordinated service and support plan addendum. The assigned
267.11 license holder must monitor the psychotropic medication as required by this section.

267.12 Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the
267.13 person's legal representative refuses to authorize the administration of a psychotropic
267.14 medication as ordered by the prescriber, the license holder must follow the requirement
267.15 in section 245D.05, subdivision 2, paragraph (b), clause (2). After reporting the refusal
267.16 to the prescriber, the license holder must follow any directives or orders given by the
267.17 prescriber. A court order must be obtained to override the refusal. Refusal to authorize
267.18 administration of a specific psychotropic medication is not grounds for service termination
267.19 and does not constitute an emergency. A decision to terminate services must be reached in
267.20 compliance with section 245D.10, subdivision 3.

267.21 **EFFECTIVE DATE.** This section is effective January 1, 2014.

267.22 Sec. 22. Minnesota Statutes 2012, section 245D.06, is amended to read:

267.23 **245D.06 PROTECTION STANDARDS.**

267.24 Subdivision 1. **Incident response and reporting.** (a) The license holder must
267.25 respond to all incidents under section 245D.02, subdivision 11, that occur while providing
267.26 services to protect the health and safety of and minimize risk of harm to the person.

267.27 (b) The license holder must maintain information about and report incidents to the
267.28 person's legal representative or designated emergency contact and case manager within 24
267.29 hours of an incident occurring while services are being provided, or within 24 hours of
267.30 discovery or receipt of information that an incident occurred, unless the license holder
267.31 has reason to know that the incident has already been reported, or as otherwise directed
267.32 in a person's coordinated service and support plan or coordinated service and support
267.33 plan addendum. An incident of suspected or alleged maltreatment must be reported as

268.1 required under paragraph (d), and an incident of serious injury or death must be reported
268.2 as required under paragraph (e).

268.3 (c) When the incident involves more than one person, the license holder must not
268.4 disclose personally identifiable information about any other person when making the report
268.5 to each person and case manager unless the license holder has the consent of the person.

268.6 (d) Within 24 hours of reporting maltreatment as required under section 626.556
268.7 or 626.557, the license holder must inform the case manager of the report unless there is
268.8 reason to believe that the case manager is involved in the suspected maltreatment. The
268.9 license holder must disclose the nature of the activity or occurrence reported and the
268.10 agency that received the report.

268.11 (e) The license holder must report the death or serious injury of the person to the legal
268.12 representative, if any, and case manager, as required in paragraph (b) and to the Department
268.13 of Human Services Licensing Division, and the Office of Ombudsman for Mental Health
268.14 and Developmental Disabilities as required under section 245.94, subdivision 2a, within
268.15 24 hours of the death, or receipt of information that the death occurred, unless the license
268.16 holder has reason to know that the death has already been reported.

268.17 (f) When a death or serious injury occurs in a facility certified as an intermediate
268.18 care facility for persons with developmental disabilities, the death or serious injury must
268.19 be reported to the Department of Health, Office of Health Facility Complaints, and the
268.20 Office of Ombudsman for Mental Health and Developmental Disabilities, as required
268.21 under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to
268.22 know that the death has already been reported.

268.23 (f) (g) The license holder must conduct a an internal review of incident reports of
268.24 deaths and serious injuries that occurred while services were being provided and that
268.25 were not reported by the program as alleged or suspected maltreatment, for identification
268.26 of incident patterns, and implementation of corrective action as necessary to reduce
268.27 occurrences. The review must include an evaluation of whether related policies and
268.28 procedures were followed, whether the policies and procedures were adequate, whether
268.29 there is a need for additional staff training, whether the reported event is similar to past
268.30 events with the persons or the services involved, and whether there is a need for corrective
268.31 action by the license holder to protect the health and safety of persons receiving services.
268.32 Based on the results of this review, the license holder must develop, document, and
268.33 implement a corrective action plan designed to correct current lapses and prevent future
268.34 lapses in performance by staff or the license holder, if any.

268.35 (h) The license holder must verbally report the emergency use of manual restraint of
268.36 a person as required in paragraph (b), within 24 hours of the occurrence. The license holder

269.1 must ensure the written report and internal review of all incident reports of the emergency
269.2 use of manual restraints are completed according to the requirements in section 245D.061.

269.3 Subd. 2. **Environment and safety.** The license holder must:

269.4 (1) ensure the following when the license holder is the owner, lessor, or tenant
269.5 of ~~the~~ an unlicensed service site:

269.6 (i) the service site is a safe and hazard-free environment;

269.7 (ii) ~~doors are locked or toxic substances or dangerous items normally accessible are~~
269.8 inaccessible to persons served by the program ~~are stored in locked cabinets, drawers, or~~
269.9 ~~containers only to protect the safety of a person receiving services and not as a substitute~~
269.10 ~~for staff supervision or interactions with a person who is receiving services. If doors are~~
269.11 ~~locked or toxic substances or dangerous items normally accessible to persons served by the~~
269.12 ~~program are stored in locked cabinets, drawers, or containers~~ are made inaccessible, the
269.13 license holder must ~~justify and document how this determination was made in consultation~~
269.14 ~~with the person or person's legal representative, and how access will otherwise be provided~~
269.15 ~~to the person and all other affected persons receiving services; and~~ document an assessment
269.16 of the physical plant, its environment, and its population identifying the risk factors which
269.17 require toxic substances or dangerous items to be inaccessible and a statement of specific
269.18 measures to be taken to minimize the safety risk to persons receiving services;

269.19 (iii) doors are locked from the inside to prevent a person from exiting only when
269.20 necessary to protect the safety of a person receiving services and not as a substitute for
269.21 staff supervision or interactions with the person. If doors are locked from the inside, the
269.22 license holder must document an assessment of the physical plant, the environment and
269.23 the population served, identifying the risk factors which require the use of locked doors,
269.24 and a statement of specific measures to be taken to minimize the safety risk to persons
269.25 receiving services at the service site; and

269.26 (iii) (iv) a staff person is available on site who is trained in basic first aid and, when
269.27 required in a person's coordinated service and support plan or coordinated service and
269.28 support plan addendum, cardiopulmonary resuscitation, whenever persons are present and
269.29 staff are required to be at the site to provide direct service. The training must include
269.30 in-person instruction, hands-on practice, and an observed skills assessment under the
269.31 direct supervision of a first aid instructor;

269.32 (2) maintain equipment, vehicles, supplies, and materials owned or leased by the
269.33 license holder in good condition when used to provide services;

269.34 (3) follow procedures to ensure safe transportation, handling, and transfers of the
269.35 person and any equipment used by the person, when the license holder is responsible for
269.36 transportation of a person or a person's equipment;

270.1 (4) be prepared for emergencies and follow emergency response procedures to
270.2 ensure the person's safety in an emergency; and

270.3 (5) follow universal precautions and sanitary practices, including hand washing, for
270.4 infection prevention and control, and to prevent communicable diseases.

270.5 ~~Subd. 3. **Compliance with fire and safety codes.** When services are provided at a~~
270.6 ~~service site licensed according to chapter 245A or where the license holder is the owner,~~
270.7 ~~lessor, or tenant of the service site, the license holder must document compliance with~~
270.8 ~~applicable building codes, fire and safety codes, health rules, and zoning ordinances, or~~
270.9 ~~document that an appropriate waiver has been granted.~~

270.10 Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person
270.11 with the safekeeping of funds or other property according to section 245A.04, subdivision
270.12 13, the license holder must have obtain written authorization to do so from the person or
270.13 the person's legal representative and the case manager. Authorization must be obtained
270.14 within five working days of service initiation and renewed annually thereafter. At the time
270.15 initial authorization is obtained, the license holder must survey, document, and implement
270.16 the preferences of the person or the person's legal representative and the case manager
270.17 for frequency of receiving a statement that itemizes receipts and disbursements of funds
270.18 or other property. The license holder must document changes to these preferences when
270.19 they are requested.

270.20 (b) A license holder or staff person may not accept powers-of-attorney from a
270.21 person receiving services from the license holder for any purpose, ~~and may not accept an~~
270.22 ~~appointment as guardian or conservator of a person receiving services from the license~~
270.23 ~~holder.~~ This does not apply to license holders that are Minnesota counties or other
270.24 units of government or to staff persons employed by license holders who were acting
270.25 as ~~power-of-attorney, guardian, or conservator~~ attorney-in-fact for specific individuals
270.26 prior to ~~April 23, 2012~~ implementation of this chapter. The license holder must maintain
270.27 documentation of the power-of-attorney, ~~guardianship, or conservatorship~~ in the service
270.28 recipient record.

270.29 (c) Upon the transfer or death of a person, any funds or other property of the person
270.30 must be surrendered to the person or the person's legal representative, or given to the
270.31 executor or administrator of the estate in exchange for an itemized receipt.

270.32 Subd. 5. **Prohibitions.** (a) The license holder is prohibited from using ~~psychotropic~~
270.33 ~~medication~~ chemical restraints, mechanical restraint practices, manual restraints, time out,
270.34 or seclusion as a substitute for adequate staffing, for a behavioral or therapeutic program
270.35 to reduce or eliminate behavior, as punishment, or ~~for staff convenience, or for any reason~~
270.36 ~~other than as prescribed.~~

271.1 ~~(b) The license holder is prohibited from using restraints or seclusion under any~~
271.2 ~~circumstance, unless the commissioner has approved a variance request from the license~~
271.3 ~~holder that allows for the emergency use of restraints and seclusion according to terms~~
271.4 ~~and conditions approved in the variance. Applicants and license holders who have~~
271.5 ~~reason to believe they may be serving an individual who will need emergency use of~~
271.6 ~~restraints or seclusion may request a variance on the application or reapplication, and~~
271.7 ~~the commissioner shall automatically review the request for a variance as part of the~~
271.8 ~~application or reapplication process. License holders may also request the variance any~~
271.9 ~~time after issuance of a license. In the event a license holder uses restraint or seclusion for~~
271.10 ~~any reason without first obtaining a variance as required, the license holder must report~~
271.11 ~~the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the~~
271.12 ~~occurrence and request the required variance.~~

271.13 (b) For the purposes of this subdivision, "chemical restraint" means the
271.14 administration of a drug or medication to control the person's behavior or restrict the
271.15 person's freedom of movement and is not a standard treatment of dosage for the person's
271.16 medical or psychological condition.

271.17 (c) For the purposes of this subdivision, "mechanical restraint practice" means the
271.18 use of any adaptive equipment or safety device to control the person's behavior or restrict
271.19 the person's freedom of movement and not as ordered by a licensed health professional.
271.20 Mechanical restraint practices include, but are not limited to, the use of bed rails or similar
271.21 devices on a bed to prevent the person from getting out of bed, chairs that prevent a person
271.22 from rising, or placing a person in a wheelchair so close to a wall that the wall prevents
271.23 the person from rising. Wrist bands or devices on clothing that trigger electronic alarms to
271.24 warn staff that a person is leaving a room or area do not, in and of themselves, restrict
271.25 freedom of movement and should not be considered restraints.

271.26 (d) A license holder must not use manual restraints, time out, or seclusion under any
271.27 circumstance, except for emergency use of manual restraints according to the requirements
271.28 in section 245D.061 or the use of controlled procedures with a person with a developmental
271.29 disability as governed by Minnesota Rules, parts 9525.2700 to 9525.2810, or its successor
271.30 provisions. License holders implementing nonemergency use of manual restraint, or any
271.31 other programmatic use of mechanical restraint, time out, or seclusion with persons who
271.32 do not have a developmental disability that is not subject to the requirements of Minnesota
271.33 Rules, parts 9525.2700 to 9525.2810, must submit a variance request to the commissioner
271.34 for continued use of the procedure within three months of implementation of this chapter.

271.35 **EFFECTIVE DATE.** This section is effective January 1, 2014.

272.1 Sec. 23. **[245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

272.2 **Subdivision 1. Standards for emergency use of manual restraints.** Except
272.3 for the emergency use of controlled procedures with a person with a developmental
272.4 disability as governed by Minnesota Rules, part 9525.2770, or its successor provisions,
272.5 the license holder must ensure that emergency use of manual restraints complies with the
272.6 requirements of this chapter and the license holder's policy and procedures as required
272.7 under subdivision 10.

272.8 **Subd. 2. Definitions.** (a) The terms used in this section have the meaning given
272.9 them in this subdivision.

272.10 (b) "Manual restraint" means physical intervention intended to hold a person
272.11 immobile or limit a person's voluntary movement by using body contact as the only source
272.12 of physical restraint.

272.13 (c) "Mechanical restraint" means the use of devices, materials, or equipment attached
272.14 or adjacent to the person's body, or the use of practices which restrict freedom of movement
272.15 or normal access to one's body or body parts, or limits a person's voluntary movement
272.16 or holds a person immobile as an intervention precipitated by a person's behavior. The
272.17 term does apply to mechanical restraint used to prevent injury with persons who engage in
272.18 self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue
272.19 damage that have caused or could cause medical problems resulting from the self-injury.

272.20 **Subd. 3. Conditions for emergency use of manual restraint.** Emergency use of
272.21 manual restraint must meet the following conditions:

272.22 (1) immediate intervention must be needed to protect the person or others from
272.23 imminent risk of physical harm; and

272.24 (2) the type of manual restraint used must be the least restrictive intervention to
272.25 eliminate the immediate risk of harm and effectively achieve safety. The manual restraint
272.26 must end when the threat of harm ends.

272.27 **Subd. 4. Permitted instructional techniques and therapeutic conduct.** (a) Use of
272.28 physical contact as therapeutic conduct or as an instructional technique as identified in
272.29 paragraphs (b) and (c), is permitted and is not subject to the requirements of this section
272.30 when such use is addressed in a person's coordinated service and support plan addendum
272.31 and the required conditions have been met. For the purposes of this subdivision,
272.32 "therapeutic conduct" has the meaning given in section 626.5572, subdivision 20.

272.33 (b) Physical contact or instructional techniques must use the least restrictive
272.34 alternative possible to meet the needs of the person and may be used:

272.35 (1) to calm or comfort a person by holding that person with no resistance from
272.36 that person;

273.1 (2) to protect a person known to be at risk of injury due to frequent falls as a result of
273.2 a medical condition; or

273.3 (3) to position a person with physical disabilities in a manner specified in the
273.4 person's coordinated service and support plan addendum.

273.5 (c) Restraint may be used as therapeutic conduct:

273.6 (1) to allow a licensed health care professional to safely conduct a medical
273.7 examination or to provide medical treatment ordered by a licensed health care professional
273.8 to a person necessary to promote healing or recovery from an acute, meaning short-term,
273.9 medical condition;

273.10 (2) to facilitate the person's completion of a task or response when the person does
273.11 not resist or the person's resistance is minimal in intensity and duration;

273.12 (3) to briefly block or redirect a person's limbs or body without holding the person
273.13 or limiting the person's movement to interrupt the person's behavior that may result in
273.14 injury to self or others; or

273.15 (4) to assist in the safe evacuation of a person in the event of an emergency or to
273.16 redirect a person who is at imminent risk of harm in a dangerous situation.

273.17 (d) A plan for using restraint as therapeutic conduct must be developed according to
273.18 the requirements in sections 245D.07 and 245D.071, and must include methods to reduce
273.19 or eliminate the use of and need for restraint.

273.20 **Subd. 5. Restrictions when implementing emergency use of manual restraint.**

273.21 (a) Emergency use of manual restraint procedures must not:

273.22 (1) be implemented with a child in a manner that constitutes sexual abuse, neglect,
273.23 physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

273.24 (2) be implemented with an adult in a manner that constitutes abuse or neglect as
273.25 defined in section 626.5572, subdivisions 2 and 17;

273.26 (3) be implemented in a manner that violates a person's rights and protections
273.27 identified in section 245D.04;

273.28 (4) restrict a person's normal access to a nutritious diet, drinking water, adequate
273.29 ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping
273.30 conditions, or necessary clothing, or to any protection required by state licensing standards
273.31 and federal regulations governing the program;

273.32 (5) deny the person visitation or ordinary contact with legal counsel, a legal
273.33 representative, or next of kin;

273.34 (6) be used as a substitute for adequate staffing, for the convenience of staff, as
273.35 punishment, or as a consequence if the person refuses to participate in the treatment
273.36 or services provided by the program; or

274.1 (7) use prone restraint. For the purposes of this section, "prone restraint" means use
274.2 of manual restraint that places a person in a face-down position. This does not include
274.3 brief physical holding of a person who, during an emergency use of manual restraint, rolls
274.4 into a prone position, and the person is restored to a standing, sitting, or side-lying position
274.5 as quickly as possible. Applying back or chest pressure while a person is in the prone or
274.6 supine position or face-up is prohibited.

274.7 Subd. 6. **Monitoring emergency use of manual restraint.** The license holder shall
274.8 monitor a person's health and safety during an emergency use of a manual restraint. Staff
274.9 monitoring the procedure must not be the staff implementing the procedure when possible.
274.10 The license holder shall complete a monitoring form, approved by the commissioner, for
274.11 each incident involving the emergency use of a manual restraint.

274.12 Subd. 7. **Reporting emergency use of manual restraint incident.** (a) Within
274.13 three calendar days after an emergency use of a manual restraint, the staff person who
274.14 implemented the emergency use must report in writing to the designated coordinator the
274.15 following information about the emergency use:

274.16 (1) the staff and persons receiving services who were involved in the incident
274.17 leading up to the emergency use of manual restraint;

274.18 (2) a description of the physical and social environment, including who was present
274.19 before and during the incident leading up to the emergency use of manual restraint;

274.20 (3) a description of what less restrictive alternative measures were attempted to
274.21 de-escalate the incident and maintain safety before the manual restraint was implemented
274.22 that identifies when, how, and how long the alternative measures were attempted before
274.23 manual restraint was implemented;

274.24 (4) a description of the mental, physical, and emotional condition of the person who
274.25 was restrained, and other persons involved in the incident leading up to, during, and
274.26 following the manual restraint;

274.27 (5) whether there was any injury to the person who was restrained or other persons
274.28 involved in the incident, including staff, before or as a result of the use of manual
274.29 restraint; and

274.30 (6) whether there was an attempt to debrief with the staff, and, if not contraindicated,
274.31 with the person who was restrained and other persons who were involved in or who
274.32 witnessed the restraint, following the incident and the outcome of the debriefing. If the
274.33 debriefing was not conducted at the time the incident report was made, the report should
274.34 identify whether a debriefing is planned.

275.1 (b) Each single incident of emergency use of manual restraint must be reported
275.2 separately. For the purposes of this subdivision, an incident of emergency use of manual
275.3 restraint is a single incident when the following conditions have been met:

275.4 (1) after implementing the manual restraint, staff attempt to release the person at the
275.5 moment staff believe the person's conduct no longer poses an imminent risk of physical
275.6 harm to self or others and less restrictive strategies can be implemented to maintain safety;

275.7 (2) upon the attempt to release the restraint, the person's behavior immediately
275.8 re-escalates; and

275.9 (3) staff must immediately reimplement the restraint in order to maintain safety.

275.10 Subd. 8. **Internal review of emergency use of manual restraint.** (a) Within five
275.11 working days of the emergency use of manual restraint, the license holder must complete
275.12 an internal review of each report of emergency use of manual restraint. The review must
275.13 include an evaluation of whether:

275.14 (1) the person's service and support strategies developed according to sections
275.15 245D.07 and 245D.071 need to be revised;

275.16 (2) related policies and procedures were followed;

275.17 (3) the policies and procedures were adequate;

275.18 (4) there is a need for additional staff training;

275.19 (5) the reported event is similar to past events with the persons, staff, or the services
275.20 involved; and

275.21 (6) there is a need for corrective action by the license holder to protect the health
275.22 and safety of persons.

275.23 (b) Based on the results of the internal review, the license holder must develop,
275.24 document, and implement a corrective action plan for the program designed to correct
275.25 current lapses and prevent future lapses in performance by individuals or the license
275.26 holder, if any. The corrective action plan, if any, must be implemented within 30 days of
275.27 the internal review being completed.

275.28 Subd. 9. **Expanded support team review.** (a) Within five working days after the
275.29 completion of the internal review required in subdivision 8, the license holder must consult
275.30 with the expanded support team following the emergency use of manual restraint to:

275.31 (1) discuss the incident reported in subdivision 7, to define the antecedent or event
275.32 that gave rise to the behavior resulting in the manual restraint and identify the perceived
275.33 function the behavior served; and

275.34 (2) determine whether the person's coordinated service and support plan addendum
275.35 needs to be revised according to sections 245D.07 and 245D.071 to positively and

276.1 effectively help the person maintain stability and to reduce or eliminate future occurrences
276.2 requiring emergency use of manual restraint.

276.3 Subd. 10. **Emergency use of manual restraints policy and procedures.** The
276.4 license holder must develop, document, and implement a policy and procedures that
276.5 promote service recipient rights and protect health and safety during the emergency use of
276.6 manual restraints. The policy and procedures must comply with the requirements of this
276.7 section and must specify the following:

276.8 (1) a description of the positive support strategies and techniques staff must use to
276.9 attempt to de-escalate a person's behavior before it poses an imminent risk of physical
276.10 harm to self or others;

276.11 (2) a description of the types of manual restraints the license holder allows staff to
276.12 use on an emergency basis, if any. If the license holder will not allow the emergency use
276.13 of manual restraint, the policy and procedure must identify the alternative measures the
276.14 license holder will require staff to use when a person's conduct poses an imminent risk of
276.15 physical harm to self or others and less restrictive strategies would not achieve safety;

276.16 (3) instructions for safe and correct implementation of the allowed manual restraint
276.17 procedures;

276.18 (4) the training that staff must complete and the timelines for completion, before they
276.19 may implement an emergency use of manual restraint. In addition to the training on this
276.20 policy and procedure and the orientation and annual training required in section 245D.09,
276.21 subdivision 4, the training for emergency use of manual restraint must incorporate the
276.22 following subjects:

276.23 (i) alternatives to manual restraint procedures, including techniques to identify
276.24 events and environmental factors that may escalate conduct that poses an imminent risk of
276.25 physical harm to self or others;

276.26 (ii) de-escalation methods, positive support strategies, and how to avoid power
276.27 struggles;

276.28 (iii) simulated experiences of administering and receiving manual restraint
276.29 procedures allowed by the license holder on an emergency basis;

276.30 (iv) how to properly identify thresholds for implementing and ceasing restrictive
276.31 procedures;

276.32 (v) how to recognize, monitor, and respond to the person's physical signs of distress,
276.33 including positional asphyxia;

276.34 (vi) the physiological and psychological impact on the person and the staff when
276.35 restrictive procedures are used;

276.36 (vii) the communicative intent of behaviors; and

- 277.1 (viii) relationship building;
 277.2 (5) the procedures and forms to be used to monitor the emergency use of manual
 277.3 restraints, including what must be monitored and the frequency of monitoring per
 277.4 each incident of emergency use of manual restraint, and the person or position who is
 277.5 responsible for monitoring the use;
 277.6 (6) the instructions, forms, and timelines required for completing and submitting an
 277.7 incident report by the person or persons who implemented the manual restraint; and
 277.8 (7) the procedures and timelines for conducting the internal review and the expanded
 277.9 support team review, and the person or position responsible for completing the reviews and
 277.10 who is responsible for ensuring that corrective action is taken or the person's coordinated
 277.11 service and support plan addendum is revised, when determined necessary.

277.12 **EFFECTIVE DATE.** This section is effective January 1, 2014.

277.13 Sec. 24. Minnesota Statutes 2012, section 245D.07, is amended to read:

277.14 **245D.07 SERVICE NEEDS PLANNING AND DELIVERY.**

277.15 Subdivision 1. **Provision of services.** The license holder must provide services as
 277.16 ~~specified assigned~~ in the coordinated service and support plan ~~and assigned to the license~~
 277.17 ~~holder.~~ The provision of services must comply with the requirements of this chapter and
 277.18 the federal waiver plans.

277.19 **Subd. 1a. Person-centered planning and service delivery.** (a) The license holder
 277.20 must provide services in response to the person's identified needs, interests, preferences,
 277.21 and desired outcomes as specified in the coordinated service and support plan, the
 277.22 coordinated service and support plan addendum, and in compliance with the requirements
 277.23 of this chapter. License holders providing intensive support services must also provide
 277.24 outcome-based services according to the requirements in section 245D.071.

277.25 (b) Services must be provided in a manner that supports the person's preferences,
 277.26 daily needs, and activities and accomplishment of the person's personal goals and service
 277.27 outcomes, consistent with the principles of:

277.28 (1) person-centered service planning and delivery that:

277.29 (i) identifies and supports what is important to the person as well as what is
 277.30 important for the person, including preferences for when, how, and by whom direct
 277.31 support service is provided;

277.32 (ii) uses that information to identify outcomes the person desires; and

277.33 (iii) respects each person's history, dignity, and cultural background;

277.34 (2) self-determination that supports and provides:

278.1 (i) opportunities for the development and exercise of functional and age-appropriate
 278.2 skills, decision making and choice, personal advocacy, and communication; and

278.3 (ii) the affirmation and protection of each person's civil and legal rights;

278.4 (3) providing the most integrated setting and inclusive service delivery that supports,
 278.5 promotes, and allows:

278.6 (i) inclusion and participation in the person's community as desired by the person
 278.7 in a manner that enables the person to interact with nondisabled persons to the fullest
 278.8 extent possible and supports the person in developing and maintaining a role as a valued
 278.9 community member;

278.10 (ii) opportunities for self-sufficiency as well as developing and maintaining social
 278.11 relationships and natural supports; and

278.12 (iii) a balance between risk and opportunity, meaning the least restrictive supports or
 278.13 interventions necessary are provided in the most integrated settings in the most inclusive
 278.14 manner possible to support the person to engage in activities of the person's own choosing
 278.15 that may otherwise present a risk to the person's health, safety, or rights.

278.16 **Subd. 2. Service planning requirements for basic support services.** (a) License
 278.17 holders providing basic support services must meet the requirements of this subdivision.

278.18 (b) Within 15 days of service initiation the license holder must complete a
 278.19 preliminary coordinated service and support plan addendum based on the coordinated
 278.20 service and support plan.

278.21 (c) Within 60 days of service initiation the license holder must review and revise as
 278.22 needed the preliminary coordinated service and support plan addendum to document the
 278.23 services that will be provided including how, when, and by whom services will be provided,
 278.24 and the person responsible for overseeing the delivery and coordination of services.

278.25 (d) The license holder must participate in service planning and support team
 278.26 meetings related to for the person following stated timelines established in the person's
 278.27 coordinated service and support plan or as requested by the support team, the person, or
 278.28 the person's legal representative, the support team or the expanded support team.

278.29 **Subd. 3. Reports.** The license holder must provide written reports regarding the
 278.30 person's progress or status as requested by the person, the person's legal representative, the
 278.31 case manager, or the team.

278.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

278.33 **Sec. 25. [245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE**
 278.34 **SUPPORT SERVICES.**

279.1 Subdivision 1. **Requirements for intensive support services.** A license holder
279.2 providing intensive support services identified in section 245D.03, subdivision 1,
279.3 paragraph (c), must comply with the requirements in section 245D.07, subdivisions 1
279.4 and 3, and this section.

279.5 Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder
279.6 must develop, document, and implement an abuse prevention plan according to section
279.7 245A.65, subdivision 2.

279.8 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service
279.9 initiation the license holder must complete a preliminary coordinated service and support
279.10 plan addendum based on the coordinated service and support plan.

279.11 (b) Within 45 days of service initiation the license holder must meet with the person,
279.12 the person's legal representative, the case manager, and other members of the support team
279.13 or expanded support team to assess and determine the following based on the person's
279.14 coordinated service and support plan and the requirements in subdivision 4 and section
279.15 245D.07, subdivision 1a:

279.16 (1) the scope of the services to be provided to support the person's daily needs
279.17 and activities;

279.18 (2) the person's desired outcomes and the supports necessary to accomplish the
279.19 person's desired outcomes;

279.20 (3) the person's preferences for how services and supports are provided;

279.21 (4) whether the current service setting is the most integrated setting available and
279.22 appropriate for the person; and

279.23 (5) how services must be coordinated across other providers licensed under this
279.24 chapter serving the same person to ensure continuity of care for the person.

279.25 (c) Within the scope of services, the license holder must, at a minimum, assess
279.26 the following areas:

279.27 (1) the person's ability to self-manage health and medical needs to maintain or
279.28 improve physical, mental, and emotional well-being, including, when applicable, allergies,
279.29 seizures, choking, special dietary needs, chronic medical conditions, self-administration
279.30 of medication or treatment orders, preventative screening, and medical and dental
279.31 appointments;

279.32 (2) the person's ability to self-manage personal safety to avoid injury or accident in
279.33 the service setting, including, when applicable, risk of falling, mobility, regulating water
279.34 temperature, community survival skills, water safety skills, and sensory disabilities; and

279.35 (3) the person's ability to self-manage symptoms or behavior that may otherwise
279.36 result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to

280.1 (7), suspension or termination of services by the license holder, or other symptoms
280.2 or behaviors that may jeopardize the health and safety of the person or others. The
280.3 assessments must produce information about the person that is descriptive of the person's
280.4 overall strengths, functional skills and abilities, and behaviors or symptoms.

280.5 Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the
280.6 45-day meeting, the license holder must develop and document the service outcomes and
280.7 supports based on the assessments completed under subdivision 3 and the requirements
280.8 in section 245D.07, subdivision 1a. The outcomes and supports must be included in the
280.9 coordinated service and support plan addendum.

280.10 (b) The license holder must document the supports and methods to be implemented
280.11 to support the accomplishment of outcomes related to acquiring, retaining, or improving
280.12 skills. The documentation must include:

280.13 (1) the methods or actions that will be used to support the person and to accomplish
280.14 the service outcomes, including information about:

280.15 (i) any changes or modifications to the physical and social environments necessary
280.16 when the service supports are provided;

280.17 (ii) any equipment and materials required; and

280.18 (iii) techniques that are consistent with the person's communication mode and
280.19 learning style;

280.20 (2) the measurable and observable criteria for identifying when the desired outcome
280.21 has been achieved and how data will be collected;

280.22 (3) the projected starting date for implementing the supports and methods and
280.23 the date by which progress towards accomplishing the outcomes will be reviewed and
280.24 evaluated; and

280.25 (4) the names of the staff or position responsible for implementing the supports
280.26 and methods.

280.27 (c) Within 20 working days of the 45-day meeting, the license holder must obtain
280.28 dated signatures from the person or the person's legal representative and case manager
280.29 to document completion and approval of the assessment and coordinated service and
280.30 support plan addendum.

280.31 Subd. 5. **Progress reviews.** (a) The license holder must give the person or the
280.32 person's legal representative and case manager an opportunity to participate in the ongoing
280.33 review and development of the methods used to support the person and accomplish
280.34 outcomes identified in subdivisions 3 and 4. The license holder, in coordination with
280.35 the person's support team or expanded support team, must meet with the person, the
280.36 person's legal representative, and the case manager, and participate in progress review

281.1 meetings following stated timelines established in the person's coordinated service and
 281.2 support plan or coordinated service and support plan addendum or within 30 days of a
 281.3 written request by the person, the person's legal representative, or the case manager,
 281.4 at a minimum of once per year.

281.5 (b) The license holder must summarize the person's progress toward achieving the
 281.6 identified outcomes and make recommendations and identify the rationale for changing,
 281.7 continuing, or discontinuing implementation of supports and methods identified in
 281.8 subdivision 4 in a written report sent to the person or the person's legal representative
 281.9 and case manager five working days prior to the review meeting, unless the person, the
 281.10 person's legal representative, or the case manager request to receive the report at the
 281.11 time of the meeting.

281.12 (c) Within ten working days of the progress review meeting, the license holder
 281.13 must obtain dated signatures from the person or the person's legal representative and
 281.14 the case manager to document approval of any changes to the coordinated service and
 281.15 support plan addendum.

281.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

281.17 Sec. 26. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND**
 281.18 **OVERSIGHT.**

281.19 Subdivision 1. **Program coordination and evaluation.** (a) The license holder
 281.20 is responsible for:

281.21 (1) coordination of service delivery and evaluation for each person served by the
 281.22 program as identified in subdivision 2; and

281.23 (2) program management and oversight that includes evaluation of the program
 281.24 quality and program improvement for services provided by the license holder as identified
 281.25 in subdivision 3.

281.26 (b) The same person may perform the functions in paragraph (a) if the work and
 281.27 education qualifications are met in subdivisions 2 and 3.

281.28 Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery
 281.29 and evaluation of services provided by the license holder must be coordinated by a
 281.30 designated staff person. The designated coordinator must provide supervision, support,
 281.31 and evaluation of activities that include:

281.32 (1) oversight of the license holder's responsibilities assigned in the person's
 281.33 coordinated service and support plan and the coordinated service and support plan
 281.34 addendum;

282.1 (2) taking the action necessary to facilitate the accomplishment of the outcomes
282.2 according to the requirements in section 245D.07;

282.3 (3) instruction and assistance to direct support staff implementing the coordinated
282.4 service and support plan and the service outcomes, including direct observation of service
282.5 delivery sufficient to assess staff competency; and

282.6 (4) evaluation of the effectiveness of service delivery, methodologies, and progress on
282.7 the person's outcomes based on the measurable and observable criteria for identifying when
282.8 the desired outcome has been achieved according to the requirements in section 245D.07.

282.9 (b) The license holder must ensure that the designated coordinator is competent to
282.10 perform the required duties identified in paragraph (a) through education and training in
282.11 human services and disability-related fields, and work experience in providing direct care
282.12 services and supports to persons with disabilities. The designated coordinator must have
282.13 the skills and ability necessary to develop effective plans and to design and use data
282.14 systems to measure effectiveness of services and supports. The license holder must verify
282.15 and document competence according to the requirements in section 245D.09, subdivision

282.16 3. The designated coordinator must minimally have:

282.17 (1) a baccalaureate degree in a field related to human services, and one year of
282.18 full-time work experience providing direct care services to persons with disabilities or
282.19 persons age 65 and older;

282.20 (2) an associate degree in a field related to human services, and two years of
282.21 full-time work experience providing direct care services to persons with disabilities or
282.22 persons age 65 and older;

282.23 (3) a diploma in a field related to human services from an accredited postsecondary
282.24 institution and three years of full-time work experience providing direct care services to
282.25 persons with disabilities or persons age 65 and older; or

282.26 (4) a minimum of 50 hours of education and training related to human services
282.27 and disabilities; and

282.28 (5) four years of full-time work experience providing direct care services to persons
282.29 with disabilities or persons age 65 and older under the supervision of a staff person who
282.30 meets the qualifications identified in clauses (1) to (3).

282.31 Subd. 3. **Program management and oversight.** (a) The license holder must
282.32 designate a managerial staff person or persons to provide program management and
282.33 oversight of the services provided by the license holder. The designated manager is
282.34 responsible for the following:

282.35 (1) maintaining a current understanding of the licensing requirements sufficient to
282.36 ensure compliance throughout the program as identified in section 245A.04, subdivision

283.1 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21,
 283.2 paragraph (b);

283.3 (2) ensuring the duties of the designated coordinator are fulfilled according to the
 283.4 requirements in subdivision 2;

283.5 (3) ensuring the program implements corrective action identified as necessary
 283.6 by the program following review of incident and emergency reports according to the
 283.7 requirements in section 245D.11, subdivision 2, clause (7). An internal review of
 283.8 incident reports of alleged or suspected maltreatment must be conducted according to the
 283.9 requirements in section 245A.65, subdivision 1, paragraph (b);

283.10 (4) evaluation of satisfaction of persons served by the program, the person's legal
 283.11 representative, if any, and the case manager, with the service delivery and progress
 283.12 towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and
 283.13 ensuring and protecting each person's rights as identified in section 245D.04;

283.14 (5) ensuring staff competency requirements are met according to the requirements in
 283.15 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
 283.16 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

283.17 (6) ensuring corrective action is taken when ordered by the commissioner and that
 283.18 the terms and condition of the license and any variances are met; and

283.19 (7) evaluating the information identified in clauses (1) to (6) to develop, document,
 283.20 and implement ongoing program improvements.

283.21 (b) The designated manager must be competent to perform the duties as required and
 283.22 must minimally meet the education and training requirements identified in subdivision
 283.23 2, paragraph (b), and have a minimum of three years of supervisory level experience in
 283.24 a program providing direct support services to persons with disabilities or persons age
 283.25 65 and older.

283.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

283.27 Sec. 27. Minnesota Statutes 2012, section 245D.09, is amended to read:

283.28 **245D.09 STAFFING STANDARDS.**

283.29 Subdivision 1. **Staffing requirements.** The license holder must provide the level of
 283.30 direct service support staff sufficient supervision, assistance, and training necessary:

283.31 (1) to ensure the health, safety, and protection of rights of each person; and

283.32 (2) to be able to implement the responsibilities assigned to the license holder in each
 283.33 person's coordinated service and support plan or identified in the coordinated service and
 283.34 support plan addendum, according to the requirements of this chapter.

284.1 Subd. 2. **Supervision of staff having direct contact.** Except for a license holder
284.2 who is the sole direct ~~service~~ support staff, the license holder must provide adequate
284.3 supervision of staff providing direct ~~service~~ support to ensure the health, safety, and
284.4 protection of rights of each person and implementation of the responsibilities assigned to
284.5 the license holder in each person's ~~service plan~~ coordinated service and support plan or
284.6 coordinated service and support plan addendum.

284.7 Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing
284.8 direct support, or staff who have responsibilities related to supervising or managing the
284.9 provision of direct support service, is competent as demonstrated through skills and
284.10 knowledge training, experience, and education to meet the person's needs and additional
284.11 requirements as written in the coordinated service and support plan or coordinated
284.12 service and support plan addendum, or when otherwise required by the case manager or
284.13 the federal waiver plan. The license holder must verify and maintain evidence of staff
284.14 competency, including documentation of:

284.15 (1) education and experience qualifications relevant to the job responsibilities
284.16 assigned to the staff and the needs of the general population of persons served by the
284.17 program, including a valid degree and transcript, or a current license, registration, or
284.18 certification, when a degree or licensure, registration, or certification is required by this
284.19 chapter or in the coordinated service and support plan or coordinated service and support
284.20 plan addendum;

284.21 (2) ~~completion of required~~ demonstrated competency in the orientation and training
284.22 areas required under this chapter, including and when applicable, completion of continuing
284.23 education required to maintain professional licensure, registration, or certification
284.24 requirements. Competency in these areas is determined by the license holder through
284.25 knowledge testing and observed skill assessment conducted by the trainer or instructor; and

284.26 (3) except for a license holder who is the sole direct ~~service~~ support staff, periodic
284.27 performance evaluations completed by the license holder of the direct service support staff
284.28 person's ability to perform the job functions based on direct observation.

284.29 (b) Staff under 18 years of age may not perform overnight duties or administer
284.30 medication.

284.31 Subd. 4. **Orientation to program requirements.** (a) Except for a license holder
284.32 who does not supervise any direct ~~service~~ support staff, within ~~90 days of hiring direct~~
284.33 ~~service staff~~ 60 days of hire, unless stated otherwise, the license holder must provide
284.34 and ensure completion of orientation for direct support staff that combines supervised
284.35 on-the-job training with review of and instruction on in the following areas:

284.36 (1) the job description and how to complete specific job functions, including:

285.1 (i) responding to and reporting incidents as required under section 245D.06,
285.2 subdivision 1; and

285.3 (ii) following safety practices established by the license holder and as required in
285.4 section 245D.06, subdivision 2;

285.5 (2) the license holder's current policies and procedures required under this chapter,
285.6 including their location and access, and staff responsibilities related to implementation
285.7 of those policies and procedures;

285.8 (3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the
285.9 federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff
285.10 responsibilities related to complying with data privacy practices;

285.11 (4) the service recipient rights ~~under section 245D.04~~, and staff responsibilities
285.12 related to ensuring the exercise and protection of those rights according to the requirements
285.13 in section 245D.04;

285.14 (5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment
285.15 reporting and service planning for children and vulnerable adults, and staff responsibilities
285.16 related to protecting persons from maltreatment and reporting maltreatment. This
285.17 orientation must be provided within 72 hours of first providing direct contact services and
285.18 annually thereafter according to section 245A.65, subdivision 3;

285.19 (6) ~~what constitutes use of restraints, seclusion, and psychotropic medications,~~
285.20 ~~and staff responsibilities related to the prohibitions of their use~~ the principles of
285.21 person-centered service planning and delivery as identified in section 245D.07, subdivision
285.22 1a, and how they apply to direct support service provided by the staff person; and

285.23 (7) other topics as determined necessary in the person's coordinated service and
285.24 support plan by the case manager or other areas identified by the license holder.

285.25 (b) ~~License holders who provide direct service themselves must complete the~~
285.26 ~~orientation required in paragraph (a), clauses (3) to (7).~~

285.27 Subd. 4a. Orientation to individual service recipient needs. (e) (a) Before
285.28 providing having unsupervised direct service to contact with a person served by the
285.29 program, or for whom the staff person has not previously provided direct service support,
285.30 or any time the plans or procedures identified in ~~clauses (1) and (2)~~ paragraphs (b) to
285.31 (f) are revised, the staff person must review and receive instruction on the following
285.32 as it relates requirements in paragraphs (b) to (f) as they relate to the staff person's job
285.33 functions for that person.

285.34 (b) Orientation training and competency evaluation of direct care staff in a program
285.35 providing 24-hour care for a client with corporate supervision must be provided under

286.1 the direction of a registered nurse. Training and competency evaluations must include
 286.2 the following:

286.3 (1) documentation requirements for all services provided;

286.4 (2) reports of changes in the client's condition to the supervisor designated by the
 286.5 home care provider;

286.6 (3) basic infection control, including blood-borne pathogens;

286.7 (4) maintenance of a clean and safe environment;

286.8 (5) appropriate and safe techniques in personal hygiene and grooming, including
 286.9 hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities
 286.10 of daily living (ADLs);

286.11 (6) an understanding of what constitutes a healthy diet according to data from the
 286.12 Centers for Disease Control and the skills necessary to prepare that diet;

286.13 (7) skills necessary to provide appropriate support in instrumental activities of
 286.14 daily living (IADLs); and

286.15 (8) demonstrated competence in providing first aid.

286.16 ~~(1) (c) The staff person must review and receive instruction on the person's~~
 286.17 ~~coordinated service and support plan or coordinated service and support plan addendum as~~
 286.18 ~~it relates to the responsibilities assigned to the license holder, and when applicable, the~~
 286.19 ~~person's individual abuse prevention plan according to section 245A.65, to achieve and~~
 286.20 ~~demonstrate an understanding of the person as a unique individual, and how to implement~~
 286.21 ~~those plans; and.~~

286.22 ~~(2) (d) The staff person must review and receive instruction on medication~~
 286.23 ~~administration procedures established for the person when medication administration is~~
 286.24 ~~assigned to the license holder according to section 245D.05, subdivision 1, paragraph~~
 286.25 ~~(b). Unlicensed staff may administer medications only after successful completion of a~~
 286.26 ~~medication administration training, from a training curriculum developed by a registered~~
 286.27 ~~nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse~~
 286.28 ~~practitioner, physician's assistant, or physician incorporating. The training curriculum~~
 286.29 ~~must incorporate an observed skill assessment conducted by the trainer to ensure staff~~
 286.30 ~~demonstrate the ability to safely and correctly follow medication procedures.~~

286.31 Medication administration must be taught by a registered nurse, clinical nurse
 286.32 specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of
 286.33 service initiation or any time thereafter, the person has or develops a health care condition
 286.34 that affects the service options available to the person because the condition requires:

286.35 ~~(1) (1) specialized or intensive medical or nursing supervision; and~~

287.1 ~~(ii) (2)~~ nonmedical service providers to adapt their services to accommodate the
287.2 health and safety needs of the person; ~~and~~.

287.3 ~~(iii) necessary training in order to meet the health service needs of the person as~~
287.4 ~~determined by the person's physician.~~

287.5 (e) The staff person must review and receive instruction on the safe and correct
287.6 operation of medical equipment used by the person to sustain life, including but not
287.7 limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided
287.8 by a licensed health care professional or a manufacturer's representative and incorporate
287.9 an observed skill assessment to ensure staff demonstrate the ability to safely and correctly
287.10 operate the equipment according to the treatment orders and the manufacturer's instructions.

287.11 (f) The staff person must review and receive instruction on what constitutes use of
287.12 restraints, time out, and seclusion, including chemical restraint, and staff responsibilities
287.13 related to the prohibitions of their use according to the requirements in section 245D.06,
287.14 subdivision 5, why such procedures are not effective for reducing or eliminating symptoms
287.15 or undesired behavior and why they are not safe, and the safe and correct use of manual
287.16 restraint on an emergency basis according to the requirements in section 245D.061.

287.17 (g) In the event of an emergency service initiation, the license holder must ensure
287.18 the training required in this subdivision occurs within 72 hours of the direct support staff
287.19 person first having unsupervised contact with the person receiving services. The license
287.20 holder must document the reason for the unplanned or emergency service initiation and
287.21 maintain the documentation in the person's service recipient record.

287.22 (h) License holders who provide direct support services themselves must complete
287.23 the orientation required in subdivision 4, clauses (3) to (7).

287.24 Subd. 5. **Annual training.** ~~(a)~~ A license holder must provide annual training to
287.25 direct ~~service support~~ staff on the topics identified in subdivision 4, ~~paragraph (a),~~ clauses
287.26 (3) to ~~(6)~~ (7), and subdivision 4a, paragraphs (a) to (h). A license holder providing 24-hour
287.27 care with corporate supervision must provide a minimum of 24 hours of annual training
287.28 to direct service staff in topics described in subdivisions 4, clauses (1) to (7), and 4a,
287.29 paragraphs (a) to (h). Training on relevant topics received from sources other than the
287.30 license holder may count toward training requirements.

287.31 ~~(b) A license holder providing behavioral programming, specialist services, personal~~
287.32 ~~support, 24-hour emergency assistance, night supervision, independent living skills,~~
287.33 ~~structured day, prevocational, or supported employment services must provide a minimum~~
287.34 ~~of eight hours of annual training to direct service staff that addresses:~~

287.35 ~~(1) topics related to the general health, safety, and service needs of the population~~
287.36 ~~served by the license holder; and~~

288.1 ~~(2) other areas identified by the license holder or in the person's current service plan.~~
288.2 ~~Training on relevant topics received from sources other than the license holder~~
288.3 ~~may count toward training requirements.~~

288.4 ~~(e) When the license holder is the owner, lessor, or tenant of the service site and~~
288.5 ~~whenever a person receiving services is present at the site, the license holder must have~~
288.6 ~~a staff person available on site who is trained in basic first aid and, when required in a~~
288.7 ~~person's service plan, cardiopulmonary resuscitation.~~

288.8 Subd. 5a. **Alternative sources of training.** Orientation or training received by the
288.9 staff person from sources other than the license holder in the same subjects as identified
288.10 in subdivision 4 may count toward the orientation and annual training requirements if
288.11 received in the 12-month period before the staff person's date of hire. The license holder
288.12 must maintain documentation of the training received from other sources and of each staff
288.13 person's competency in the required area according to the requirements in subdivision 3.

288.14 Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a
288.15 subcontractor or temporary staff to perform services licensed under this chapter on the
288.16 license holder's behalf, the license holder must ensure that the subcontractor or temporary
288.17 staff meets and maintains compliance with all requirements under this chapter that apply
288.18 to the services to be provided, including training, orientation, and supervision necessary
288.19 to fulfill their responsibilities. The license holder must ensure that a background study
288.20 has been completed according to the requirements in sections 245C.03, subdivision 1,
288.21 and 245C.04. Subcontractors and temporary staff hired by the license holder must meet
288.22 the Minnesota licensing requirements applicable to the disciplines in which they are
288.23 providing services. The license holder must maintain documentation that the applicable
288.24 requirements have been met.

288.25 Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide
288.26 direct support services to persons served by the program receive the training, orientation,
288.27 and supervision necessary to fulfill their responsibilities. The license holder must ensure
288.28 that a background study has been completed according to the requirements in sections
288.29 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation
288.30 that the applicable requirements have been met.

288.31 Subd. 8. **Staff orientation and training plan.** The license holder must develop
288.32 a staff orientation and training plan documenting when and how compliance with
288.33 subdivisions 4, 4a, and 5 will be met.

288.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

288.35 Sec. 28. **[245D.091] INTERVENTION SERVICES.**

289.1 Subdivision 1. Licensure requirements. An individual meeting the staff
 289.2 qualification requirements of this section who is an employee of a program licensed
 289.3 according to this chapter and providing behavioral support services, specialist services,
 289.4 or crisis respite services is not required to hold a separate license under this chapter.
 289.5 An individual meeting the staff qualifications of this section who is not providing these
 289.6 services as an employee of a program licensed according to this chapter must obtain a
 289.7 license according to this chapter.

289.8 Subd. 2. Behavior professional qualifications. A behavior professional, as defined
 289.9 in the brain injury and community alternatives for disabled individuals waiver plans or
 289.10 successor plans, must have competencies in areas related to:

289.11 (1) ethical considerations;

289.12 (2) functional assessment;

289.13 (3) functional analysis;

289.14 (4) measurement of behavior and interpretation of data;

289.15 (5) selecting intervention outcomes and strategies;

289.16 (6) behavior reduction and elimination strategies that promote least restrictive
 289.17 approved alternatives;

289.18 (7) data collection;

289.19 (8) staff and caregiver training;

289.20 (9) support plan monitoring;

289.21 (10) co-occurring mental disorders or neuro-cognitive disorder;

289.22 (11) demonstrated expertise with populations being served; and

289.23 (12) must be a:

289.24 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the
 289.25 Board of Psychology competencies in the above identified areas;

289.26 (ii) clinical social worker licensed as an independent clinical social worker under
 289.27 chapter 148D, or a person with a master's degree in social work from an accredited college
 289.28 or university, with at least 4,000 hours of post-master's supervised experience in the
 289.29 delivery of clinical services in the areas identified in clauses (1) to (11);

289.30 (iii) physician licensed under chapter 147 and certified by the American Board
 289.31 of Psychiatry and Neurology or eligible for board certification in psychiatry with
 289.32 competencies in the areas identified in clauses (1) to (11);

289.33 (iv) licensed professional clinical counselor licensed under sections 148B.29 to
 289.34 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery
 289.35 of clinical services who has demonstrated competencies in the areas identified in clauses
 289.36 (1) to (11);

290.1 (v) person with a master's degree from an accredited college or university in one
290.2 of the behavioral sciences or related fields, with at least 4,000 hours of post-master's
290.3 supervised experience in the delivery of clinical services with demonstrated competencies
290.4 in the areas identified in clauses (1) to (11); or

290.5 (vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is
290.6 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
290.7 mental health nursing by a national nurse certification organization, or who has a master's
290.8 degree in nursing or one of the behavioral sciences or related fields from an accredited
290.9 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
290.10 experience in the delivery of clinical services.

290.11 Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in
290.12 the brain injury and community alternatives for disabled individuals waiver plans or
290.13 successor plans, must:

290.14 (1) have obtained a baccalaureate degree, master's degree, or a PhD in a social
290.15 services discipline; or

290.16 (2) meet the qualifications of a mental health practitioner as defined in section
290.17 245.462, subdivision 17.

290.18 (b) In addition, a behavior analyst must:

290.19 (1) have four years of supervised experience working with individuals who exhibit
290.20 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;

290.21 (2) have received ten hours of instruction in functional assessment and functional
290.22 analysis;

290.23 (3) have received 20 hours of instruction in the understanding of the function of
290.24 behavior;

290.25 (4) have received ten hours of instruction on design of positive practices behavior
290.26 support strategies;

290.27 (5) have received 20 hours of instruction on the use of behavior reduction approved
290.28 strategies used only in combination with behavior positive practices strategies;

290.29 (6) be determined by a behavior professional to have the training and prerequisite
290.30 skills required to provide positive practice strategies as well as behavior reduction
290.31 approved and permitted intervention to the person who receives behavioral support; and

290.32 (7) be under the direct supervision of a behavior professional.

290.33 Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined
290.34 in the brain injury and community alternatives for disabled individuals waiver plans or
290.35 successor plans, must meet the following qualifications:

290.36 (1) have an associate's degree in a social services discipline; or

291.1 (2) have two years of supervised experience working with individuals who exhibit
 291.2 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.

291.3 (b) In addition, a behavior specialist must:

291.4 (1) have received a minimum of four hours of training in functional assessment;

291.5 (2) have received 20 hours of instruction in the understanding of the function of
 291.6 behavior;

291.7 (3) have received ten hours of instruction on design of positive practices behavioral
 291.8 support strategies;

291.9 (4) be determined by a behavior professional to have the training and prerequisite
 291.10 skills required to provide positive practices strategies as well as behavior reduction
 291.11 approved intervention to the person who receives behavioral support; and

291.12 (5) be under the direct supervision of a behavior professional.

291.13 Subd. 5. **Specialist services qualifications.** An individual providing specialist
 291.14 services, as defined in the developmental disabilities waiver plan or successor plan, must
 291.15 have:

291.16 (1) the specific experience and skills required of the specialist to meet the needs of
 291.17 the person identified by the person's service planning team; and

291.18 (2) the qualifications of the specialist identified in the person's coordinated service
 291.19 and support plan.

291.20 **EFFECTIVE DATE.** This section is effective January 1, 2014.

291.21 Sec. 29. **[245D.095] RECORD REQUIREMENTS.**

291.22 Subdivision 1. **Record-keeping systems.** The license holder must ensure that the
 291.23 content and format of service recipient, personnel, and program records are uniform and
 291.24 legible according to the requirements of this chapter.

291.25 Subd. 2. **Admission and discharge register.** The license holder must keep a written
 291.26 or electronic register, listing in chronological order the dates and names of all persons
 291.27 served by the program who have been admitted, discharged, or transferred, including
 291.28 service terminations initiated by the license holder and deaths.

291.29 Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of
 291.30 current services provided to each person on the premises where the services are provided
 291.31 or coordinated. When the services are provided in a licensed facility, the records must
 291.32 be maintained at the facility, otherwise the records must be maintained at the license
 291.33 holder's program office. The license holder must protect service recipient records against
 291.34 loss, tampering, or unauthorized disclosure according to the requirements in sections
 291.35 13.01 to 13.10 and 13.46.

292.1 (b) The license holder must maintain the following information for each person:

292.2 (1) an admission form signed by the person or the person's legal representative
292.3 that includes:

292.4 (i) identifying information, including the person's name, date of birth, address,
292.5 and telephone number; and

292.6 (ii) the name, address, and telephone number of the person's legal representative, if
292.7 any, and a primary emergency contact, the case manager, and family members or others as
292.8 identified by the person or case manager;

292.9 (2) service information, including service initiation information, verification of the
292.10 person's eligibility for services, documentation verifying that services have been provided
292.11 as identified in the coordinated service and support plan or coordinated service and support
292.12 plan addendum according to paragraph (a), and date of admission or readmission;

292.13 (3) health information, including medical history, special dietary needs, and
292.14 allergies, and when the license holder is assigned responsibility for meeting the person's
292.15 health service needs according to section 245D.05:

292.16 (i) current orders for medication, treatments, or medical equipment and a signed
292.17 authorization from the person or the person's legal representative to administer or assist in
292.18 administering the medication or treatments, if applicable;

292.19 (ii) a signed statement authorizing the license holder to act in a medical emergency
292.20 when the person's legal representative, if any, cannot be reached or is delayed in arriving;

292.21 (iii) medication administration procedures;

292.22 (iv) a medication administration record documenting the implementation of the
292.23 medication administration procedures, the medication administration record reviews, and
292.24 including any agreements for administration of injectable medications by the license
292.25 holder according to the requirements in section 245D.05; and

292.26 (v) a medical appointment schedule when the license holder is assigned
292.27 responsibility for assisting with medical appointments;

292.28 (4) the person's current coordinated service and support plan or that portion of the
292.29 plan assigned to the license holder;

292.30 (5) copies of the individual abuse prevention plan and assessments as required under
292.31 section 245D.071, subdivisions 2 and 3;

292.32 (6) a record of other service providers serving the person when the person's
292.33 coordinated service and support plan or coordinated service and support plan addendum
292.34 identifies the need for coordination between the service providers, that includes a contact
292.35 person and telephone numbers, services being provided, and names of staff responsible for
292.36 coordination;

293.1 (7) documentation of orientation to service recipient rights according to section
293.2 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to
293.3 section 245A.65, subdivision 1, paragraph (c);

293.4 (8) copies of authorizations to handle a person's funds, according to section 245D.06,
293.5 subdivision 4, paragraph (a);

293.6 (9) documentation of complaints received and grievance resolution;

293.7 (10) incident reports involving the person, required under section 245D.06,
293.8 subdivision 1;

293.9 (11) copies of written reports regarding the person's status when requested according
293.10 to section 245D.07, subdivision 3, progress review reports as required under section
293.11 245D.071, subdivision 5, progress or daily log notes that are recorded by the program,
293.12 and reports received from other agencies involved in providing services or care to the
293.13 person; and

293.14 (12) discharge summary, including service termination notice and related
293.15 documentation, when applicable.

293.16 Subd. 4. **Access to service recipient records.** The license holder must ensure that
293.17 the following people have access to the information in subdivision 1 in accordance with
293.18 applicable state and federal law, regulation, or rule:

293.19 (1) the person, the person's legal representative, and anyone properly authorized
293.20 by the person;

293.21 (2) the person's case manager;

293.22 (3) staff providing services to the person unless the information is not relevant to
293.23 carrying out the coordinated service and support plan or coordinated service and support
293.24 plan addendum; and

293.25 (4) the county child or adult foster care licenser, when services are also licensed as
293.26 child or adult foster care.

293.27 Subd. 5. **Personnel records.** (a) The license holder must maintain a personnel
293.28 record of each employee to document and verify staff qualifications, orientation, and
293.29 training. The personnel record must include:

293.30 (1) the employee's date of hire, completed application, an acknowledgement signed
293.31 by the employee that job duties were reviewed with the employee and the employee
293.32 understands those duties, and documentation that the employee meets the position
293.33 requirements as determined by the license holder;

293.34 (2) documentation of staff qualifications, orientation, training, and performance
293.35 evaluations as required under section 245D.09, subdivisions 3 to 5, including the date

294.1 the training was completed, the number of hours per subject area, and the name of the
294.2 trainer or instructor; and

294.3 (3) a completed background study as required under chapter 245C.

294.4 (b) For employees hired after January 1, 2014, the license holder must maintain
294.5 documentation in the personnel record or elsewhere, sufficient to determine the date of the
294.6 employee's first supervised direct contact with a person served by the program, and the
294.7 date of first unsupervised direct contact with a person served by the program.

294.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

294.9 Sec. 30. Minnesota Statutes 2012, section 245D.10, is amended to read:

294.10 **245D.10 POLICIES AND PROCEDURES.**

294.11 Subdivision 1. **Policy and procedure requirements.** The A license holder
294.12 providing either basic or intensive supports and services must establish, enforce, and
294.13 maintain policies and procedures as required in this chapter, chapter 245A, and other
294.14 applicable state and federal laws and regulations governing the provision of home and
294.15 community-based services licensed according to this chapter.

294.16 Subd. 2. **Grievances.** The license holder must establish policies and procedures
294.17 that provide promote service recipient rights by providing a simple complaint process for
294.18 persons served by the program and their authorized representatives to bring a grievance that:

294.19 (1) provides staff assistance with the complaint process when requested, and the
294.20 addresses and telephone numbers of outside agencies to assist the person;

294.21 (2) allows the person to bring the complaint to the highest level of authority in the
294.22 program if the grievance cannot be resolved by other staff members, and that provides
294.23 the name, address, and telephone number of that person;

294.24 (3) requires the license holder to promptly respond to all complaints affecting a
294.25 person's health and safety. For all other complaints, the license holder must provide an
294.26 initial response within 14 calendar days of receipt of the complaint. All complaints must
294.27 be resolved within 30 calendar days of receipt or the license holder must document the
294.28 reason for the delay and a plan for resolution;

294.29 (4) requires a complaint review that includes an evaluation of whether:

294.30 (i) related policies and procedures were followed and adequate;

294.31 (ii) there is a need for additional staff training;

294.32 (iii) the complaint is similar to past complaints with the persons, staff, or services
294.33 involved; and

295.1 (iv) there is a need for corrective action by the license holder to protect the health
295.2 and safety of persons receiving services;

295.3 (5) based on the review in clause (4), requires the license holder to develop,
295.4 document, and implement a corrective action plan designed to correct current lapses and
295.5 prevent future lapses in performance by staff or the license holder, if any;

295.6 (6) provides a written summary of the complaint and a notice of the complaint
295.7 resolution to the person and case manager that:

295.8 (i) identifies the nature of the complaint and the date it was received;

295.9 (ii) includes the results of the complaint review;

295.10 (iii) identifies the complaint resolution, including any corrective action; and

295.11 (7) requires that the complaint summary and resolution notice be maintained in the
295.12 service recipient record.

295.13 Subd. 3. **Service suspension and service termination.** (a) The license holder must
295.14 establish policies and procedures for temporary service suspension and service termination
295.15 that promote continuity of care and service coordination with the person and the case
295.16 manager and with other licensed caregivers, if any, who also provide support to the person.

295.17 (b) The policy must include the following requirements:

295.18 (1) the license holder must notify the person or the person's legal representative and
295.19 case manager in writing of the intended termination or temporary service suspension, and
295.20 the person's right to seek a temporary order staying the termination of service according to
295.21 the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

295.22 (2) notice of the proposed termination of services, including those situations
295.23 that began with a temporary service suspension, must be given at least 60 days before
295.24 the proposed termination is to become effective when a license holder is providing
295.25 ~~independent living skills training, structured day, prevocational or supported employment~~
295.26 ~~services to the person~~ intensive supports and services identified in section 245D.03,
295.27 subdivision 1, paragraph (c), and 30 days prior to termination for all other services
295.28 licensed under this chapter;

295.29 (3) the license holder must provide information requested by the person or case
295.30 manager when services are temporarily suspended or upon notice of termination;

295.31 (4) prior to giving notice of service termination or temporary service suspension,
295.32 the license holder must document actions taken to minimize or eliminate the need for
295.33 service suspension or termination;

295.34 (5) during the temporary service suspension or service termination notice period,
295.35 the license holder will work with the appropriate county agency to develop reasonable
295.36 alternatives to protect the person and others;

296.1 (6) the license holder must maintain information about the service suspension or
296.2 termination, including the written termination notice, in the service recipient record; and

296.3 (7) the license holder must restrict temporary service suspension to situations in
296.4 which the person's ~~behavior causes immediate and serious danger to the health and safety~~
296.5 ~~of the person or others~~ conduct poses an imminent risk of physical harm to self or others
296.6 and less restrictive or positive support strategies would not achieve safety.

296.7 Subd. 4. **Availability of current written policies and procedures.** (a) The license
296.8 holder must review and update, as needed, the written policies and procedures required
296.9 under this chapter.

296.10 (b)(1) The license holder must inform the person and case manager of the policies
296.11 and procedures affecting a person's rights under section 245D.04, and provide copies of
296.12 those policies and procedures, within five working days of service initiation.

296.13 (2) If a license holder only provides basic services and supports, this includes the:

296.14 (i) grievance policy and procedure required under subdivision 2; and

296.15 (ii) service suspension and termination policy and procedure required under
296.16 subdivision 3.

296.17 (3) For all other license holders this includes the:

296.18 (i) policies and procedures in clause (2);

296.19 (ii) emergency use of manual restraints policy and procedure required under
296.20 subdivision 3a; and

296.21 (iii) data privacy requirements under section 245D.11, subdivision 3.

296.22 (c) The license holder must provide a written notice at least 30 days before
296.23 implementing any ~~revised policies and procedures~~ procedural revisions to policies
296.24 affecting a person's service-related or protection-related rights under section 245D.04 and
296.25 maltreatment reporting policies and procedures. The notice must explain the revision that
296.26 was made and include a copy of the revised policy and procedure. The license holder
296.27 must document the ~~reason~~ reasonable cause for not providing the notice at least 30 days
296.28 before implementing the revisions.

296.29 (d) Before implementing revisions to required policies and procedures, the license
296.30 holder must inform all employees of the revisions and provide training on implementation
296.31 of the revised policies and procedures.

296.32 (e) The license holder must annually notify all persons, or their legal representatives,
296.33 and case managers of any procedural revisions to policies required under this chapter,
296.34 other than those in paragraph (c). Upon request, the license holder must provide the
296.35 person, or the person's legal representative, and case manager with copies of the revised
296.36 policies and procedures.

297.1 **EFFECTIVE DATE.** This section is effective January 1, 2014.

297.2 Sec. 31. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT**
 297.3 **SERVICES.**

297.4 **Subdivision 1. Policy and procedure requirements.** A license holder providing
 297.5 intensive support services as identified in section 245D.03, subdivision 1, paragraph (c),
 297.6 must establish, enforce, and maintain policies and procedures as required in this section.

297.7 **Subd. 2. Health and safety.** The license holder must establish policies and
 297.8 procedures that promote health and safety by ensuring:

297.9 (1) use of universal precautions and sanitary practices in compliance with section
 297.10 245D.06, subdivision 2, clause (5);

297.11 (2) if the license holder operates a residential program, health service coordination
 297.12 and care according to the requirements in section 245D.05, subdivision 1;

297.13 (3) safe medication assistance and administration according to the requirements
 297.14 in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
 297.15 consultation with a registered nurse, nurse practitioner, physician's assistant, or medical
 297.16 doctor and require completion of medication administration training according to the
 297.17 requirements in section 245D.09, subdivision 4a, paragraph (c). Medication assistance
 297.18 and administration includes, but is not limited to:

297.19 (i) providing medication-related services for a person;

297.20 (ii) medication setup;

297.21 (iii) medication administration;

297.22 (iv) medication storage and security;

297.23 (v) medication documentation and charting;

297.24 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
 297.25 handling and administration;

297.26 (vii) coordination of medication refills;

297.27 (viii) handling changes to prescriptions and implementation of those changes;

297.28 (ix) communicating with the pharmacy; and

297.29 (x) coordination and communication with prescriber;

297.30 (4) safe transportation, when the license holder is responsible for transportation of
 297.31 persons, with provisions for handling emergency situations according to the requirements
 297.32 in section 245D.06, subdivision 2, clauses (2) to (4);

297.33 (5) a plan for ensuring the safety of persons served by the program in emergencies as
 297.34 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
 297.35 to the license holder. A license holder with a community residential setting or a day service

298.1 facility license must ensure the policy and procedures comply with the requirements in
298.2 section 245D.22, subdivision 4;

298.3 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision
298.4 11; and reporting all incidents required to be reported according to section 245D.06,
298.5 subdivision 1. The plan must:

298.6 (i) provide the contact information of a source of emergency medical care and
298.7 transportation; and

298.8 (ii) require staff to first call 911 when the staff believes a medical emergency may be
298.9 life threatening, or to call the mental health crisis intervention team when the person is
298.10 experiencing a mental health crisis; and

298.11 (7) a procedure for the review of incidents and emergencies to identify trends or
298.12 patterns, and corrective action if needed. The license holder must establish and maintain
298.13 a record-keeping system for the incident and emergency reports. Each incident and
298.14 emergency report file must contain a written summary of the incident. The license holder
298.15 must conduct a review of incident reports for identification of incident patterns, and
298.16 implementation of corrective action as necessary to reduce occurrences. Each incident
298.17 report must include:

298.18 (i) the name of the person or persons involved in the incident. It is not necessary
298.19 to identify all persons affected by or involved in an emergency unless the emergency
298.20 resulted in an incident;

298.21 (ii) the date, time, and location of the incident or emergency;

298.22 (iii) a description of the incident or emergency;

298.23 (iv) a description of the response to the incident or emergency and whether a person's
298.24 coordinated service and support plan addendum or program policies and procedures were
298.25 implemented as applicable;

298.26 (v) the name of the staff person or persons who responded to the incident or
298.27 emergency; and

298.28 (vi) the determination of whether corrective action is necessary based on the results
298.29 of the review.

298.30 Subd. 3. **Data privacy.** The license holder must establish policies and procedures that
298.31 promote service recipient rights by ensuring data privacy according to the requirements in:

298.32 (1) the Minnesota Government Data Practices Act, section 13.46, and all other
298.33 applicable Minnesota laws and rules in handling all data related to the services provided;

298.34 and

298.35 (2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the
298.36 extent that the license holder performs a function or activity involving the use of protected

299.1 health information as defined under Code of Federal Regulations, title 45, section 164.501,
299.2 including, but not limited to, providing health care services; health care claims processing
299.3 or administration; data analysis, processing, or administration; utilization review; quality
299.4 assurance; billing; benefit management; practice management; repricing; or as otherwise
299.5 provided by Code of Federal Regulations, title 45, section 160.103. The license holder
299.6 must comply with the Health Insurance Portability and Accountability Act of 1996 and
299.7 its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164,
299.8 and all applicable requirements.

299.9 Subd. 4. **Admission criteria.** The license holder must establish policies and
299.10 procedures that promote continuity of care by ensuring that admission or service initiation
299.11 criteria:

299.12 (1) is consistent with the license holder's registration information identified in the
299.13 requirements in section 245D.031, subdivision 2, and with the service-related rights
299.14 identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

299.15 (2) identifies the criteria to be applied in determining whether the license holder
299.16 can develop services to meet the needs specified in the person's coordinated service and
299.17 support plan;

299.18 (3) requires a license holder providing services in a health care facility to comply
299.19 with the requirements in section 243.166, subdivision 4b, to provide notification to
299.20 residents when a registered predatory offender is admitted into the program or to a
299.21 potential admission when the facility was already serving a registered predatory offender.
299.22 For purposes of this clause, "health care facility" means a facility licensed by the
299.23 commissioner as a residential facility under chapter 245A to provide adult foster care or
299.24 residential services to persons with disabilities; and

299.25 (4) requires that when a person or the person's legal representative requests services
299.26 from the license holder, a refusal to admit the person must be based on an evaluation of
299.27 the person's assessed needs and the license holder's lack of capacity to meet the needs of
299.28 the person. The license holder must not refuse to admit a person based solely on the
299.29 type of residential services the person is receiving, or solely on the person's severity of
299.30 disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of
299.31 communication skills, physical disabilities, toilet habits, behavioral disorders, or past
299.32 failure to make progress. Documentation of the basis for refusal must be provided to the
299.33 person or the person's legal representative and case manager upon request.

299.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

300.1 Sec. 32. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND**
300.2 **APPLICATION PROCESS.**

300.3 Subdivision 1. Community residential settings and day service facilities. For
300.4 purposes of this section, "facility" means both a community residential setting and day
300.5 service facility and the physical plant.

300.6 Subd. 2. Inspections and code compliance. (a) Physical plants must comply with
300.7 applicable state and local fire, health, building, and zoning codes.

300.8 (b)(1) The facility must be inspected by a fire marshal or their delegate within
300.9 12 months before initial licensure to verify that it meets the applicable occupancy
300.10 requirements as defined in the State Fire Code and that the facility complies with the fire
300.11 safety standards for that occupancy code contained in the State Fire Code.

300.12 (2) The fire marshal inspection of a community residential setting must verify the
300.13 residence is a dwelling unit within a residential occupancy as defined in section 9.117 of
300.14 the State Fire Code. A home safety checklist, approved by the commissioner, must be
300.15 completed for a community residential setting by the license holder and the commissioner
300.16 before the satellite license is reissued.

300.17 (3) The facility shall be inspected according to the facility capacity specified on the
300.18 initial application form.

300.19 (4) If the commissioner has reasonable cause to believe that a potentially hazardous
300.20 condition may be present or the licensed capacity is increased, the commissioner shall
300.21 request a subsequent inspection and written report by a fire marshal to verify the absence
300.22 of hazard.

300.23 (5) Any condition cited by a fire marshal, building official, or health authority as
300.24 hazardous or creating an immediate danger of fire or threat to health and safety must be
300.25 corrected before a license is issued by the department, and for community residential
300.26 settings, before a license is reissued.

300.27 (c) The facility must maintain in a permanent file the reports of health, fire, and
300.28 other safety inspections.

300.29 (d) The facility's plumbing, ventilation, heating, cooling, lighting, and other
300.30 fixtures and equipment, including elevators or food service, if provided, must conform to
300.31 applicable health, sanitation, and safety codes and regulations.

300.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

300.33 Sec. 33. **[245D.22] FACILITY SANITATION AND HEALTH.**

300.34 Subdivision 1. General maintenance. The license holder must maintain the interior
300.35 and exterior of buildings, structures, or enclosures used by the facility, including walls,

301.1 floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a
301.2 sanitary and safe condition. The facility must be clean and free from accumulations of
301.3 dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must
301.4 correct building and equipment deterioration, safety hazards, and unsanitary conditions.

301.5 Subd. 2. **Hazards and toxic substances.** (a) The license holder must ensure that
301.6 service sites owned or leased by the license holder are free from hazards that would
301.7 threaten the health or safety of a person receiving services by ensuring the requirements
301.8 in paragraphs (b) to (h) are met.

301.9 (b) Chemicals, detergents, and other hazardous or toxic substances must not be
301.10 stored with food products or in any way that poses a hazard to persons receiving services.

301.11 (c) The license holder must install handrails and nonslip surfaces on interior and
301.12 exterior runways, stairways, and ramps according to the applicable building code.

301.13 (d) If there are elevators in the facility, the license holder must have elevators
301.14 inspected each year. The date of the inspection, any repairs needed, and the date the
301.15 necessary repairs were made must be documented.

301.16 (e) The license holder must keep stairways, ramps, and corridors free of obstructions.

301.17 (f) Outside property must be free from debris and safety hazards. Exterior stairs and
301.18 walkways must be kept free of ice and snow.

301.19 (g) Heating, ventilation, air conditioning units, and other hot surfaces and moving
301.20 parts of machinery must be shielded or enclosed.

301.21 (h) Use of dangerous items or equipment by persons served by the program must be
301.22 allowed in accordance with the person's coordinated service and support plan addendum
301.23 or the program abuse prevention plan, if not addressed in the coordinated service and
301.24 support plan addendum.

301.25 Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in
301.26 the facility that are named in section 152.02, subdivision 3, must be stored in a locked
301.27 storage area permitting access only by persons and staff authorized to administer the
301.28 medication. This must be incorporated into the license holder's medication administration
301.29 policy and procedures required under section 245D.11, subdivision 2, clause (3).
301.30 Medications must be disposed of according to the Environmental Protection Agency
301.31 recommendations.

301.32 Subd. 4. **First aid must be available on site.** (a) A staff person trained in first aid
301.33 must be available on site and, when required in a person's coordinated service and support
301.34 plan or coordinated service and support plan addendum, cardiopulmonary resuscitation,
301.35 whenever persons are present and staff are required to be at the site to provide direct

302.1 service. The training must include in-person instruction, hands-on practice, and an
302.2 observed skills assessment under the direct supervision of a first aid instructor.

302.3 (b) A facility must have first aid kits readily available for use by, and that meets
302.4 the needs of, persons receiving services and staff. At a minimum, the first aid kit must
302.5 be equipped with accessible first aid supplies including bandages, sterile compresses,
302.6 scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap,
302.7 adhesive tape, and first aid manual.

302.8 Subd. 5. **Emergencies.** (a) The license holder must have a written plan for
302.9 responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the
302.10 safety of persons served in the facility. The plan must include:

302.11 (1) procedures for emergency evacuation and emergency sheltering, including:

302.12 (i) how to report a fire or other emergency;

302.13 (ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive
302.14 procedures or equipment to assist with the safe evacuation of persons with physical or
302.15 sensory disabilities; and

302.16 (iii) instructions on closing off the fire area, using fire extinguishers, and activating
302.17 and responding to alarm systems;

302.18 (2) a floor plan that identifies:

302.19 (i) the location of fire extinguishers;

302.20 (ii) the location of audible or visual alarm systems, including but not limited to
302.21 manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and
302.22 sprinkler systems;

302.23 (iii) the location of exits, primary and secondary evacuation routes, and accessible
302.24 egress routes, if any; and

302.25 (iv) the location of emergency shelter within the facility;

302.26 (3) a site plan that identifies:

302.27 (i) designated assembly points outside the facility;

302.28 (ii) the locations of fire hydrants; and

302.29 (iii) the routes of fire department access;

302.30 (4) the responsibilities each staff person must assume in case of emergency;

302.31 (5) procedures for conducting quarterly drills each year and recording the date of
302.32 each drill in the file of emergency plans;

302.33 (6) procedures for relocation or service suspension when services are interrupted
302.34 for more than 24 hours;

302.35 (7) for a community residential setting with three or more dwelling units, a floor
302.36 plan that identifies the location of enclosed exit stairs; and

303.1 (8) an emergency escape plan for each resident.

303.2 (b) The license holder must:

303.3 (1) maintain a log of quarterly fire drills on file in the facility;

303.4 (2) provide an emergency response plan that is readily available to staff and persons
303.5 receiving services;

303.6 (3) inform each person of a designated area within the facility where the person
303.7 should go to for emergency shelter during severe weather and the designated assembly
303.8 points outside the facility; and

303.9 (4) maintain emergency contact information for persons served at the facility that
303.10 can be readily accessed in an emergency.

303.11 Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable
303.12 radio or television set that do not require electricity and can be used if a power failure
303.13 occurs.

303.14 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated
303.15 telephone that is readily accessible. A list of emergency numbers must be posted in a
303.16 prominent location. When an area has a 911 number or a mental health crisis intervention
303.17 team number, both numbers must be posted and the emergency number listed must be
303.18 911. In areas of the state without a 911 number, the numbers listed must be those of the
303.19 local fire department, police department, emergency transportation, and poison control
303.20 center. The names and telephone numbers of each person's representative, physician, and
303.21 dentist must be readily available.

303.22 **EFFECTIVE DATE.** This section is effective January 1, 2014.

303.23 Sec. 34. **[245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE**
303.24 **LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

303.25 Subdivision 1. **Separate satellite license required for separate sites.** (a) A license
303.26 holder providing residential support services must obtain a separate satellite license for
303.27 each community residential setting located at separate addresses when the community
303.28 residential settings are to be operated by the same license holder. For purposes of this
303.29 chapter, a community residential setting is a satellite of the home and community-based
303.30 services license.

303.31 (b) Community residential settings are permitted single-family use homes. After a
303.32 license has been issued, the commissioner shall notify the local municipality where the
303.33 residence is located of the approved license.

303.34 Subd. 2. **Notification to local agency.** The license holder must notify the local
303.35 agency within 24 hours of the onset of changes in a residence resulting from construction,

304.1 remodeling, or damages requiring repairs that require a building permit or may affect a
304.2 licensing requirement in this chapter.

304.3 Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate
304.4 overnight supervision technology adult foster care license according to section 245A.11,
304.5 subdivision 7a, that converts to a community residential setting satellite license according
304.6 to this chapter must retain that designation.

304.7 **EFFECTIVE DATE.** This section is effective January 1, 2014.

304.8 Sec. 35. **[245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL**
304.9 **PLANT AND ENVIRONMENT.**

304.10 Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling
304.11 unit in a residential occupancy.

304.12 Subd. 2. **Common area requirements.** The living area must be provided with an
304.13 adequate number of furnishings for the usual functions of daily living and social activities.
304.14 The dining area must be furnished to accommodate meals shared by all persons living in
304.15 the residence. These furnishings must be in good repair and functional to meet the daily
304.16 needs of the persons living in the residence.

304.17 Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in
304.18 writing, to sharing a bedroom with one another. No more than two people receiving
304.19 services may share one bedroom.

304.20 (b) A single occupancy bedroom must have at least 80 square feet of floor space with
304.21 a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
304.22 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and
304.23 other habitable rooms by floor to ceiling walls containing no openings except doorways
304.24 and must not serve as a corridor to another room used in daily living.

304.25 (c) A person's personal possessions and items for the person's own use are the only
304.26 items permitted to be stored in a person's bedroom.

304.27 (d) Unless otherwise documented through assessment as a safety concern for the
304.28 person, each person must be provided with the following furnishings:

304.29 (1) a separate bed of proper size and height for the convenience and comfort of the
304.30 person, with a clean mattress in good repair;

304.31 (2) clean bedding appropriate for the season for each person;

304.32 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
304.33 possessions and clothing; and

304.34 (4) a mirror for grooming.

305.1 (e) When possible, a person must be allowed to have items of furniture that the
305.2 person personally owns in the bedroom, unless doing so would interfere with safety
305.3 precautions, violate a building or fire code, or interfere with another person's use of the
305.4 bedroom. A person may choose to not have a cabinet, dresser, shelves, or a mirror in the
305.5 bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may
305.6 choose to use a mattress other than an innerspring mattress and may choose to not have
305.7 the mattress on a mattress frame or support. If a person chooses not to have a piece of
305.8 required furniture, the license holder must document this choice and is not required to
305.9 provide the item. If a person chooses to use a mattress other than an innerspring mattress
305.10 or chooses to not have a mattress frame or support, the license holder must document this
305.11 choice and allow the alternative desired by the person.

305.12 (f) A person must be allowed to bring personal possessions into the bedroom
305.13 and other designated storage space, if such space is available, in the residence. The
305.14 person must be allowed to accumulate possessions to the extent the residence is able to
305.15 accommodate them, unless doing so is contraindicated for the person's physical or mental
305.16 health, would interfere with safety precautions or another person's use of the bedroom, or
305.17 would violate a building or fire code. The license holder must allow for locked storage
305.18 of personal items. Any restriction on the possession or locked storage of personal items,
305.19 including requiring a person to use a lock provided by the license holder, must comply
305.20 with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if
305.21 and when the license holder opens the lock.

305.22 **EFFECTIVE DATE.** This section is effective January 1, 2014.

305.23 Sec. 36. **[245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND**
305.24 **WATER.**

305.25 Subdivision 1. **Water.** Potable water from privately owned wells must be tested
305.26 annually by a Department of Health-certified laboratory for coliform bacteria and nitrate
305.27 nitrogens to verify safety. The health authority may require retesting and corrective
305.28 measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in
305.29 the event of a flooding or incident which may put the well at risk of contamination. To
305.30 prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

305.31 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as
305.32 prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day
305.33 must be served or made available to persons, and nutritious snacks must be available
305.34 between meals.

306.1 Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to
306.2 prevent contamination, spoilage, or a threat to the health of a person.

306.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

306.4 Sec. 37. **[245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION**
306.5 **AND HEALTH.**

306.6 Subdivision 1. **Goods provided by the license holder.** Individual clean bed linens
306.7 appropriate for the season and the person's comfort, including towels and wash cloths,
306.8 must be available for each person. Usual or customary goods for the operation of a
306.9 residence which are communally used by all persons receiving services living in the
306.10 residence must be provided by the license holder, including household items for meal
306.11 preparation, cleaning supplies to maintain the cleanliness of the residence, window
306.12 coverings on windows for privacy, toilet paper, and hand soap.

306.13 Subd. 2. **Personal items.** Personal health and hygiene items must be stored in a
306.14 safe and sanitary manner.

306.15 Subd. 3. **Pets and service animals.** Pets and service animals housed within
306.16 the residence must be immunized and maintained in good health as required by local
306.17 ordinances and state law. The license holder must ensure that the person and the person's
306.18 representative is notified before admission of the presence of pets in the residence.

306.19 Subd. 4. **Smoking in the residence.** License holders must comply with the
306.20 requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when
306.21 smoking is permitted in the residence.

306.22 Subd. 5. **Weapons.** Weapons and ammunition must be stored separately in locked
306.23 areas that are inaccessible to a person receiving services. For purposes of this subdivision,
306.24 "weapons" means firearms and other instruments or devices designed for and capable of
306.25 producing bodily harm.

306.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

306.27 Sec. 38. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE**
306.28 **REQUIREMENTS AND APPLICATION PROCESS.**

306.29 Except for day service facilities on the same or adjoining lot, the license holder
306.30 providing day services must apply for a separate license for each facility-based service
306.31 site when the license holder is the owner, lessor, or tenant of the service site at which
306.32 persons receive day services and the license holder's employees who provide day services
306.33 are present for a cumulative total of more than 30 days within any 12-month period. For

307.1 purposes of this chapter, a day services facility license is a satellite license of the day
307.2 services program. A day services program may operate multiple licensed day service
307.3 facilities in one or more counties in the state. For the purposes of this section, "adjoining
307.4 lot" means day services facilities that are next door to or across the street from one another.

307.5 **EFFECTIVE DATE.** This section is effective January 1, 2014.

307.6 Sec. 39. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND**
307.7 **SPACE REQUIREMENTS.**

307.8 Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility
307.9 capacity of each day service facility must be determined by the amount of primary space
307.10 available, the scheduling of activities at other service sites, and the space requirements of
307.11 all persons receiving services at the facility, not just the licensed services. The facility
307.12 capacity must specify the maximum number of persons that may receive services on
307.13 site at any one time.

307.14 (b) When a facility is located in a multifunctional organization, the facility may
307.15 share common space with the multifunctional organization if the required available
307.16 primary space for use by persons receiving day services is maintained while the facility is
307.17 operating. The license holder must comply at all times with all applicable fire and safety
307.18 codes under section 245A.04, subdivision 2a, and adequate supervision requirements
307.19 under section 245D.31 for all persons receiving day services.

307.20 (c) A day services facility must have a minimum of 40 square feet of primary
307.21 space available for each consumer who is present at the site at any one time. Primary
307.22 space does not include:

307.23 (1) common areas, such as hallways, stairways, closets, utility areas, bathrooms,
307.24 and kitchens;

307.25 (2) floor areas beneath stationary equipment; or

307.26 (3) any space occupied by persons associated with the multifunctional organization
307.27 while persons receiving day services are using common space.

307.28 Subd. 2. **Individual personal articles.** Each person must be provided space in a
307.29 closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own
307.30 use while receiving services at the facility, unless doing so would interfere with safety
307.31 precautions, another person's work space, or violate a building or fire code.

307.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

308.1 Sec. 40. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY**
308.2 **REQUIREMENTS.**

308.3 Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service
308.4 sites owned or leased by the license holder for storing perishable foods and perishable
308.5 portions of bag lunches, whether the foods are supplied by the license holder or the
308.6 persons receiving services, the refrigeration must have a temperature of 40 degrees
308.7 Fahrenheit or less.

308.8 Subd. 2. **Drinking water.** Drinking water must be available to all persons
308.9 receiving services. If a person is unable to request or obtain drinking water, it must be
308.10 provided according to that person's individual needs. Drinking water must be provided in
308.11 single-service containers or from drinking fountains accessible to all persons.

308.12 Subd. 3. **Individuals who become ill during the day.** There must be an area in
308.13 which a person receiving services can rest if:

308.14 (1) the person becomes ill during the day;

308.15 (2) the person does not live in a licensed residential site;

308.16 (3) the person requires supervision; and

308.17 (4) there is not a caretaker immediately available. Supervision must be provided
308.18 until the caretaker arrives to bring the person home.

308.19 Subd. 4. **Safety procedures.** The license holder must establish general written
308.20 safety procedures that include criteria for selecting, training, and supervising persons who
308.21 work with hazardous machinery, tools, or substances. Safety procedures specific to each
308.22 person's activities must be explained and be available in writing to all staff members
308.23 and persons receiving services.

308.24 **EFFECTIVE DATE.** This section is effective January 1, 2014.

308.25 Sec. 41. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND**
308.26 **FACILITY COVERAGE.**

308.27 Subdivision 1. **Scope.** This section applies only to facility-based day services.

308.28 Subd. 2. **Factors.** (a) The number of direct support service staff members that a
308.29 license holder must have on duty at the facility at a given time to meet the minimum
308.30 staffing requirements established in this section varies according to:

308.31 (1) the number of persons who are enrolled and receiving direct support services
308.32 at that given time;

308.33 (2) the staff ratio requirement established under subdivision 3 for each person who
308.34 is present; and

309.1 (3) whether the conditions described in subdivision 8 exist and warrant additional
309.2 staffing beyond the number determined to be needed under subdivision 7.

309.3 (b) The commissioner must consider the factors in paragraph (a) in determining a
309.4 license holder's compliance with the staffing requirements and must further consider
309.5 whether the staff ratio requirement established under subdivision 3 for each person
309.6 receiving services accurately reflects the person's need for staff time.

309.7 Subd. 3. **Staff ratio requirement for each person receiving services.** The case
309.8 manager, in consultation with the interdisciplinary team, must determine at least once each
309.9 year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving
309.10 services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio
309.11 assigned each person and the documentation of how the ratio was arrived at must be kept
309.12 in each person's individual service plan. Documentation must include an assessment of the
309.13 person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard
309.14 assessment form required by the commissioner.

309.15 Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a
309.16 staff ratio requirement of one to four if:

309.17 (1) on a daily basis the person requires total care and monitoring or constant
309.18 hand-over-hand physical guidance to successfully complete at least three of the following
309.19 activities: toileting, communicating basic needs, eating, ambulating; or is not capable of
309.20 taking appropriate action for self-preservation under emergency conditions; or

309.21 (2) the person engages in conduct that poses an imminent risk of physical harm to
309.22 self or others at a documented level of frequency, intensity, or duration requiring frequent
309.23 daily ongoing intervention and monitoring as established in the person's coordinated
309.24 service and support plan or coordinated service and support plan addendum.

309.25 Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a
309.26 staff ratio requirement of one to eight if:

309.27 (1) the person does not meet the requirements in subdivision 4; and

309.28 (2) on a daily basis the person requires verbal prompts or spot checks and minimal
309.29 or no physical assistance to successfully complete at least four of the following activities:
309.30 toileting, communicating basic needs, eating, ambulating, or taking appropriate action for
309.31 self-preservation under emergency conditions.

309.32 Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have
309.33 any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio
309.34 requirement of one to six.

309.35 Subd. 7. **Determining number of direct support service staff required.** The
309.36 minimum number of direct support service staff members required at any one time to

310.1 meet the combined staff ratio requirements of the persons present at that time can be
310.2 determined by the following steps:

310.3 (1) assign each person in attendance the three-digit decimal below that corresponds
310.4 to the staff ratio requirement assigned to that person. A staff ratio requirement of one to
310.5 four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio
310.6 requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

310.7 (2) add all of the three-digit decimals (one three-digit decimal for every person in
310.8 attendance) assigned in clause (1);

310.9 (3) when the sum in clause (2) falls between two whole numbers, round off the sum
310.10 to the larger of the two whole numbers; and

310.11 (4) the larger of the two whole numbers in clause (3) equals the number of direct
310.12 support service staff members needed to meet the staff ratio requirements of the persons
310.13 in attendance.

310.14 Subd. 8. **Staff to be included in calculating minimum staffing requirement.**

310.15 Only staff providing direct support must be counted as staff members in calculating the
310.16 staff-to-participant ratio. A volunteer may be counted as a staff providing direct support
310.17 in calculating the staff-to-participant ratio if the volunteer meets the same standards
310.18 and requirements as paid staff. No person receiving services must be counted as or be
310.19 substituted for a staff member in calculating the staff-to-participant ratio.

310.20 Subd. 9. **Conditions requiring additional direct support staff.** The license holder
310.21 must increase the number of direct support staff members present at any one time beyond
310.22 the number arrived at in subdivision 4 if necessary when any one or combination of the
310.23 following circumstances can be documented by the commissioner as existing:

310.24 (1) the health and safety needs of the persons receiving services cannot be met by
310.25 the number of staff members available under the staffing pattern in effect even though the
310.26 number has been accurately calculated under subdivision 7; or

310.27 (2) the person's conduct frequently presents an imminent risk of physical harm to
310.28 self or others.

310.29 Subd. 10. **Supervision requirements.** (a) At no time must one direct support

310.30 staff member be assigned responsibility for supervision and training of more than ten
310.31 persons receiving supervision and training, except as otherwise stated in each person's risk
310.32 management plan.

310.33 (b) In the temporary absence of the director or a supervisor, a direct support staff
310.34 member must be designated to supervise the center.

310.35 Subd. 11. **Multifunctional programs.** A multifunctional program may count other
310.36 employees of the organization besides direct support staff of the day service facility in

311.1 calculating the staff to participant ratio if the employee is assigned to the day services
311.2 facility for a specified amount of time, during which the employee is not assigned to
311.3 another organization or program.

311.4 **EFFECTIVE DATE.** This section is effective January 1, 2014.

311.5 Sec. 42. **[245D.32] ALTERNATIVE LICENSING INSPECTIONS.**

311.6 **Subdivision 1. Eligibility for an alternative licensing inspection.** (a) A license
311.7 holder providing services licensed under this chapter, with a qualifying accreditation and
311.8 meeting the eligibility criteria in paragraphs (b) and (c) may request approval for an
311.9 alternative licensing inspection when all services provided under the license holder's
311.10 license are accredited. A license holder with a qualifying accreditation and meeting
311.11 the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative
311.12 licensing inspection for individual community residential settings or day services facilities
311.13 licensed under this chapter.

311.14 (b) In order to be eligible for an alternative licensing inspection, the program must
311.15 have had at least one inspection by the commissioner following issuance of the initial
311.16 license. For programs operating a day services facility, each facility must have had at least
311.17 one on-site inspection by the commissioner following issuance of the initial license.

311.18 (c) In order to be eligible for an alternative licensing inspection, the program must
311.19 have been in "substantial and consistent compliance" at the time of the last licensing
311.20 inspection and during the current licensing period. For purposes of this section, substantial
311.21 and consistent compliance means:

311.22 (1) the license holder's license was not made conditional, suspended, or revoked;

311.23 (2) there have been no substantiated allegations of maltreatment against the license
311.24 holder;

311.25 (3) there were no program deficiencies identified that would jeopardize the health,
311.26 safety, or rights of persons being served; and

311.27 (4) the license holder maintained substantial compliance with the other requirements
311.28 of chapters 245A and 245C and other applicable laws and rules.

311.29 (d) For the purposes of this section, the license holder's license includes services
311.30 licensed under this chapter that were previously licensed under chapter 245B until
311.31 December 31, 2013.

311.32 **Subd. 2. Qualifying accreditation.** The commissioner must accept a three-year
311.33 accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)
311.34 as a qualifying accreditation.

312.1 Subd. 3. **Request for approval of an alternative inspection status.** (a) A request
312.2 for an alternative inspection must be made on the forms and in the manner prescribed
312.3 by the commissioner. When submitting the request, the license holder must submit all
312.4 documentation issued by the accrediting body verifying that the license holder has obtained
312.5 and maintained the qualifying accreditation and has complied with recommendations
312.6 or requirements from the accrediting body during the period of accreditation. Based
312.7 on the request and the additional required materials, the commissioner may approve
312.8 an alternative inspection status.

312.9 (b) The commissioner must notify the license holder in writing that the request for
312.10 an alternative inspection status has been approved. Approval must be granted until the
312.11 end of the qualifying accreditation period.

312.12 (c) The license holder must submit a written request for approval to be renewed
312.13 one month before the end of the current approval period according to the requirements
312.14 in paragraph (a). If the license holder does not submit a request to renew approval as
312.15 required, the commissioner must conduct a licensing inspection.

312.16 Subd. 4. **Programs approved for alternative licensing inspection; deemed**
312.17 **compliance licensing requirements.** (a) A license holder approved for alternative
312.18 licensing inspection under this section is required to maintain compliance with all
312.19 licensing standards according to this chapter.

312.20 (b) A license holder approved for alternative licensing inspection under this section
312.21 must be deemed to be in compliance with all the requirements of this chapter, and the
312.22 commissioner must not perform routine licensing inspections.

312.23 (c) Upon receipt of a complaint regarding the services of a license holder approved
312.24 for alternative licensing inspection under this section, the commissioner must investigate
312.25 the complaint and may take any action as provided under section 245A.06 or 245A.07.

312.26 Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this
312.27 section changes the commissioner's responsibilities to investigate alleged or suspected
312.28 maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

312.29 Subd. 6. **Termination or denial of subsequent approval.** Following approval of
312.30 an alternative licensing inspection, the commissioner may terminate or deny subsequent
312.31 approval of an alternative licensing inspection if the commissioner determines that:

312.32 (1) the license holder has not maintained the qualifying accreditation;

312.33 (2) the commissioner has substantiated maltreatment for which the license holder or
312.34 facility is determined to be responsible during the qualifying accreditation period; or

313.1 (3) during the qualifying accreditation period, the license holder has been issued
 313.2 an order for conditional license, fine, suspension, or license revocation that has not been
 313.3 reversed upon appeal.

313.4 Subd. 7. Appeals. The commissioner's decision that the conditions for approval for
 313.5 an alternative licensing inspection have not been met is final and not subject to appeal
 313.6 under the provisions of chapter 14.

313.7 Subd. 8. Commissioner's programs. Home and community-based services licensed
 313.8 under this chapter for which the commissioner is the license holder with a qualifying
 313.9 accreditation are excluded from being approved for an alternative licensing inspection.

313.10 EFFECTIVE DATE. This section is effective January 1, 2014.

313.11 Sec. 43. [245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.

313.12 (a) The commissioner of human services shall issue a mental health certification
 313.13 for services licensed under this chapter, when a license holder is determined to have met
 313.14 the requirements under paragraph (b). This certification is voluntary for license holders.
 313.15 The certification shall be printed on the license and identified on the commissioner's
 313.16 public Web site.

313.17 (b) The requirements for certification are:

313.18 (1) all staff have received at least seven hours of annual training covering all of
 313.19 the following topics:

313.20 (i) mental health diagnoses;

313.21 (ii) mental health crisis response and de-escalation techniques;

313.22 (iii) recovery from mental illness;

313.23 (iv) treatment options, including evidence-based practices;

313.24 (v) medications and their side effects;

313.25 (vi) co-occurring substance abuse and health conditions; and

313.26 (vii) community resources;

313.27 (2) a mental health professional, as defined in section 245.462, subdivision 18, or a
 313.28 mental health practitioner as defined in section 245.462, subdivision 17, is available
 313.29 for consultation and assistance;

313.30 (3) there is a plan and protocol in place to address a mental health crisis; and

313.31 (4) each person's individual service and support plan identifies who is providing
 313.32 clinical services and their contact information, and includes an individual crisis prevention
 313.33 and management plan developed with the person.

313.34 (c) License holders seeking certification under this section must request this
 313.35 certification on forms and in the manner prescribed by the commissioner.

314.1 (d) If the commissioner finds that the license holder has failed to comply with the
 314.2 certification requirements under paragraph (b), the commissioner may issue a correction
 314.3 order and an order of conditional license in accordance with section 245A.06 or may
 314.4 issue a sanction in accordance with section 245A.07, including and up to removal of
 314.5 the certification.

314.6 (e) A denial of the certification or the removal of the certification based on a
 314.7 determination that the requirements under paragraph (b) have not been met is not subject to
 314.8 appeal. A license holder that has been denied a certification or that has had a certification
 314.9 removed may again request certification when the license holder is in compliance with the
 314.10 requirements of paragraph (b).

314.11 **EFFECTIVE DATE.** This section is effective January 1, 2014.

314.12 Sec. 44. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

314.13 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
 314.14 established a new service called residential support that is available on the community
 314.15 alternative care, community alternatives for disabled individuals, developmental
 314.16 disabilities, and brain injury waivers. Existing waiver service descriptions must be
 314.17 modified to the extent necessary to ensure there is no duplication between other services.
 314.18 Residential support services must be provided by vendors licensed as a community
 314.19 residential setting as defined in section 245A.11, subdivision 8, a foster care setting
 314.20 licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care
 314.21 setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

314.22 (b) Residential support services must meet the following criteria:

314.23 ~~(1) providers of residential support services must own or control the residential site;~~

314.24 ~~(2) the residential site must not be the primary residence of the license holder;~~

314.25 ~~(3) (1) the residential site must have a designated program supervisor person~~
 314.26 responsible for program management, oversight, development, and implementation of
 314.27 policies and procedures;

314.28 ~~(4) (2) the provider of residential support services must provide supervision, training,~~
 314.29 and assistance as described in the person's coordinated service and support plan; and

314.30 ~~(5) (3) the provider of residential support services must meet the requirements of~~
 314.31 licensure and additional requirements of the person's coordinated service and support plan.

314.32 (c) Providers of residential support services that meet the definition in paragraph (a)
 314.33 ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~
 314.34 must be licensed according to chapter 245D. Providers licensed to provide child foster care
 314.35 under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under

315.1 Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section
315.2 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

315.3 Sec. 45. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

315.4 Subdivision 1. **Provider qualifications.** (a) For the home and community-based
315.5 waivers providing services to seniors and individuals with disabilities under sections
315.6 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

315.7 (1) agreements with enrolled waiver service providers to ensure providers meet
315.8 Minnesota health care program requirements;

315.9 (2) regular reviews of provider qualifications, and including requests of proof of
315.10 documentation; and

315.11 (3) processes to gather the necessary information to determine provider qualifications.

315.12 (b) Beginning July 1, 2012, staff that provide direct contact, as defined in section
315.13 245C.02, subdivision 11, for services specified in the federally approved waiver plans
315.14 must meet the requirements of chapter 245C prior to providing waiver services and as
315.15 part of ongoing enrollment. Upon federal approval, this requirement must also apply to
315.16 consumer-directed community supports.

315.17 (c) Beginning January 1, 2014, service owners and managerial officials overseeing
315.18 the management or policies of services that provide direct contact as specified in the
315.19 federally approved waiver plans must meet the requirements of chapter 245C prior to
315.20 reenrollment or, for new providers, prior to initial enrollment if they have not already done
315.21 so as a part of service licensure requirements.

315.22 Sec. 46. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:

315.23 Subd. 7. **Applicant and license holder training.** An applicant or license holder
315.24 for the home and community-based waivers providing services to seniors and individuals
315.25 with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is
315.26 not enrolled as a Minnesota health care program home and community-based services
315.27 waiver provider at the time of application must ensure that at least one controlling
315.28 individual completes a onetime training on the requirements for providing home and
315.29 community-based services from a qualified source as determined by the commissioner,
315.30 before a provider is enrolled or license is issued. Within six months of enrollment, a newly
315.31 enrolled home and community-based waiver service provider must ensure that at least one
315.32 controlling individual has completed training on waiver and related program billing.

316.1 Sec. 47. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
316.2 subdivision to read:

316.3 Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1,
316.4 2013, facilities and services to be licensed under chapter 245D shall submit data regarding
316.5 the use of emergency use of manual restraint as identified in section 245D.061 in a format
316.6 and at a frequency identified by the commissioner.

316.7 Sec. 48. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
316.8 subdivision to read:

316.9 Subd. 9. **Definitions.** (a) For the purposes of this section the following terms have
316.10 the meanings given them.

316.11 (b) "Controlling individual" means a public body, governmental agency, business
316.12 entity, officer, owner, or managerial official whose responsibilities include the direction of
316.13 the management or policies of a program.

316.14 (c) "Managerial official" means an individual who has decision-making authority
316.15 related to the operation of the program and responsibility for the ongoing management of
316.16 or direction of the policies, services, or employees of the program.

316.17 (d) "Owner" means an individual who has direct or indirect ownership interest in
316.18 a corporation or partnership, or business association enrolling with the Department of
316.19 Human Services as a provider of waiver services.

316.20 Sec. 49. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
316.21 subdivision to read:

316.22 Subd. 10. **Enrollment requirements.** All home and community-based waiver
316.23 providers must provide, at the time of enrollment and within 30 days of a request, in a
316.24 format determined by the commissioner, information and documentation that includes, but
316.25 is not limited to, the following:

316.26 (1) proof of surety bond coverage in the amount of \$50,000 or ten percent of the
316.27 provider's payments from Medicaid in the previous calendar year, whichever is greater;

316.28 (2) proof of fidelity bond coverage in the amount of \$20,000; and

316.29 (3) proof of liability insurance.

316.30 Sec. 50. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:

316.31 **Subd. 9a. Evaluation and referral of reports made to common entry point unit.**

316.32 The common entry point must screen the reports of alleged or suspected maltreatment for
316.33 immediate risk and make all necessary referrals as follows:

317.1 (1) if the common entry point determines that there is an immediate need for
 317.2 adult protective services, the common entry point agency shall immediately notify the
 317.3 appropriate county agency;

317.4 (2) if the report contains suspected criminal activity against a vulnerable adult, the
 317.5 common entry point shall immediately notify the appropriate law enforcement agency;

317.6 (3) the common entry point shall refer all reports of alleged or suspected
 317.7 maltreatment to the appropriate lead investigative agency as soon as possible, but in any
 317.8 event no longer than two working days; and

317.9 ~~(4) if the report involves services licensed by the Department of Human Services~~
 317.10 ~~and subject to chapter 245D, the common entry point shall refer the report to the county as~~
 317.11 ~~the lead agency according to clause (3), but shall also notify the Department of Human~~
 317.12 ~~Services of the report; and~~

317.13 ~~(5)~~ (4) if the report contains information about a suspicious death, the common
 317.14 entry point shall immediately notify the appropriate law enforcement agencies, the local
 317.15 medical examiner, and the ombudsman for mental health and developmental disabilities
 317.16 established under section 245.92. Law enforcement agencies shall coordinate with the
 317.17 local medical examiner and the ombudsman as provided by law.

317.18 Sec. 51. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:

317.19 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
 317.20 administrative agency responsible for investigating reports made under section 626.557.

317.21 (a) The Department of Health is the lead investigative agency for facilities or
 317.22 services licensed or required to be licensed as hospitals, home care providers, nursing
 317.23 homes, boarding care homes, hospice providers, residential facilities that are also federally
 317.24 certified as intermediate care facilities that serve people with developmental disabilities,
 317.25 or any other facility or service not listed in this subdivision that is licensed or required to
 317.26 be licensed by the Department of Health for the care of vulnerable adults. "Home care
 317.27 provider" has the meaning provided in section 144A.43, subdivision 4, and applies when
 317.28 care or services are delivered in the vulnerable adult's home, whether a private home or a
 317.29 housing with services establishment registered under chapter 144D, including those that
 317.30 offer assisted living services under chapter 144G.

317.31 ~~(b) Except as provided under paragraph (c), for services licensed according to~~
 317.32 ~~chapter 245D, The Department of Human Services is the lead investigative agency for~~
 317.33 facilities or services licensed or required to be licensed as adult day care, adult foster care,
 317.34 programs for people with developmental disabilities, family adult day services, mental
 317.35 health programs, mental health clinics, chemical dependency programs, the Minnesota

318.1 sex offender program, or any other facility or service not listed in this subdivision that is
 318.2 licensed or required to be licensed by the Department of Human Services.

318.3 (c) The county social service agency or its designee is the lead investigative agency
 318.4 for all other reports, including, but not limited to, reports involving vulnerable adults
 318.5 receiving services from a personal care provider organization under section 256B.0659;
 318.6 ~~or receiving home and community-based services licensed by the Department of Human~~
 318.7 ~~Services and subject to chapter 245D.~~

318.8 **Sec. 52. INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
 318.9 **AND COMMUNITY-BASED SERVICES.**

318.10 (a) The Department of Health Compliance Monitoring Division and the Department
 318.11 of Human Services Licensing Division shall jointly develop an integrated licensing system
 318.12 for providers of both home care services subject to licensure under Minnesota Statutes,
 318.13 chapter 144A, and for home and community-based services subject to licensure under
 318.14 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

318.15 (1) require only one license of any provider of services under Minnesota Statutes,
 318.16 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

318.17 (2) promote quality services that recognize a person's individual needs and protect
 318.18 the person's health, safety, rights, and well-being;

318.19 (3) promote provider accountability through application requirements, compliance
 318.20 inspections, investigations, and enforcement actions;

318.21 (4) reference other applicable requirements in existing state and federal laws,
 318.22 including the federal Affordable Care Act;

318.23 (5) establish internal procedures to facilitate ongoing communications between the
 318.24 agencies, and with providers and services recipients about the regulatory activities;

318.25 (6) create a link between the agency Web sites so that providers and the public can
 318.26 access the same information regardless of which Web site is accessed initially; and

318.27 (7) collect data on identified outcome measures as necessary for the agencies to
 318.28 report to the Centers for Medicare and Medicaid Services.

318.29 (b) The joint recommendations for legislative changes to implement the integrated
 318.30 licensing system are due to the legislature by February 15, 2014.

318.31 (c) Before implementation of the integrated licensing system, providers licensed as
 318.32 home care providers under Minnesota Statutes, chapter 144A, may also provide home
 318.33 and community-based services subject to licensure under Minnesota Statutes, chapter
 318.34 245D, without obtaining a home and community-based services license under Minnesota

319.1 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
 319.2 apply to these providers:

319.3 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
 319.4 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

319.5 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
 319.6 enforced by the Department of Health under the enforcement authority set forth in
 319.7 Minnesota Statutes, section 144A.475; and

319.8 (3) the Department of Health will provide information to the Department of Human
 319.9 Services about each provider licensed under this section, including the provider's license
 319.10 application, licensing documents, inspections, information about complaints received, and
 319.11 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

319.12 **Sec. 53. REPEALER.**

319.13 (a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031;
 319.14 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and
 319.15 245B.08, are repealed effective January 1, 2014.

319.16 (b) Minnesota Statutes 2012, section 245D.08, is repealed.

319.17 **ARTICLE 9**

319.18 **WAIVER PROVIDER STANDARDS TECHNICAL CHANGES**

319.19 Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:

319.20 Subd. 5. **Specific purchases.** The solicitation process described in this chapter is
 319.21 not required for acquisition of the following:

319.22 (1) merchandise for resale purchased under policies determined by the commissioner;

319.23 (2) farm and garden products which, as determined by the commissioner, may be
 319.24 purchased at the prevailing market price on the date of sale;

319.25 (3) goods and services from the Minnesota correctional facilities;

319.26 (4) goods and services from rehabilitation facilities and extended employment
 319.27 providers that are certified by the commissioner of employment and economic
 319.28 development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01~~
 319.29 ~~to 245B.08~~ chapter 245D;

319.30 (5) goods and services for use by a community-based facility operated by the
 319.31 commissioner of human services;

319.32 (6) goods purchased at auction or when submitting a sealed bid at auction provided
 319.33 that before authorizing such an action, the commissioner consult with the requesting
 319.34 agency to determine a fair and reasonable value for the goods considering factors

320.1 including, but not limited to, costs associated with submitting a bid, travel, transportation,
320.2 and storage. This fair and reasonable value must represent the limit of the state's bid;

320.3 (7) utility services where no competition exists or where rates are fixed by law or
320.4 ordinance; and

320.5 (8) goods and services from Minnesota sex offender program facilities.

320.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

320.7 Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:

320.8 Subdivision 1. **Service contracts.** The commissioner of administration shall
320.9 ensure that a portion of all contracts for janitorial services; document imaging;
320.10 document shredding; and mailing, collating, and sorting services be awarded by the
320.11 state to rehabilitation programs and extended employment providers that are certified
320.12 by the commissioner of employment and economic development, and day ~~training and~~
320.13 ~~habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D. The
320.14 amount of each contract awarded under this section may exceed the estimated fair market
320.15 price as determined by the commissioner for the same goods and services by up to six
320.16 percent. The aggregate value of the contracts awarded to eligible providers under this
320.17 section in any given year must exceed 19 percent of the total value of all contracts for
320.18 janitorial services; document imaging; document shredding; and mailing, collating, and
320.19 sorting services entered into in the same year. For the 19 percent requirement to be
320.20 applicable in any given year, the contract amounts proposed by eligible providers must be
320.21 within six percent of the estimated fair market price for at least 19 percent of the contracts
320.22 awarded for the corresponding service area.

320.23 **EFFECTIVE DATE.** This section is effective January 1, 2014.

320.24 Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:

320.25 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing
320.26 with services establishment" or "establishment" means:

320.27 (1) an establishment providing sleeping accommodations to one or more adult
320.28 residents, at least 80 percent of which are 55 years of age or older, and offering or
320.29 providing, for a fee, one or more regularly scheduled health-related services or two or
320.30 more regularly scheduled supportive services, whether offered or provided directly by the
320.31 establishment or by another entity arranged for by the establishment; or

320.32 (2) an establishment that registers under section 144D.025.

320.33 (b) Housing with services establishment does not include:

- 321.1 (1) a nursing home licensed under chapter 144A;
- 321.2 (2) a hospital, certified boarding care home, or supervised living facility licensed
321.3 under sections 144.50 to 144.56;
- 321.4 (3) a board and lodging establishment licensed under chapter 157 and Minnesota
321.5 Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660,
321.6 or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;
- 321.7 (4) a board and lodging establishment which serves as a shelter for battered women
321.8 or other similar purpose;
- 321.9 (5) a family adult foster care home licensed by the Department of Human Services;
- 321.10 (6) private homes in which the residents are related by kinship, law, or affinity with
321.11 the providers of services;
- 321.12 (7) residential settings for persons with developmental disabilities in which the
321.13 services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable
321.14 successor rules or laws;
- 321.15 (8) a home-sharing arrangement such as when an elderly or disabled person or
321.16 single-parent family makes lodging in a private residence available to another person
321.17 in exchange for services or rent, or both;
- 321.18 (9) a duly organized condominium, cooperative, common interest community, or
321.19 owners' association of the foregoing where at least 80 percent of the units that comprise the
321.20 condominium, cooperative, or common interest community are occupied by individuals
321.21 who are the owners, members, or shareholders of the units; or
- 321.22 (10) services for persons with developmental disabilities that are provided under
321.23 a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until
321.24 January 1, 1998, or under chapter ~~245B~~ 245D.

321.25 **EFFECTIVE DATE.** This section is effective January 1, 2014.

321.26 Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:

321.27 Subdivision 1. **Applicability.** (a) The operating standards for special transportation
321.28 service adopted under this section do not apply to special transportation provided by:

- 321.29 (1) a common carrier operating on fixed routes and schedules;
- 321.30 (2) a volunteer driver using a private automobile;
- 321.31 (3) a school bus as defined in section 169.011, subdivision 71; or
- 321.32 (4) an emergency ambulance regulated under chapter 144.

321.33 (b) The operating standards adopted under this section only apply to providers
321.34 of special transportation service who receive grants or other financial assistance from
321.35 either the state or the federal government, or both, to provide or assist in providing that

322.1 service; except that the operating standards adopted under this section do not apply
322.2 to any nursing home licensed under section 144A.02, to any board and care facility
322.3 licensed under section 144.50, or to any day training and habilitation services, day care,
322.4 or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or
322.5 program provides transportation to nonresidents on a regular basis and the facility receives
322.6 reimbursement, other than per diem payments, for that service under rules promulgated
322.7 by the commissioner of human services.

322.8 (c) Notwithstanding paragraph (b), the operating standards adopted under this
322.9 section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that
322.10 provides transportation services to consumers or residents of other vendors licensed under
322.11 chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents
322.12 and the driver.

322.13 **EFFECTIVE DATE.** This section is effective January 1, 2014.

322.14 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:

322.15 Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the
322.16 meanings given them in this section.

322.17 **EFFECTIVE DATE.** This section is effective January 1, 2014.

322.18 Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:

322.19 Subd. 9. **License holder.** "License holder" means an individual, corporation,
322.20 partnership, voluntary association, or other organization that is legally responsible for the
322.21 operation of the program, has been granted a license by the commissioner under this chapter
322.22 or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

322.23 **EFFECTIVE DATE.** This section is effective January 1, 2014.

322.24 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

322.25 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
322.26 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
322.27 person receiving supported living services may provide licensed services to that person if:

322.28 (1) the person who receives supported living services received these services in a
322.29 residential site on July 1, 2005;

322.30 (2) the services under clause (1) were provided in a corporate foster care setting for
322.31 adults and were funded by the developmental disabilities home and community-based
322.32 services waiver defined in section 256B.092;

323.1 (3) the individual who is related obtains and maintains both a license under chapter
 323.2 ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105
 323.3 to 9555.6265; and

323.4 (4) the individual who is related is not the guardian of the person receiving supported
 323.5 living services.

323.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

323.7 Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:

323.8 Subd. 13. **Funds and property; other requirements.** (a) A license holder must
 323.9 ensure that persons served by the program retain the use and availability of personal funds
 323.10 or property unless restrictions are justified in the person's individual plan. ~~This subdivision~~
 323.11 ~~does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~

323.12 (b) The license holder must ensure separation of funds of persons served by the
 323.13 program from funds of the license holder, the program, or program staff.

323.14 (c) Whenever the license holder assists a person served by the program with the
 323.15 safekeeping of funds or other property, the license holder must:

323.16 (1) immediately document receipt and disbursement of the person's funds or other
 323.17 property at the time of receipt or disbursement, including the person's signature, or the
 323.18 signature of the conservator or payee; and

323.19 (2) return to the person upon the person's request, funds and property in the license
 323.20 holder's possession subject to restrictions in the person's treatment plan, as soon as
 323.21 possible, but no later than three working days after the date of request.

323.22 (d) License holders and program staff must not:

323.23 (1) borrow money from a person served by the program;

323.24 (2) purchase personal items from a person served by the program;

323.25 (3) sell merchandise or personal services to a person served by the program;

323.26 (4) require a person served by the program to purchase items for which the license
 323.27 holder is eligible for reimbursement; or

323.28 (5) use funds of persons served by the program to purchase items for which the
 323.29 facility is already receiving public or private payments.

323.30 **EFFECTIVE DATE.** This section is effective January 1, 2014.

323.31 Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:

323.32 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may
 323.33 suspend or revoke a license, or impose a fine if:

324.1 (1) a license holder fails to comply fully with applicable laws or rules;

324.2 (2) a license holder, a controlling individual, or an individual living in the household
324.3 where the licensed services are provided or is otherwise subject to a background study has
324.4 a disqualification which has not been set aside under section 245C.22;

324.5 (3) a license holder knowingly withholds relevant information from or gives false
324.6 or misleading information to the commissioner in connection with an application for
324.7 a license, in connection with the background study status of an individual, during an
324.8 investigation, or regarding compliance with applicable laws or rules; or

324.9 (4) after July 1, 2012, and upon request by the commissioner, a license holder fails
324.10 to submit the information required of an applicant under section 245A.04, subdivision 1,
324.11 paragraph (f) or (g).

324.12 A license holder who has had a license suspended, revoked, or has been ordered
324.13 to pay a fine must be given notice of the action by certified mail or personal service. If
324.14 mailed, the notice must be mailed to the address shown on the application or the last
324.15 known address of the license holder. The notice must state the reasons the license was
324.16 suspended, revoked, or a fine was ordered.

324.17 (b) If the license was suspended or revoked, the notice must inform the license
324.18 holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
324.19 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
324.20 a license. The appeal of an order suspending or revoking a license must be made in writing
324.21 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
324.22 the commissioner within ten calendar days after the license holder receives notice that the
324.23 license has been suspended or revoked. If a request is made by personal service, it must be
324.24 received by the commissioner within ten calendar days after the license holder received
324.25 the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits
324.26 a timely appeal of an order suspending or revoking a license, the license holder may
324.27 continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs
324.28 (g) and (h), until the commissioner issues a final order on the suspension or revocation.

324.29 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the
324.30 license holder of the responsibility for payment of fines and the right to a contested case
324.31 hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal
324.32 of an order to pay a fine must be made in writing by certified mail or personal service. If
324.33 mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
324.34 days after the license holder receives notice that the fine has been ordered. If a request is
324.35 made by personal service, it must be received by the commissioner within ten calendar
324.36 days after the license holder received the order.

325.1 (2) The license holder shall pay the fines assessed on or before the payment date
325.2 specified. If the license holder fails to fully comply with the order, the commissioner
325.3 may issue a second fine or suspend the license until the license holder complies. If the
325.4 license holder receives state funds, the state, county, or municipal agencies or departments
325.5 responsible for administering the funds shall withhold payments and recover any payments
325.6 made while the license is suspended for failure to pay a fine. A timely appeal shall stay
325.7 payment of the fine until the commissioner issues a final order.

325.8 (3) A license holder shall promptly notify the commissioner of human services,
325.9 in writing, when a violation specified in the order to forfeit a fine is corrected. If upon
325.10 reinspection the commissioner determines that a violation has not been corrected as
325.11 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
325.12 commissioner shall notify the license holder by certified mail or personal service that a
325.13 second fine has been assessed. The license holder may appeal the second fine as provided
325.14 under this subdivision.

325.15 (4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for
325.16 each determination of maltreatment of a child under section 626.556 or the maltreatment
325.17 of a vulnerable adult under section 626.557 for which the license holder is determined
325.18 responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i),
325.19 or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit \$200 for each
325.20 occurrence of a violation of law or rule governing matters of health, safety, or supervision,
325.21 including but not limited to the provision of adequate staff-to-child or adult ratios, and
325.22 failure to comply with background study requirements under chapter 245C; and the license
325.23 holder shall forfeit \$100 for each occurrence of a violation of law or rule other than
325.24 those subject to a \$1,000 or \$200 fine above. For purposes of this section, "occurrence"
325.25 means each violation identified in the commissioner's fine order. Fines assessed against a
325.26 license holder that holds a license to provide ~~the residential-based habilitation home and~~
325.27 community-based services, as defined under identified in section 245B.02, subdivision
325.28 ~~20~~ 245D.03, subdivision 1, and a community residential setting or day services facility
325.29 ~~license to provide foster care under chapter 245D where the services are provided,~~ may be
325.30 assessed against both licenses for the same occurrence, but the combined amount of the
325.31 fines shall not exceed the amount specified in this clause for that occurrence.

325.32 (5) When a fine has been assessed, the license holder may not avoid payment by
325.33 closing, selling, or otherwise transferring the licensed program to a third party. In such an
325.34 event, the license holder will be personally liable for payment. In the case of a corporation,
325.35 each controlling individual is personally and jointly liable for payment.

326.1 (d) Except for background study violations involving the failure to comply with an
326.2 order to immediately remove an individual or an order to provide continuous, direct
326.3 supervision, the commissioner shall not issue a fine under paragraph (c) relating to a
326.4 background study violation to a license holder who self-corrects a background study
326.5 violation before the commissioner discovers the violation. A license holder who has
326.6 previously exercised the provisions of this paragraph to avoid a fine for a background
326.7 study violation may not avoid a fine for a subsequent background study violation unless at
326.8 least 365 days have passed since the license holder self-corrected the earlier background
326.9 study violation.

326.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

326.11 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to
326.12 read:

326.13 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance
326.14 services provided by an individual who is qualified to provide the services according to
326.15 subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a
326.16 plan, and supervised by a qualified professional.

326.17 "Qualified professional" means a mental health professional as defined in section
326.18 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
326.19 or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker
326.20 as defined in sections 148E.010 and 148E.055, or a qualified ~~developmental disabilities~~
326.21 ~~specialist under section 245B.07, subdivision 4~~ designated coordinator under section
326.22 245D.081, subdivision 2. The qualified professional shall perform the duties required in
326.23 section 256B.0659.

326.24 **EFFECTIVE DATE.** This section is effective January 1, 2014.

326.25 Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

326.26 Subd. 2. **Contract provisions.** (a) The service contract with each intermediate
326.27 care facility must include provisions for:

- 326.28 (1) modifying payments when significant changes occur in the needs of the
326.29 consumers;
- 326.30 (2) appropriate and necessary statistical information required by the commissioner;
- 326.31 (3) annual aggregate facility financial information; and
- 326.32 (4) additional requirements for intermediate care facilities not meeting the standards
326.33 set forth in the service contract.

327.1 (b) The commissioner of human services and the commissioner of health, in
327.2 consultation with representatives from counties, advocacy organizations, and the provider
327.3 community, shall review ~~the consolidated standards under chapter 245B and the home and~~
327.4 community-based services standards under chapter 245D and the supervised living facility
327.5 rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota
327.6 Rules, chapter 4665, may be waived by the commissioner of health for intermediate care
327.7 facilities in order to enable facilities to implement the performance measures in their
327.8 contract and provide quality services to residents without a duplication of or increase in
327.9 regulatory requirements.

327.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

327.11 Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:

327.12 Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered
327.13 into through action of their governing bodies, may jointly or cooperatively exercise
327.14 any power common to the contracting parties or any similar powers, including those
327.15 which are the same except for the territorial limits within which they may be exercised.
327.16 The agreement may provide for the exercise of such powers by one or more of the
327.17 participating governmental units on behalf of the other participating units. The term
327.18 "governmental unit" as used in this section includes every city, county, town, school
327.19 district, independent nonprofit firefighting corporation, other political subdivision of
327.20 this or another state, another state, federally recognized Indian tribe, the University
327.21 of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under
327.22 sections 144.50 to 144.56, rehabilitation facilities and extended employment providers
327.23 that are certified by the commissioner of employment and economic development, ~~day~~
327.24 ~~training and habilitation services licensed under sections 245B.01 to 245B.08,~~ day and
327.25 supported employment services licensed under chapter 245D, and any agency of the state
327.26 of Minnesota or the United States, and includes any instrumentality of a governmental
327.27 unit. For the purpose of this section, an instrumentality of a governmental unit means an
327.28 instrumentality having independent policy-making and appropriating authority.

327.29 **EFFECTIVE DATE.** This section is effective January 1, 2014.

327.30 Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:

327.31 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
327.32 given them unless the specific content indicates otherwise:

328.1 (a) "Family assessment" means a comprehensive assessment of child safety, risk
328.2 of subsequent child maltreatment, and family strengths and needs that is applied to a
328.3 child maltreatment report that does not allege substantial child endangerment. Family
328.4 assessment does not include a determination as to whether child maltreatment occurred
328.5 but does determine the need for services to address the safety of family members and the
328.6 risk of subsequent maltreatment.

328.7 (b) "Investigation" means fact gathering related to the current safety of a child
328.8 and the risk of subsequent maltreatment that determines whether child maltreatment
328.9 occurred and whether child protective services are needed. An investigation must be used
328.10 when reports involve substantial child endangerment, and for reports of maltreatment in
328.11 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
328.12 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
328.13 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
328.14 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

328.15 (c) "Substantial child endangerment" means a person responsible for a child's care,
328.16 and in the case of sexual abuse includes a person who has a significant relationship to the
328.17 child as defined in section 609.341, or a person in a position of authority as defined in
328.18 section 609.341, who by act or omission commits or attempts to commit an act against a
328.19 child under their care that constitutes any of the following:

328.20 (1) egregious harm as defined in section 260C.007, subdivision 14;

328.21 (2) sexual abuse as defined in paragraph (d);

328.22 (3) abandonment under section 260C.301, subdivision 2;

328.23 (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the
328.24 child's physical or mental health, including a growth delay, which may be referred to as
328.25 failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

328.26 (5) murder in the first, second, or third degree under section 609.185, 609.19, or
328.27 609.195;

328.28 (6) manslaughter in the first or second degree under section 609.20 or 609.205;

328.29 (7) assault in the first, second, or third degree under section 609.221, 609.222, or
328.30 609.223;

328.31 (8) solicitation, inducement, and promotion of prostitution under section 609.322;

328.32 (9) criminal sexual conduct under sections 609.342 to 609.3451;

328.33 (10) solicitation of children to engage in sexual conduct under section 609.352;

328.34 (11) malicious punishment or neglect or endangerment of a child under section
328.35 609.377 or 609.378;

328.36 (12) use of a minor in sexual performance under section 617.246; or

329.1 (13) parental behavior, status, or condition which mandates that the county attorney
329.2 file a termination of parental rights petition under section 260C.301, subdivision 3,
329.3 paragraph (a).

329.4 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
329.5 child's care, by a person who has a significant relationship to the child, as defined in
329.6 section 609.341, or by a person in a position of authority, as defined in section 609.341,
329.7 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
329.8 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),
329.9 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
329.10 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
329.11 abuse also includes any act which involves a minor which constitutes a violation of
329.12 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
329.13 threatened sexual abuse which includes the status of a parent or household member
329.14 who has committed a violation which requires registration as an offender under section
329.15 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section
329.16 243.166, subdivision 1b, paragraph (a) or (b).

329.17 (e) "Person responsible for the child's care" means (1) an individual functioning
329.18 within the family unit and having responsibilities for the care of the child such as a
329.19 parent, guardian, or other person having similar care responsibilities, or (2) an individual
329.20 functioning outside the family unit and having responsibilities for the care of the child
329.21 such as a teacher, school administrator, other school employees or agents, or other lawful
329.22 custodian of a child having either full-time or short-term care responsibilities including,
329.23 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
329.24 and coaching.

329.25 (f) "Neglect" means the commission or omission of any of the acts specified under
329.26 clauses (1) to (9), other than by accidental means:

329.27 (1) failure by a person responsible for a child's care to supply a child with necessary
329.28 food, clothing, shelter, health, medical, or other care required for the child's physical or
329.29 mental health when reasonably able to do so;

329.30 (2) failure to protect a child from conditions or actions that seriously endanger the
329.31 child's physical or mental health when reasonably able to do so, including a growth delay,
329.32 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
329.33 is due to parental neglect;

329.34 (3) failure to provide for necessary supervision or child care arrangements
329.35 appropriate for a child after considering factors as the child's age, mental ability, physical

330.1 condition, length of absence, or environment, when the child is unable to care for the
330.2 child's own basic needs or safety, or the basic needs or safety of another child in their care;

330.3 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
330.4 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
330.5 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

330.6 (5) nothing in this section shall be construed to mean that a child is neglected solely
330.7 because the child's parent, guardian, or other person responsible for the child's care in
330.8 good faith selects and depends upon spiritual means or prayer for treatment or care of
330.9 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,
330.10 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
330.11 if a lack of medical care may cause serious danger to the child's health. This section does
330.12 not impose upon persons, not otherwise legally responsible for providing a child with
330.13 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

330.14 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
330.15 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
330.16 symptoms in the child at birth, results of a toxicology test performed on the mother at
330.17 delivery or the child at birth, medical effects or developmental delays during the child's
330.18 first year of life that medically indicate prenatal exposure to a controlled substance, or the
330.19 presence of a fetal alcohol spectrum disorder;

330.20 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

330.21 (8) chronic and severe use of alcohol or a controlled substance by a parent or
330.22 person responsible for the care of the child that adversely affects the child's basic needs
330.23 and safety; or

330.24 (9) emotional harm from a pattern of behavior which contributes to impaired
330.25 emotional functioning of the child which may be demonstrated by a substantial and
330.26 observable effect in the child's behavior, emotional response, or cognition that is not
330.27 within the normal range for the child's age and stage of development, with due regard to
330.28 the child's culture.

330.29 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,
330.30 inflicted by a person responsible for the child's care on a child other than by accidental
330.31 means, or any physical or mental injury that cannot reasonably be explained by the child's
330.32 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
330.33 that have not been authorized under section 121A.67 or 245.825.

330.34 Abuse does not include reasonable and moderate physical discipline of a child
330.35 administered by a parent or legal guardian which does not result in an injury. Abuse does
330.36 not include the use of reasonable force by a teacher, principal, or school employee as

331.1 allowed by section 121A.582. Actions which are not reasonable and moderate include,
331.2 but are not limited to, any of the following that are done in anger or without regard to the
331.3 safety of the child:

331.4 (1) throwing, kicking, burning, biting, or cutting a child;

331.5 (2) striking a child with a closed fist;

331.6 (3) shaking a child under age three;

331.7 (4) striking or other actions which result in any nonaccidental injury to a child
331.8 under 18 months of age;

331.9 (5) unreasonable interference with a child's breathing;

331.10 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

331.11 (7) striking a child under age one on the face or head;

331.12 (8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
331.13 substances which were not prescribed for the child by a practitioner, in order to control or
331.14 punish the child; or other substances that substantially affect the child's behavior, motor
331.15 coordination, or judgment or that results in sickness or internal injury, or subjects the
331.16 child to medical procedures that would be unnecessary if the child were not exposed
331.17 to the substances;

331.18 (9) unreasonable physical confinement or restraint not permitted under section
331.19 609.379, including but not limited to tying, caging, or chaining; or

331.20 (10) in a school facility or school zone, an act by a person responsible for the child's
331.21 care that is a violation under section 121A.58.

331.22 (h) "Report" means any report received by the local welfare agency, police
331.23 department, county sheriff, or agency responsible for assessing or investigating
331.24 maltreatment pursuant to this section.

331.25 (i) "Facility" means:

331.26 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
331.27 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
331.28 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;

331.29 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
331.30 124D.10; or

331.31 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
331.32 subdivision 16, and 256B.0625, subdivision 19a.

331.33 (j) "Operator" means an operator or agency as defined in section 245A.02.

331.34 (k) "Commissioner" means the commissioner of human services.

332.1 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
332.2 not limited to employee assistance counseling and the provision of guardian ad litem and
332.3 parenting time expeditor services.

332.4 (m) "Mental injury" means an injury to the psychological capacity or emotional
332.5 stability of a child as evidenced by an observable or substantial impairment in the child's
332.6 ability to function within a normal range of performance and behavior with due regard to
332.7 the child's culture.

332.8 (n) "Threatened injury" means a statement, overt act, condition, or status that
332.9 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
332.10 injury includes, but is not limited to, exposing a child to a person responsible for the
332.11 child's care, as defined in paragraph (e), clause (1), who has:

332.12 (1) subjected a child to, or failed to protect a child from, an overt act or condition
332.13 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
332.14 similar law of another jurisdiction;

332.15 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
332.16 (4), or a similar law of another jurisdiction;

332.17 (3) committed an act that has resulted in an involuntary termination of parental rights
332.18 under section 260C.301, or a similar law of another jurisdiction; or

332.19 (4) committed an act that has resulted in the involuntary transfer of permanent
332.20 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section
332.21 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a
332.22 similar law of another jurisdiction.

332.23 A child is the subject of a report of threatened injury when the responsible social
332.24 services agency receives birth match data under paragraph (o) from the Department of
332.25 Human Services.

332.26 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a
332.27 birth record or recognition of parentage identifying a child who is subject to threatened
332.28 injury under paragraph (n), the Department of Human Services shall send the data to the
332.29 responsible social services agency. The data is known as "birth match" data. Unless the
332.30 responsible social services agency has already begun an investigation or assessment of the
332.31 report due to the birth of the child or execution of the recognition of parentage and the
332.32 parent's previous history with child protection, the agency shall accept the birth match
332.33 data as a report under this section. The agency may use either a family assessment or
332.34 investigation to determine whether the child is safe. All of the provisions of this section
332.35 apply. If the child is determined to be safe, the agency shall consult with the county
332.36 attorney to determine the appropriateness of filing a petition alleging the child is in need

333.1 of protection or services under section 260C.007, subdivision 6, clause (16), in order to
333.2 deliver needed services. If the child is determined not to be safe, the agency and the county
333.3 attorney shall take appropriate action as required under section 260C.301, subdivision 3.

333.4 (p) Persons who conduct assessments or investigations under this section shall take
333.5 into account accepted child-rearing practices of the culture in which a child participates
333.6 and accepted teacher discipline practices, which are not injurious to the child's health,
333.7 welfare, and safety.

333.8 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected
333.9 occurrence or event which:

333.10 (1) is not likely to occur and could not have been prevented by exercise of due
333.11 care; and

333.12 (2) if occurring while a child is receiving services from a facility, happens when the
333.13 facility and the employee or person providing services in the facility are in compliance
333.14 with the laws and rules relevant to the occurrence or event.

333.15 (r) "Nonmaltreatment mistake" means:

333.16 (1) at the time of the incident, the individual was performing duties identified in the
333.17 center's child care program plan required under Minnesota Rules, part 9503.0045;

333.18 (2) the individual has not been determined responsible for a similar incident that
333.19 resulted in a finding of maltreatment for at least seven years;

333.20 (3) the individual has not been determined to have committed a similar
333.21 nonmaltreatment mistake under this paragraph for at least four years;

333.22 (4) any injury to a child resulting from the incident, if treated, is treated only with
333.23 remedies that are available over the counter, whether ordered by a medical professional or
333.24 not; and

333.25 (5) except for the period when the incident occurred, the facility and the individual
333.26 providing services were both in compliance with all licensing requirements relevant to the
333.27 incident.

333.28 This definition only applies to child care centers licensed under Minnesota
333.29 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of
333.30 substantiated maltreatment by the individual, the commissioner of human services shall
333.31 determine that a nonmaltreatment mistake was made by the individual.

333.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

333.33 Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:

333.34 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
333.35 to believe a child is being neglected or physically or sexually abused, as defined in

334.1 subdivision 2, or has been neglected or physically or sexually abused within the preceding
334.2 three years, shall immediately report the information to the local welfare agency, agency
334.3 responsible for assessing or investigating the report, police department, or the county
334.4 sheriff if the person is:

334.5 (1) a professional or professional's delegate who is engaged in the practice of
334.6 the healing arts, social services, hospital administration, psychological or psychiatric
334.7 treatment, child care, education, correctional supervision, probation and correctional
334.8 services, or law enforcement; or

334.9 (2) employed as a member of the clergy and received the information while
334.10 engaged in ministerial duties, provided that a member of the clergy is not required by
334.11 this subdivision to report information that is otherwise privileged under section 595.02,
334.12 subdivision 1, paragraph (c).

334.13 The police department or the county sheriff, upon receiving a report, shall
334.14 immediately notify the local welfare agency or agency responsible for assessing or
334.15 investigating the report, orally and in writing. The local welfare agency, or agency
334.16 responsible for assessing or investigating the report, upon receiving a report, shall
334.17 immediately notify the local police department or the county sheriff orally and in writing.
334.18 The county sheriff and the head of every local welfare agency, agency responsible
334.19 for assessing or investigating reports, and police department shall each designate a
334.20 person within their agency, department, or office who is responsible for ensuring that
334.21 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
334.22 this subdivision shall be construed to require more than one report from any institution,
334.23 facility, school, or agency.

334.24 (b) Any person may voluntarily report to the local welfare agency, agency responsible
334.25 for assessing or investigating the report, police department, or the county sheriff if the
334.26 person knows, has reason to believe, or suspects a child is being or has been neglected or
334.27 subjected to physical or sexual abuse. The police department or the county sheriff, upon
334.28 receiving a report, shall immediately notify the local welfare agency or agency responsible
334.29 for assessing or investigating the report, orally and in writing. The local welfare agency or
334.30 agency responsible for assessing or investigating the report, upon receiving a report, shall
334.31 immediately notify the local police department or the county sheriff orally and in writing.

334.32 (c) A person mandated to report physical or sexual child abuse or neglect occurring
334.33 within a licensed facility shall report the information to the agency responsible for
334.34 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or
334.35 chapter ~~245B~~ 245D; or a nonlicensed personal care provider organization as defined in
334.36 sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections

335.1 agency receiving a report may request the local welfare agency to provide assistance
335.2 pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees
335.3 perform work within a school facility, upon receiving a complaint of alleged maltreatment,
335.4 shall provide information about the circumstances of the alleged maltreatment to the
335.5 commissioner of education. Section 13.03, subdivision 4, applies to data received by the
335.6 commissioner of education from a licensing entity.

335.7 (d) Any person mandated to report shall receive a summary of the disposition of
335.8 any report made by that reporter, including whether the case has been opened for child
335.9 protection or other services, or if a referral has been made to a community organization,
335.10 unless release would be detrimental to the best interests of the child. Any person who is
335.11 not mandated to report shall, upon request to the local welfare agency, receive a concise
335.12 summary of the disposition of any report made by that reporter, unless release would be
335.13 detrimental to the best interests of the child.

335.14 (e) For purposes of this section, "immediately" means as soon as possible but in
335.15 no event longer than 24 hours.

335.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

335.17 Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

335.18 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is
335.19 received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while
335.20 in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
335.21 sanitarium, or other facility or institution required to be licensed according to sections
335.22 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ 245D, or a school as
335.23 defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed
335.24 personal care provider organization as defined in section 256B.04, subdivision 16, and
335.25 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing
335.26 or investigating the report or local welfare agency investigating the report shall provide
335.27 the following information to the parent, guardian, or legal custodian of a child alleged to
335.28 have been neglected, physically abused, sexually abused, or the victim of maltreatment
335.29 of a child in the facility: the name of the facility; the fact that a report alleging neglect,
335.30 physical abuse, sexual abuse, or maltreatment of a child in the facility has been received;
335.31 the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child
335.32 in the facility; that the agency is conducting an assessment or investigation; any protective
335.33 or corrective measures being taken pending the outcome of the investigation; and that a
335.34 written memorandum will be provided when the investigation is completed.

336.1 (b) The commissioner of the agency responsible for assessing or investigating the
336.2 report or local welfare agency may also provide the information in paragraph (a) to the
336.3 parent, guardian, or legal custodian of any other child in the facility if the investigative
336.4 agency knows or has reason to believe the alleged neglect, physical abuse, sexual
336.5 abuse, or maltreatment of a child in the facility has occurred. In determining whether
336.6 to exercise this authority, the commissioner of the agency responsible for assessing
336.7 or investigating the report or local welfare agency shall consider the seriousness of the
336.8 alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the
336.9 number of children allegedly neglected, physically abused, sexually abused, or victims of
336.10 maltreatment of a child in the facility; the number of alleged perpetrators; and the length
336.11 of the investigation. The facility shall be notified whenever this discretion is exercised.

336.12 (c) When the commissioner of the agency responsible for assessing or investigating
336.13 the report or local welfare agency has completed its investigation, every parent, guardian,
336.14 or legal custodian previously notified of the investigation by the commissioner or
336.15 local welfare agency shall be provided with the following information in a written
336.16 memorandum: the name of the facility investigated; the nature of the alleged neglect,
336.17 physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's
336.18 name; a summary of the investigation findings; a statement whether maltreatment was
336.19 found; and the protective or corrective measures that are being or will be taken. The
336.20 memorandum shall be written in a manner that protects the identity of the reporter and
336.21 the child and shall not contain the name, or to the extent possible, reveal the identity of
336.22 the alleged perpetrator or of those interviewed during the investigation. If maltreatment
336.23 is determined to exist, the commissioner or local welfare agency shall also provide the
336.24 written memorandum to the parent, guardian, or legal custodian of each child in the facility
336.25 who had contact with the individual responsible for the maltreatment. When the facility is
336.26 the responsible party for maltreatment, the commissioner or local welfare agency shall also
336.27 provide the written memorandum to the parent, guardian, or legal custodian of each child
336.28 who received services in the population of the facility where the maltreatment occurred.
336.29 This notification must be provided to the parent, guardian, or legal custodian of each child
336.30 receiving services from the time the maltreatment occurred until either the individual
336.31 responsible for maltreatment is no longer in contact with a child or children in the facility
336.32 or the conclusion of the investigation. In the case of maltreatment within a school facility,
336.33 as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner
336.34 of education need not provide notification to parents, guardians, or legal custodians of
336.35 each child in the facility, but shall, within ten days after the investigation is completed,
336.36 provide written notification to the parent, guardian, or legal custodian of any student

337.1 alleged to have been maltreated. The commissioner of education may notify the parent,
337.2 guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

337.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

337.4 Sec. 16. **REPEALER.**

337.5 Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective
337.6 January 1, 2014.

337.7 **ARTICLE 10**

337.8 **MISCELLANEOUS**

337.9 Section 1. Minnesota Statutes 2012, section 62A.65, subdivision 2, is amended to read:

337.10 Subd. 2. **Guaranteed renewal.** (a) No individual health plan may be offered, sold,
337.11 issued, or renewed to a Minnesota resident unless the health plan provides that the plan
337.12 is guaranteed renewable at a premium rate that does not take into account the claims
337.13 experience or any change in the health status of any covered person that occurred after
337.14 the initial issuance of the health plan to the person. The premium rate upon renewal
337.15 must also otherwise comply with this section. A health carrier must not refuse to renew
337.16 an individual health plan, except for nonpayment of premiums, fraud, or intentional
337.17 misrepresentation of a material fact.

337.18 (b) A health carrier may elect to discontinue health plan coverage of an individual in
337.19 the individual market only, excluding a grandfathered plan as defined in section 62A.011,
337.20 subdivision 1c, in one or more of the following situations:

337.21 (1) the health carrier is ceasing to offer individual health plan coverage in the
337.22 individual market in accordance with sections 62A.65, subdivision 8, 62E.11, subdivision
337.23 9, and federal law;

337.24 (2) for network plans, the individual no longer resides, lives, or works in the
337.25 service area of the health carrier, or the area for which the health carrier is authorized to
337.26 do business, but only if coverage is terminated uniformly without regard to any health
337.27 status-related factor of covered individuals; or

337.28 (3) a decision by the health carrier to discontinue offering a particular type of
337.29 individual health plan if it meets the following requirements:

337.30 (i) provides notice in writing to each individual provided coverage of that type of
337.31 health plan at least 90 days before the date coverage will be discontinued;

337.32 (ii) provides notice to the commissioner of commerce at least 30 business days
337.33 before the issuer or health carrier gives notice to the individuals;

338.1 (iii) offers to each covered individual information about products currently offered
338.2 that are closest in actuarial equivalence;

338.3 (iv) offers to each covered individual, on a guaranteed issue basis, the option to
338.4 purchase any other individual health plan currently being offered by the health carrier or
338.5 related health carrier for individuals in the market; and

338.6 (v) acts uniformly without regard to any health status-related factor of covered
338.7 individuals or dependents of covered individuals who may become eligible for coverage.

338.8 Sec. 2. Minnesota Statutes 2012, section 62A.65, is amended by adding a subdivision
338.9 to read:

338.10 Subd. 2a. **Modification of plan.** At the time of coverage renewal, an issuer or
338.11 health carrier may modify the health plan, excluding a grandfathered plan as defined under
338.12 section 62A.011, subdivision 1c, providing individual health plan coverage offered to
338.13 individuals in the individual market, so long as the modification is consistent with state
338.14 law and is effective on a uniform basis for individuals with that coverage.

338.15 Sec. 3. Minnesota Statutes 2012, section 119B.13, subdivision 7, is amended to read:

338.16 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
338.17 must not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding
338.18 holidays, in a fiscal year, or for more than ten consecutive full-day absent days. Legal
338.19 nonlicensed family child care providers must not be reimbursed for absent days. If a child
338.20 attends for part of the time authorized to be in care in a day, but is absent for part of the
338.21 time authorized to be in care in that same day, the absent time must be reimbursed but
338.22 the time must not count toward the ~~ten~~ absent day days limit. Child care providers must
338.23 only be reimbursed for absent days if the provider has a written policy for child absences
338.24 and charges all other families in care for similar absences.

338.25 (b) Notwithstanding paragraph (a), children with documented medical conditions
338.26 that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive
338.27 full-day absent days limit. Absences due to a documented medical condition of a parent
338.28 or sibling who lives in the same residence as the child receiving child care assistance
338.29 do not count against the absent days limit in a fiscal year. Documentation of medical
338.30 conditions must be on the forms and submitted according to the timelines established by
338.31 the commissioner. A public health nurse or school nurse may verify the illness in lieu of
338.32 a medical practitioner. If a provider sends a child home early due to a medical reason,
338.33 including, but not limited to, fever or contagious illness, the child care center director or
338.34 lead teacher may verify the illness in lieu of a medical practitioner.

339.1 ~~(b)~~ (c) Notwithstanding paragraph (a), children in families may exceed the ten absent
 339.2 days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school
 339.3 or general equivalency diploma; and (3) is a student in a school district or another similar
 339.4 program that provides or arranges for child care, parenting support, social services, career
 339.5 and employment supports, and academic support to achieve high school graduation, upon
 339.6 request of the program and approval of the county. If a child attends part of an authorized
 339.7 day, payment to the provider must be for the full amount of care authorized for that day.

339.8 ~~(e)~~ (d) Child care providers must be reimbursed for up to ten federal or state holidays
 339.9 or designated holidays per year when the provider charges all families for these days and the
 339.10 holiday or designated holiday falls on a day when the child is authorized to be in attendance.
 339.11 Parents may substitute other cultural or religious holidays for the ten recognized state and
 339.12 federal holidays. Holidays do not count toward the ten absent day days limit.

339.13 ~~(d)~~ (e) A family or child care provider must not be assessed an overpayment for an
 339.14 absent day payment unless (1) there was an error in the amount of care authorized for the
 339.15 family, (2) all of the allowed full-day absent payments for the child have been paid, or (3)
 339.16 the family or provider did not timely report a change as required under law.

339.17 ~~(e)~~ (f) The provider and family shall receive notification of the number of absent
 339.18 days used upon initial provider authorization for a family and ongoing notification of the
 339.19 number of absent days used as of the date of the notification.

339.20 (g) For purposes of this subdivision, "absent days limit" means 25 full-day absent
 339.21 days per child, excluding holidays, in a fiscal year; and ten consecutive full-day absent days.

339.22 Sec. 4. **[214.075] HEALTH-RELATED LICENSING BOARDS; CRIMINAL**
 339.23 **BACKGROUND CHECKS.**

339.24 Subdivision 1. Applications. (a) By January 1, 2018, each health-related licensing
 339.25 board, as defined in section 214.01, subdivision 2, shall require applicants for initial
 339.26 licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse
 339.27 in licensure, as defined by the individual health-related licensing boards to submit to
 339.28 a criminal history records check of state data completed by the Bureau of Criminal
 339.29 Apprehension (BCA) and a national criminal history records check, including a search of
 339.30 the records of the Federal Bureau of Investigation (FBI).

339.31 (b) An applicant must complete a criminal background check if more than one year
 339.32 has elapsed since the applicant last submitted a background check to the board.

339.33 Subd. 2. Investigations. If a health-related licensing board has reasonable cause
 339.34 to believe a licensee has been charged with or convicted of a crime in this or any other
 339.35 jurisdiction, the health-related licensing board may require the licensee to submit to a

340.1 criminal history records check of state data completed by the BCA and a national criminal
340.2 history records check, including a search of the records of the FBI.

340.3 Subd. 3. **Consent form; fees; fingerprints.** In order to effectuate the federal
340.4 and state level, fingerprint-based criminal background check, the applicant or licensee
340.5 must submit a completed criminal history records check consent form and a full set of
340.6 fingerprints to the respective health-related licensing board or a designee in the manner
340.7 and form specified by the board. The applicant or licensee is responsible for all fees
340.8 associated with preparation of the fingerprints, the criminal records check consent form,
340.9 and the criminal background check. The fees for the criminal records background check
340.10 shall be set by the BCA and the FBI and are not refundable.

340.11 Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue
340.12 a license to any applicant who refuses to consent to a criminal background check or fails
340.13 to submit fingerprints within 90 days after submission of an application for licensure. Any
340.14 fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent
340.15 to the criminal background check or fails to submit the required fingerprints.

340.16 (b) The failure of a licensee to submit to a criminal background check as provided in
340.17 subdivision 3 is grounds for disciplinary action by the respective health licensing board.

340.18 Subd. 5. **Submission of fingerprints to BCA.** The health-related licensing board
340.19 or designee shall submit applicant or licensee fingerprints to the BCA. The BCA shall
340.20 perform a check for state criminal justice information and shall forward the applicant's
340.21 or licensee's fingerprints to the FBI to perform a check for national criminal justice
340.22 information regarding the applicant or licensee. The BCA shall report to the board the
340.23 results of the state and national criminal justice information checks.

340.24 Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The
340.25 health-related licensing board may require an alternative method of criminal history
340.26 checks for an applicant or licensee who has submitted at least three sets of fingerprints in
340.27 accordance with this section that have been unreadable by the BCA or FBI.

340.28 Subd. 7. **Opportunity to challenge accuracy of report.** Prior to taking disciplinary
340.29 action against an applicant or a licensee based on a criminal conviction, the health-related
340.30 licensing board shall provide the applicant or licensee an opportunity to complete or
340.31 challenge the accuracy of the criminal history information reported to the board. The
340.32 applicant or licensee shall have 30 calendar days following notice from the board of the
340.33 intent to deny licensure or take disciplinary action to request an opportunity to correct or
340.34 complete the record prior to the board taking disciplinary action based on the information
340.35 reported to the board. The board shall provide the applicant up to 180 days to challenge
340.36 the accuracy or completeness of the report with the agency responsible for the record. This

341.1 subdivision does not affect the right of the subject of the data to contest the accuracy or
341.2 completeness under section 13.04, subdivision 4.

341.3 Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in
341.4 collaboration with the commissioner of human services and the BCA, shall establish a
341.5 plan for completing criminal background checks of all licensees who were licensed before
341.6 the effective date requirement under subdivision 1. The plan must seek to minimize
341.7 duplication of requirements for background checks of licensed health professionals. The
341.8 plan for background checks of current licensees shall be developed no later than January
341.9 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI
341.10 in which any new crimes that an applicant or licensee commits after an initial background
341.11 check are flagged in the BCA's or FBI's database and reported back to the board. The plan
341.12 shall include recommendations for any necessary statutory changes.

341.13 Sec. 5. Minnesota Statutes 2012, section 214.40, subdivision 1, is amended to read:

341.14 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this
341.15 section.

341.16 (b) "Administrative services unit" means the administrative services unit for the
341.17 health-related licensing boards.

341.18 (c) "Charitable organization" means a charitable organization within the meaning of
341.19 section 501(c)(3) of the Internal Revenue Code that has as a purpose the sponsorship or
341.20 support of programs designed to improve the quality, awareness, and availability of health
341.21 care services and that serves as a funding mechanism for providing those services.

341.22 (d) "Health care facility or organization" means a health care facility licensed under
341.23 chapter 144 or 144A, or a charitable organization.

341.24 (e) "Health care provider" means a physician licensed under chapter 147, physician
341.25 assistant registered and practicing under chapter 147A, nurse licensed and registered to
341.26 practice under chapter 148, or dentist or dental hygienist, dental therapist, or advanced
341.27 dental therapist licensed under chapter 150A.

341.28 (f) "Health care services" means health promotion, health monitoring, health
341.29 education, diagnosis, treatment, minor surgical procedures, the administration of local
341.30 anesthesia for the stitching of wounds, and primary dental services, including preventive,
341.31 diagnostic, restorative, and emergency treatment. Health care services do not include the
341.32 administration of general anesthesia or surgical procedures other than minor surgical
341.33 procedures.

341.34 (g) "Medical professional liability insurance" means medical malpractice insurance
341.35 as defined in section 62F.03.

342.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

342.2 Sec. 6. Minnesota Statutes 2012, section 245A.07, subdivision 2a, is amended to read:

342.3 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days
342.4 of receipt of the license holder's timely appeal, the commissioner shall request assignment
342.5 of an administrative law judge. The request must include a proposed date, time, and place
342.6 of a hearing. A hearing must be conducted by an administrative law judge within 30
342.7 calendar days of the request for assignment, unless an extension is requested by either
342.8 party and granted by the administrative law judge for good cause. The commissioner shall
342.9 issue a notice of hearing by certified mail or personal service at least ten working days
342.10 before the hearing. The scope of the hearing shall be limited solely to the issue of whether
342.11 the temporary immediate suspension should remain in effect pending the commissioner's
342.12 final order under section 245A.08, regarding a licensing sanction issued under subdivision
342.13 3 following the immediate suspension. The burden of proof in expedited hearings under
342.14 this subdivision shall be limited to the commissioner's demonstration that reasonable
342.15 cause exists to believe that the license holder's actions or failure to comply with applicable
342.16 law or rule poses, or if the actions of other individuals or conditions in the program
342.17 poses an imminent risk of harm to the health, safety, or rights of persons served by the
342.18 program. "Reasonable cause" means there exist specific articulable facts or circumstances
342.19 which provide the commissioner with a reasonable suspicion that there is an imminent
342.20 risk of harm to the health, safety, or rights of persons served by the program. When the
342.21 commissioner has determined there is reasonable cause to order the temporary immediate
342.22 suspension of a license based on a violation of safe sleep requirements, as defined in
342.23 section 245A.1435, the commissioner is not required to demonstrate that an infant died or
342.24 was injured as a result of the safe sleep violations.

342.25 (b) The administrative law judge shall issue findings of fact, conclusions, and a
342.26 recommendation within ten working days from the date of hearing. The parties shall have
342.27 ten calendar days to submit exceptions to the administrative law judge's report. The
342.28 record shall close at the end of the ten-day period for submission of exceptions. The
342.29 commissioner's final order shall be issued within ten working days from the close of the
342.30 record. Within 90 calendar days after a final order affirming an immediate suspension, the
342.31 commissioner shall make a determination regarding whether a final licensing sanction
342.32 shall be issued under subdivision 3. The license holder shall continue to be prohibited
342.33 from operation of the program during this 90-day period.

342.34 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
342.35 final licensing sanction is issued under subdivision 3 and the license holder appeals that

343.1 sanction, the license holder continues to be prohibited from operation of the program
343.2 pending a final commissioner's order under section 245A.08, subdivision 5, regarding the
343.3 final licensing sanction.

343.4 Sec. 7. Minnesota Statutes 2012, section 245A.1435, is amended to read:

343.5 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT**
343.6 **DEATH SYNDROME IN LICENSED PROGRAMS.**

343.7 (a) When a license holder is placing an infant to sleep, the license holder must
343.8 place the infant on the infant's back, unless the license holder has documentation from
343.9 the infant's parent physician directing an alternative sleeping position for the infant. The
343.10 parent physician directive must be on a form approved by the commissioner and must
343.11 include a statement that the parent or legal guardian has read the information provided by
343.12 the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance
343.13 of placing an infant or child on its back to sleep to reduce the risk of SIDS. remain on file
343.14 at the licensed location. An infant who independently rolls onto its stomach after being
343.15 placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant
343.16 is at least six months of age or the license holder has a signed statement from the parent
343.17 indicating that the infant regularly rolls over at home.

343.18 (b) ~~The license holder must place the infant in a crib directly on a firm mattress with~~
343.19 ~~a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be~~
343.20 ~~dislodged by pulling on the corner of the sheet. The license holder must not place pillows,~~
343.21 ~~quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib~~
343.22 ~~with the infant~~ The license holder must place the infant in a crib directly on a firm mattress
343.23 with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress,
343.24 and that overlaps the underside of the mattress so it cannot be dislodged by pulling on the
343.25 corner of the sheet with reasonable effort. The license holder must not place anything in
343.26 the crib with the infant except for the infant's pacifier. For the purposes of this section, a
343.27 pacifier is defined as a synthetic nipple designed for infant sucking with nothing attached
343.28 to it. The requirements of this section apply to license holders serving infants up to and
343.29 including 12 months younger than one year of age. Licensed child care providers must
343.30 meet the crib requirements under section 245A.146.

343.31 (c) If an infant falls asleep before being placed in a crib, the license holder must
343.32 move the infant to a crib as soon as practicable, and must keep the infant within sight of
343.33 the license holder until the infant is placed in a crib. When an infant falls asleep while
343.34 being held, the license holder must consider the supervision needs of other children in
343.35 care when determining how long to hold the infant before placing the infant in a crib to

344.1 sleep. The sleeping infant must not be in a position where the airway may be blocked or
 344.2 with anything covering the infant's face.

344.3 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
 344.4 for an infant of any age and is prohibited for any infant who has begun to roll over
 344.5 independently. However, with the written consent of a parent or guardian according to this
 344.6 paragraph, a license holder may place the infant who has not yet begun to roll over on its
 344.7 own down to sleep in a one-piece sleeper equipped with an attached system that fastens
 344.8 securely only across the upper torso, with no constriction of the hips or legs, to create a
 344.9 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
 344.10 the license holder must obtain informed written consent for the use of swaddling from the
 344.11 parent or guardian of the infant on a form provided by the commissioner and prepared in
 344.12 partnership with the Minnesota Sudden Infant Death Center.

344.13 Sec. 8. Minnesota Statutes 2012, section 245A.144, is amended to read:

344.14 **245A.144 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
 344.15 **DEATH AND SHAKEN-BABY SYNDROME ABUSIVE HEAD TRAUMA FOR**
 344.16 **CHILD FOSTER CARE PROVIDERS.**

344.17 (a) Licensed child foster care providers that care for infants or children through five
 344.18 years of age must document that before staff persons and caregivers assist in the care
 344.19 of infants or children through five years of age, they are instructed on the standards in
 344.20 section 245A.1435 and receive training on reducing the risk of sudden unexpected infant
 344.21 death ~~syndrome~~ and ~~shaken-baby syndrome~~ for abusive head trauma from shaking infants
 344.22 and young children. This section does not apply to emergency relative placement under
 344.23 section 245A.035. The training on reducing the risk of sudden unexpected infant death
 344.24 ~~syndrome~~ and ~~shaken-baby syndrome~~ abusive head trauma may be provided as:

344.25 (1) orientation training to child foster care providers, who care for infants or children
 344.26 through five years of age, under Minnesota Rules, part 2960.3070, subpart 1; or

344.27 (2) in-service training to child foster care providers, who care for infants or children
 344.28 through five years of age, under Minnesota Rules, part 2960.3070, subpart 2.

344.29 (b) Training required under this section must be at least one hour in length and must
 344.30 be completed at least once every five years. At a minimum, the training must address
 344.31 the risk factors related to sudden unexpected infant death ~~syndrome~~ and ~~shaken-baby~~
 344.32 ~~syndrome~~ abusive head trauma, means of reducing the risk of sudden unexpected infant
 344.33 death ~~syndrome~~ and ~~shaken-baby syndrome~~ abusive head trauma, and license holder
 344.34 communication with parents regarding reducing the risk of sudden unexpected infant
 344.35 death ~~syndrome~~ and ~~shaken-baby syndrome~~ abusive head trauma.

345.1 (c) Training for child foster care providers must be approved by the county or
 345.2 private licensing agency that is responsible for monitoring the child foster care provider
 345.3 under section 245A.16. The approved training fulfills, in part, training required under
 345.4 Minnesota Rules, part 2960.3070.

345.5 Sec. 9. Minnesota Statutes 2012, section 245A.1444, is amended to read:

345.6 **245A.1444 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
 345.7 **DEATH SYNDROME AND SHAKEN-BABY SYNDROME ABUSIVE HEAD**
 345.8 **TRAUMA BY OTHER PROGRAMS.**

345.9 A licensed chemical dependency treatment program that serves clients with infants
 345.10 or children through five years of age, who sleep at the program and a licensed children's
 345.11 residential facility that serves infants or children through five years of age, must document
 345.12 that before program staff persons or volunteers assist in the care of infants or children
 345.13 through five years of age, they are instructed on the standards in section 245A.1435 and
 345.14 receive training on reducing the risk of sudden unexpected infant death syndrome and
 345.15 shaken baby syndrome abusive head trauma from shaking infants and young children. The
 345.16 training conducted under this section may be used to fulfill training requirements under
 345.17 Minnesota Rules, parts 2960.0100, subpart 3; and 9530.6490, subpart 4, item B.

345.18 This section does not apply to child care centers or family child care programs
 345.19 governed by sections 245A.40 and 245A.50.

345.20 Sec. 10. **[245A.1446] FAMILY CHILD CARE DIAPERING AREA**
 345.21 **DISINFECTION.**

345.22 Notwithstanding Minnesota Rules, part 9502.0435, a family child care provider may
 345.23 disinfect the diaper changing surface with either a solution of at least two teaspoons
 345.24 of chlorine bleach to one quart of water or with a surface disinfectant that meets the
 345.25 following criteria:

345.26 (1) the manufacturer's label or instructions state that the product is registered with
 345.27 the United States Environmental Protection Agency;

345.28 (2) the manufacturer's label or instructions state that the disinfectant is effective
 345.29 against Staphylococcus aureus, Salmonella choleraesuis, and Pseudomonas aeruginosa;

345.30 (3) the manufacturer's label or instructions state that the disinfectant is effective with
 345.31 a ten minute or less contact time;

345.32 (4) the disinfectant is clearly labeled by the manufacturer with directions for mixing
 345.33 and use;

345.34 (5) the disinfectant is used only in accordance with the manufacturer's directions; and

346.1 (6) the product does not include triclosan or derivatives of triclosan.

346.2 Sec. 11. **[245A.147] FAMILY CHILD CARE INFANT SLEEP SUPERVISION**
346.3 **REQUIREMENTS.**

346.4 Subdivision 1. **In-person checks on infants.** (a) License holders that serve infants
346.5 are encouraged to monitor sleeping infants by conducting in-person checks on each infant
346.6 in their care every 30 minutes.

346.7 (b) Upon enrollment of an infant in a family child care program, the license holder is
346.8 encouraged to conduct in-person checks on the sleeping infant every 15 minutes during
346.9 the first four months of care.

346.10 (c) When an infant has an upper respiratory infection, the license holder is
346.11 encouraged to conduct in-person checks on the sleeping infant every 15 minutes
346.12 throughout the hours of sleep.

346.13 Subd. 2. **Use of audio or visual monitoring devices.** In addition to conducting
346.14 the in-person checks encouraged under subdivision 1, license holders serving infants are
346.15 encouraged to use and maintain an audio or visual monitoring device to monitor each
346.16 sleeping infant in care during all hours of sleep.

346.17 Sec. 12. **[245A.152] CHILD CARE LICENSE HOLDER INSURANCE.**

346.18 (a) A license holder must provide a written notice to all parents or guardians of all
346.19 children to be accepted for care prior to admission stating whether the license holder has
346.20 liability insurance. This notice may be incorporated into and provided on the admission
346.21 form used by the license holder.

346.22 (b) If the license holder has liability insurance:

346.23 (1) the license holder shall inform parents in writing that a current certificate of
346.24 coverage for insurance is available for inspection to all parents or guardians of children
346.25 receiving services and to all parents seeking services from the family child care program;

346.26 (2) the notice must provide the parent or guardian with the date of expiration or
346.27 next renewal of the policy; and

346.28 (3) upon the expiration date of the policy, the license holder must provide a new
346.29 written notice indicating whether the insurance policy has lapsed or whether the license
346.30 holder has renewed the policy.

346.31 If the policy was renewed, the license holder must provide the new expiration date of the
346.32 policy in writing to the parents or guardians.

346.33 (c) If the license holder does not have liability insurance, the license holder must
346.34 provide an annual notice, on a form developed and made available by the commissioner,

347.1 to the parents or guardians of children in care indicating that the license holder does not
347.2 carry liability insurance.

347.3 (d) The license holder must notify all parents and guardians in writing immediately
347.4 of any change in insurance status.

347.5 (e) The license holder must make available upon request the certificate of liability
347.6 insurance to the parents of children in care, to the commissioner, and to county licensing
347.7 agents.

347.8 (f) The license holder must document, with the signature of the parent or guardian,
347.9 that the parent or guardian received the notices required by this section.

347.10 Sec. 13. Minnesota Statutes 2012, section 245A.40, subdivision 5, is amended to read:

347.11 Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~**
347.12 **abusive head trauma training.** (a) License holders must document that before staff
347.13 persons and volunteers care for infants, they are instructed on the standards in section
347.14 245A.1435 and receive training on reducing the risk of sudden unexpected infant death
347.15 ~~syndrome~~. In addition, license holders must document that before staff persons care for
347.16 infants or children under school age, they receive training on the risk of ~~shaken baby~~
347.17 ~~syndrome~~ abusive head trauma from shaking infants and young children. The training
347.18 in this subdivision may be provided as orientation training under subdivision 1 and
347.19 in-service training under subdivision 7.

347.20 (b) Sudden unexpected infant death ~~syndrome~~ reduction training required under
347.21 this subdivision must be at least one-half hour in length and must be completed at least
347.22 once every ~~five years~~ year. At a minimum, the training must address the risk factors
347.23 related to sudden unexpected infant death ~~syndrome~~, means of reducing the risk of sudden
347.24 unexpected infant death ~~syndrome~~ in child care, and license holder communication with
347.25 parents regarding reducing the risk of sudden unexpected infant death ~~syndrome~~.

347.26 (c) ~~Shaken baby syndrome~~ Abusive head trauma training under this subdivision
347.27 must be at least one-half hour in length and must be completed at least once every ~~five~~
347.28 ~~years~~ year. At a minimum, the training must address the risk factors related to ~~shaken~~
347.29 ~~baby syndrome~~ for shaking infants and young children, means to reduce the risk of ~~shaken~~
347.30 ~~baby syndrome~~ abusive head trauma in child care, and license holder communication with
347.31 parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive head trauma.

347.32 (d) The commissioner shall make available for viewing a video presentation on the
347.33 dangers associated with shaking infants and young children. The video presentation must
347.34 be part of the orientation and annual in-service training of licensed child care center
347.35 staff persons caring for children under school age. The commissioner shall provide to

348.1 child care providers and interested individuals, at cost, copies of a video approved by the
348.2 commissioner of health under section 144.574 on the dangers associated with shaking
348.3 infants and young children.

348.4 Sec. 14. Minnesota Statutes 2012, section 245A.50, is amended to read:

348.5 **245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.**

348.6 Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes must
348.7 comply with the training requirements in this section.

348.8 (b) Helpers who assist with care on a regular basis must complete six hours of
348.9 training within one year after the date of initial employment.

348.10 Subd. 2. **Child growth and development and behavior guidance training.** (a) For
348.11 purposes of family and group family child care, the license holder and each adult caregiver
348.12 who provides care in the licensed setting for more than 30 days in any 12-month period
348.13 shall complete and document at least ~~two~~ four hours of child growth and development
348.14 and behavior guidance training within the first year of prior to initial licensure, and before
348.15 caring for children. For purposes of this subdivision, "child growth and development
348.16 training" means training in understanding how children acquire language and develop
348.17 physically, cognitively, emotionally, and socially. "Behavior guidance training" means
348.18 training in the understanding of the functions of child behavior and strategies for managing
348.19 challenging situations. Child growth and development and behavior guidance training
348.20 must be repeated annually. Training curriculum shall be developed or approved by the
348.21 commissioner of human services by January 1, 2014.

348.22 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if
348.23 they:

348.24 (1) have taken a three-credit course on early childhood development within the
348.25 past five years;

348.26 (2) have received a baccalaureate or master's degree in early childhood education or
348.27 school-age child care within the past five years;

348.28 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood
348.29 educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early
348.30 childhood special education teacher, or an elementary teacher with a kindergarten
348.31 endorsement; or

348.32 (4) have received a baccalaureate degree with a Montessori certificate within the
348.33 past five years.

348.34 Subd. 3. **First aid.** (a) When children are present in a family child care home
348.35 governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person

349.1 must be present in the home who has been trained in first aid. The first aid training must
349.2 have been provided by an individual approved to provide first aid instruction. First aid
349.3 training may be less than eight hours and persons qualified to provide first aid training
349.4 include individuals approved as first aid instructors. First aid training must be repeated
349.5 every two years.

349.6 (b) A family child care provider is exempt from the first aid training requirements
349.7 under this subdivision related to any substitute caregiver who provides less than 30 hours
349.8 of care during any 12-month period.

349.9 (c) Video training reviewed and approved by the county licensing agency satisfies
349.10 the training requirement of this subdivision.

349.11 Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family
349.12 child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least
349.13 one staff person must be present in the home who has been trained in cardiopulmonary
349.14 resuscitation (CPR) and in the treatment of obstructed airways that includes CPR
349.15 techniques for infants and children. The CPR training must have been provided by an
349.16 individual approved to provide CPR instruction, must be repeated at least once every ~~three~~
349.17 two years, and must be documented in the staff person's records.

349.18 (b) A family child care provider is exempt from the CPR training requirement in
349.19 this subdivision related to any substitute caregiver who provides less than 30 hours of
349.20 care during any 12-month period.

349.21 (c) ~~Video training reviewed and approved by the county licensing agency satisfies~~
349.22 ~~the training requirement of this subdivision.~~ Persons providing CPR training must use
349.23 CPR training that has been developed:

349.24 (1) by the American Heart Association or the American Red Cross and incorporates
349.25 psychomotor skills to support the instruction; or

349.26 (2) using nationally recognized, evidence-based guidelines for CPR training and
349.27 incorporates psychomotor skills to support the instruction.

349.28 Subd. 5. **Sudden unexpected infant death syndrome and shaken baby syndrome**
349.29 **abusive head trauma training.** (a) License holders must document that before staff
349.30 persons, caregivers, and helpers assist in the care of infants, they are instructed on the
349.31 standards in section 245A.1435 and receive training on reducing the risk of sudden
349.32 unexpected infant death syndrome. In addition, license holders must document that before
349.33 staff persons, caregivers, and helpers assist in the care of infants and children under
349.34 school age, they receive training on reducing the risk of ~~shaken baby syndrome~~ abusive
349.35 head trauma from shaking infants and young children. The training in this subdivision

350.1 may be provided as initial training under subdivision 1 or ongoing annual training under
350.2 subdivision 7.

350.3 (b) Sudden unexpected infant death syndrome reduction training required under this
350.4 subdivision must be at least one-half hour in length and must be completed in person
350.5 at least once every five years two years. On the years when the license holder is not
350.6 receiving the in-person training on sudden unexpected infant death reduction, the license
350.7 holder must receive sudden unexpected infant death reduction training through a video
350.8 of no more than one hour in length developed or approved by the commissioner. At a
350.9 minimum, the training must address the risk factors related to sudden unexpected infant
350.10 death syndrome, means of reducing the risk of sudden unexpected infant death syndrome
350.11 in child care, and license holder communication with parents regarding reducing the risk
350.12 of sudden unexpected infant death syndrome.

350.13 (c) ~~Shaken baby syndrome~~ Abusive head trauma training required under this
350.14 subdivision must be at least one-half hour in length and must be completed at least once
350.15 every five years year. At a minimum, the training must address the risk factors related
350.16 to ~~shaken baby syndrome~~ shaking infants and young children, means of reducing the
350.17 risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder
350.18 communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive
350.19 head trauma.

350.20 (d) Training for family and group family child care providers must be developed
350.21 by the commissioner in conjunction with the Minnesota Sudden Infant Death Center
350.22 and approved by the county licensing agency by the Minnesota Center for Professional
350.23 Development.

350.24 (e) ~~The commissioner shall make available for viewing by all licensed child care~~
350.25 ~~providers a video presentation on the dangers associated with shaking infants and young~~
350.26 ~~children. The video presentation shall be part of the initial and ongoing annual training of~~
350.27 ~~licensed child care providers, caregivers, and helpers caring for children under school age.~~
350.28 ~~The commissioner shall provide to child care providers and interested individuals, at cost,~~
350.29 ~~copies of a video approved by the commissioner of health under section 144.574 on the~~
350.30 ~~dangers associated with shaking infants and young children.~~

350.31 Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license
350.32 holder must comply with all seat belt and child passenger restraint system requirements
350.33 under section 169.685.

350.34 (b) Family and group family child care programs licensed by the Department of
350.35 Human Services that serve a child or children under nine years of age must document
350.36 training that fulfills the requirements in this subdivision.

351.1 (1) Before a license holder, staff person, caregiver, or helper transports a child or
351.2 children under age nine in a motor vehicle, the person placing the child or children in a
351.3 passenger restraint must satisfactorily complete training on the proper use and installation
351.4 of child restraint systems in motor vehicles. Training completed under this subdivision may
351.5 be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

351.6 (2) Training required under this subdivision must be at least one hour in length,
351.7 completed at initial training, and repeated at least once every five years. At a minimum,
351.8 the training must address the proper use of child restraint systems based on the child's
351.9 size, weight, and age, and the proper installation of a car seat or booster seat in the motor
351.10 vehicle used by the license holder to transport the child or children.

351.11 (3) Training under this subdivision must be provided by individuals who are certified
351.12 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
351.13 may obtain a list of certified and approved trainers through the Department of Public
351.14 Safety Web site or by contacting the agency.

351.15 (c) Child care providers that only transport school-age children as defined in section
351.16 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
351.17 subdivision 1, paragraph (e), are exempt from this subdivision.

351.18 **Subd. 7. Training requirements for family and group family child care.** For
351.19 purposes of family and group family child care, the license holder and each primary
351.20 caregiver must complete ~~eight~~ 16 hours of ongoing training each year. For purposes
351.21 of this subdivision, a primary caregiver is an adult caregiver who provides services in
351.22 the licensed setting for more than 30 days in any 12-month period. Repeat of topical
351.23 training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training
351.24 requirement. Additional ongoing training subjects to meet the annual 16-hour training
351.25 requirement must be selected from the following areas:

351.26 (1) "child growth and development training" ~~has the meaning given in~~ under
351.27 subdivision 2, paragraph (a);

351.28 (2) "learning environment and curriculum" ~~includes,~~ including training in
351.29 establishing an environment and providing activities that provide learning experiences to
351.30 meet each child's needs, capabilities, and interests;

351.31 (3) "assessment and planning for individual needs" ~~includes,~~ including training in
351.32 observing and assessing what children know and can do in order to provide curriculum
351.33 and instruction that addresses their developmental and learning needs, including children
351.34 with special needs and bilingual children or children for whom English is not their
351.35 primary language;

352.1 (4) "interactions with children"~~includes~~, including training in establishing
 352.2 supportive relationships with children, guiding them as individuals and as part of a group;

352.3 (5) "families and communities"~~includes~~, including training in working
 352.4 collaboratively with families and agencies or organizations to meet children's needs and to
 352.5 encourage the community's involvement;

352.6 (6) "health, safety, and nutrition"~~includes~~, including training in establishing and
 352.7 maintaining an environment that ensures children's health, safety, and nourishment,
 352.8 including child abuse, maltreatment, prevention, and reporting; home and fire safety; child
 352.9 injury prevention; communicable disease prevention and control; first aid; and CPR; ~~and~~

352.10 (7) "program planning and evaluation"~~includes~~, including training in establishing,
 352.11 implementing, evaluating, and enhancing program operations; and

352.12 (8) behavior guidance, including training in the understanding of the functions of
 352.13 child behavior and strategies for managing behavior.

352.14 Subd. 8. **Other required training requirements.** (a) The training required of
 352.15 family and group family child care providers and staff must include training in the cultural
 352.16 dynamics of early childhood development and child care. The cultural dynamics and
 352.17 disabilities training and skills development of child care providers must be designed to
 352.18 achieve outcomes for providers of child care that include, but are not limited to:

352.19 (1) an understanding and support of the importance of culture and differences in
 352.20 ability in children's identity development;

352.21 (2) understanding the importance of awareness of cultural differences and
 352.22 similarities in working with children and their families;

352.23 (3) understanding and support of the needs of families and children with differences
 352.24 in ability;

352.25 (4) developing skills to help children develop unbiased attitudes about cultural
 352.26 differences and differences in ability;

352.27 (5) developing skills in culturally appropriate caregiving; and

352.28 (6) developing skills in appropriate caregiving for children of different abilities.

352.29 The commissioner shall approve the curriculum for cultural dynamics and disability
 352.30 training.

352.31 (b) The provider must meet the training requirement in section 245A.14, subdivision
 352.32 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child
 352.33 care or group family child care home to use the swimming pool located at the home.

352.34 Subd. 9. **Supervising for safety; training requirement.** Effective July 1, 2014,
 352.35 all family child care license holders and each adult caregiver who provides care in the
 352.36 licensed family child care home for more than 30 days in any 12-month period shall

353.1 complete and document at least six hours of approved training on supervising for safety
 353.2 prior to initial licensure, and before caring for children. At least two hours of training
 353.3 on supervising for safety must be repeated annually. For purposes of this subdivision,
 353.4 "supervising for safety" includes supervision basics, supervision outdoors, equipment and
 353.5 materials, illness, injuries, and disaster preparedness. The commissioner shall develop
 353.6 the supervising for safety curriculum by January 1, 2014.

353.7 Subd. 10. **Approved training.** County licensing staff must accept training approved
 353.8 by the Minnesota Center for Professional Development, including:

353.9 (1) face-to-face or classroom training;

353.10 (2) online training; and

353.11 (3) relationship-based professional development, such as mentoring, coaching,
 353.12 and consulting.

353.13 Sec. 15. Minnesota Statutes 2012, section 246.54, is amended to read:

353.14 **246.54 LIABILITY OF COUNTY; REIMBURSEMENT.**

353.15 Subdivision 1. **County portion for cost of care.** (a) Except for chemical
 353.16 dependency services provided under sections 254B.01 to 254B.09, the client's county
 353.17 shall pay to the state of Minnesota a portion of the cost of care provided in a regional
 353.18 treatment center or a state nursing facility to a client legally settled in that county. A
 353.19 county's payment shall be made from the county's own sources of revenue and payments
 353.20 shall equal a percentage of the cost of care, as determined by the commissioner, for each
 353.21 day, or the portion thereof, that the client spends at a regional treatment center or a state
 353.22 nursing facility according to the following schedule:

353.23 (1) zero percent for the first 30 days;

353.24 (2) 20 percent for days 31 to 60; and

353.25 (3) ~~50~~ 75 percent for any days over 60.

353.26 (b) The increase in the county portion for cost of care under paragraph (a), clause
 353.27 (3), shall be imposed when the treatment facility has determined that it is clinically
 353.28 appropriate for the client to be discharged.

353.29 (c) If payments received by the state under sections 246.50 to 246.53 exceed 80
 353.30 percent of the cost of care for days 31 to 60, or ~~50~~ 25 percent for days over 60, the county
 353.31 shall be responsible for paying the state only the remaining amount. The county shall
 353.32 not be entitled to reimbursement from the client, the client's estate, or from the client's
 353.33 relatives, except as provided in section 246.53.

353.34 Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the
 353.35 Minnesota Security Hospital ~~or the Minnesota extended treatment options program.~~ For

354.1 services at ~~these facilities~~ the Minnesota Security Hospital, a county's payment shall be
 354.2 made from the county's own sources of revenue and payments ~~shall be paid as follows:~~
 354.3 Excluding the state-operated forensic transition service, payments to the state from the
 354.4 county shall equal ten percent of the cost of care, as determined by the commissioner, for
 354.5 each day, or the portion thereof, that the client spends at the facility. For the state-operated
 354.6 forensic transition service, payments to the state from the county shall equal 50 percent of
 354.7 the cost of care, as determined by the commissioner, for each day, or the portion thereof,
 354.8 that the client spends in the program. If payments received by the state under sections
 354.9 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the
 354.10 state-operated forensic transition service, exceed 90 percent of the cost of care, the county
 354.11 shall be responsible for paying the state only the remaining amount. If payments received
 354.12 by the state under sections 246.50 to 246.53 for the state-operated forensic transition service
 354.13 exceed 50 percent of the cost of care, the county shall be responsible for paying the state
 354.14 only the remaining amount. The county shall not be entitled to reimbursement from the
 354.15 client, the client's estate, or from the client's relatives, except as provided in section 246.53.

354.16 (b) Regardless of the facility to which the client is committed, subdivision 1 does
 354.17 not apply to the following individuals:

354.18 ~~(1) clients who are committed as mentally ill and dangerous under section 253B.02,~~
 354.19 ~~subdivision 17;~~

354.20 ~~(2) (1) clients who are committed as sexual psychopathic personalities under section~~
 354.21 ~~253B.02, subdivision 18b; and~~

354.22 ~~(3) (2) clients who are committed as sexually dangerous persons under section~~
 354.23 ~~253B.02, subdivision 18c.~~

354.24 ~~For each of the individuals in clauses (1) to (3), the payment by the county to the state~~
 354.25 ~~shall equal ten percent of the cost of care for each day as determined by the commissioner.~~

354.26 Sec. 16. **[256.999] CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP**
 354.27 **COUNCIL.**

354.28 Subdivision 1. Establishment; purpose. There is hereby established the Cultural
 354.29 and Ethnic Communities Leadership Council for the Department of Human Services. The
 354.30 purpose of the council is to advise the commissioner of human services on reducing
 354.31 disparities that affect racial and ethnic groups.

354.32 Subd. 2. Members. (a) The council must consist of no fewer than 15 and no more
 354.33 than 25 members appointed by the commissioner of human services, in consultation with
 354.34 county, tribal, cultural, and ethnic communities; diverse program participants; and parent
 354.35 representatives from these communities. The commissioner shall direct the development

355.1 of guidelines defining the membership of the council; setting out definitions; and
355.2 developing duties of the commissioner, the council, and council members regarding racial
355.3 and ethnic disparities reduction. The guidelines must be developed in consultation with:

355.4 (1) the chairs of relevant committees; and

355.5 (2) county, tribal, and cultural communities and program participants from these
355.6 communities.

355.7 (b) Members must be appointed to allow for representation of the following groups:

355.8 (1) racial and ethnic minority groups;

355.9 (2) tribal service providers;

355.10 (3) culturally and linguistically specific advocacy groups and service providers;

355.11 (4) human services program participants;

355.12 (5) public and private institutions;

355.13 (6) parents of human services program participants;

355.14 (7) members of the faith community;

355.15 (8) Department of Human Services employees;

355.16 (9) chairs of relevant legislative committees; and

355.17 (10) any other group the commissioner deems appropriate to facilitate the goals
355.18 and duties of the council.

355.19 (c) Each member of the council must be appointed to either a one-year or two-year
355.20 term. The commissioner shall appoint one member as chair.

355.21 (d) Notwithstanding section 15.059, members of the council shall receive no
355.22 compensation for their services.

355.23 Subd. 3. **Duties of commissioner.** (a) The commissioner of human services or the
355.24 commissioner's designee shall:

355.25 (1) maintain the council established in this section;

355.26 (2) supervise and coordinate policies for persons from racial, ethnic, cultural,
355.27 linguistic, and tribal communities who experience disparities in access and outcomes;

355.28 (3) identify human services rules or statutes affecting persons from racial, ethnic,
355.29 cultural, linguistic, and tribal communities that may need to be revised;

355.30 (4) investigate and implement cost-effective models of service delivery such as
355.31 careful adaptation of clinically proven services that constitute one strategy for increasing
355.32 the number of culturally relevant services available to currently underserved populations;

355.33 (5) based on recommendations of the council, review identified department
355.34 policies that maintain racial, ethnic, cultural, linguistic, and tribal disparities, and make
355.35 adjustments to ensure those disparities are not perpetuated; and

356.1 (6) based on recommendations of the council, submit legislation to reduce disparities
 356.2 affecting racial and ethnic groups, increase access to programs, and promote better
 356.3 outcomes.

356.4 (b) The commissioner of human services or the commissioner's designee shall
 356.5 consult with the council and receive recommendations from the council when meeting
 356.6 the requirements of this section.

356.7 Subd. 4. **Duties of council.** The Cultural and Ethnic Communities Leadership
 356.8 Council shall:

356.9 (1) recommend to the commissioner for review identified policies in the Department
 356.10 of Human Services that maintain racial, ethnic, cultural, linguistic, and tribal disparities;

356.11 (2) identify issues regarding disparities by engaging diverse populations in human
 356.12 services programs;

356.13 (3) engage in mutual learning essential for achieving human services parity and
 356.14 optimal wellness for service recipients;

356.15 (4) raise awareness about human services disparities to the legislature and media;

356.16 (5) provide technical assistance and consultation support to counties, private
 356.17 nonprofit agencies, and other service providers to build their capacity to provide equitable
 356.18 human services for persons from racial, ethnic, cultural, linguistic, and tribal communities
 356.19 who experience disparities in access and outcomes;

356.20 (6) provide technical assistance to promote statewide development of culturally
 356.21 and linguistically appropriate, accessible, and cost-effective human services and related
 356.22 policies;

356.23 (7) provide training and outreach to facilitate access to culturally and linguistically
 356.24 appropriate, accessible, and cost-effective human services to prevent disparities;

356.25 (8) facilitate culturally appropriate and culturally sensitive admissions, continued
 356.26 services, discharges, and utilization review for human services agencies and institutions;

356.27 (9) form work groups to help carry out the duties of the council that include, but are
 356.28 not limited to, persons who provide and receive services and representatives of advocacy
 356.29 groups, and provide the work groups with clear guidelines, standardized parameters, and
 356.30 tasks for the work groups to accomplish; and

356.31 (10) promote information-sharing in the human services community and statewide.

356.32 Subd. 5. **Duties of council members.** The members of the council shall:

356.33 (1) attend and participate in scheduled meetings and be prepared by reviewing
 356.34 meeting notes;

356.35 (2) maintain open communication channels with respective constituencies;

357.1 (3) identify and communicate issues and risks that could impact the timely
 357.2 completion of tasks;

357.3 (4) collaborate on disparity reduction efforts;

357.4 (5) communicate updates of the council's work progress and status on the
 357.5 Department of Human Services Web site; and

357.6 (6) participate in any activities the council or chair deem appropriate and necessary
 357.7 to facilitate the goals and duties of the council.

357.8 Subd. 6. **Expiration.** Notwithstanding section 15.059, the council does not expire
 357.9 unless directed by the commissioner.

357.10 Sec. 17. Minnesota Statutes 2012, section 256I.04, subdivision 3, is amended to read:

357.11 **Subd. 3. Moratorium on development of group residential housing beds.** (a)
 357.12 County agencies shall not enter into agreements for new group residential housing beds
 357.13 with total rates in excess of the MSA equivalent rate except:

357.14 (1) for group residential housing establishments licensed under Minnesota Rules,
 357.15 parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction
 357.16 targets for persons with developmental disabilities at regional treatment centers;

357.17 (2) to ensure compliance with the federal Omnibus Budget Reconciliation Act
 357.18 alternative disposition plan requirements for inappropriately placed persons with
 357.19 developmental disabilities or mental illness;

357.20 (3) up to 80 beds in a single, specialized facility located in Hennepin County that will
 357.21 provide housing for chronic inebriates who are repetitive users of detoxification centers
 357.22 and are refused placement in emergency shelters because of their state of intoxication,
 357.23 and planning for the specialized facility must have been initiated before July 1, 1991,
 357.24 in anticipation of receiving a grant from the Housing Finance Agency under section
 357.25 462A.05, subdivision 20a, paragraph (b);

357.26 (4) notwithstanding the provisions of subdivision 2a, for up to 190 supportive
 357.27 housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a
 357.28 mental illness, a history of substance abuse, or human immunodeficiency virus or acquired
 357.29 immunodeficiency syndrome. For purposes of this section, "homeless adult" means a
 357.30 person who is living on the street or in a shelter or discharged from a regional treatment
 357.31 center, community hospital, or residential treatment program and has no appropriate
 357.32 housing available and lacks the resources and support necessary to access appropriate
 357.33 housing. At least 70 percent of the supportive housing units must serve homeless adults
 357.34 with mental illness, substance abuse problems, or human immunodeficiency virus or
 357.35 acquired immunodeficiency syndrome who are about to be or, within the previous six

358.1 months, has been discharged from a regional treatment center, or a state-contracted
358.2 psychiatric bed in a community hospital, or a residential mental health or chemical
358.3 dependency treatment program. If a person meets the requirements of subdivision 1,
358.4 paragraph (a), and receives a federal or state housing subsidy, the group residential housing
358.5 rate for that person is limited to the supplementary rate under section 256I.05, subdivision
358.6 1a, and is determined by subtracting the amount of the person's countable income that
358.7 exceeds the MSA equivalent rate from the group residential housing supplementary rate.
358.8 A resident in a demonstration project site who no longer participates in the demonstration
358.9 program shall retain eligibility for a group residential housing payment in an amount
358.10 determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service
358.11 funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching
358.12 funds are available and the services can be provided through a managed care entity. If
358.13 federal matching funds are not available, then service funding will continue under section
358.14 256I.05, subdivision 1a;

358.15 (5) for group residential housing beds in settings meeting the requirements of
358.16 subdivision 2a, clauses (1) and (3), which are used exclusively for recipients receiving
358.17 home and community-based waiver services under sections 256B.0915, 256B.092,
358.18 subdivision 5, 256B.093, and 256B.49, and who resided in a nursing facility for the six
358.19 months immediately prior to the month of entry into the group residential housing setting.
358.20 The group residential housing rate for these beds must be set so that the monthly group
358.21 residential housing payment for an individual occupying the bed when combined with the
358.22 nonfederal share of services delivered under the waiver for that person does not exceed the
358.23 nonfederal share of the monthly medical assistance payment made for the person to the
358.24 nursing facility in which the person resided prior to entry into the group residential housing
358.25 establishment. The rate may not exceed the MSA equivalent rate plus \$426.37 for any case;

358.26 (6) for an additional two beds, resulting in a total of 32 beds, for a facility located in
358.27 Hennepin County providing services for recovering and chemically dependent men that
358.28 has had a group residential housing contract with the county and has been licensed as a
358.29 board and lodge facility with special services since 1980;

358.30 (7) for a group residential housing provider located in the city of St. Cloud, or a county
358.31 contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing
358.32 through the Minnesota Housing Finance Agency Ending Long-Term Homelessness
358.33 Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

358.34 (8) for a new 65-bed facility in Crow Wing County that will serve chemically
358.35 dependent persons, operated by a group residential housing provider that currently
358.36 operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

359.1 (9) for a group residential housing provider that operates two ten-bed facilities, one
359.2 located in Hennepin County and one located in Ramsey County, that provide community
359.3 support and 24-hour-a-day supervision to serve the mental health needs of individuals
359.4 who have chronically lived unsheltered; and

359.5 (10) for a group residential facility in Hennepin County with a capacity of up to 48
359.6 beds that has been licensed since 1978 as a board and lodging facility and that until August
359.7 1, 2007, operated as a licensed chemical dependency treatment program.

359.8 (b) A county agency may enter into a group residential housing agreement for beds
359.9 with rates in excess of the MSA equivalent rate in addition to those currently covered
359.10 under a group residential housing agreement if the additional beds are only a replacement
359.11 of beds with rates in excess of the MSA equivalent rate which have been made available
359.12 due to closure of a setting, a change of licensure or certification which removes the beds
359.13 from group residential housing payment, or as a result of the downsizing of a group
359.14 residential housing setting. The transfer of available beds from one county to another can
359.15 only occur by the agreement of both counties.

359.16 (c) Effective July 1, 2013, 35 beds with rates in excess of the MSA-equivalent rate
359.17 must be designated for youth victims of sex trafficking.

359.18 Sec. 18. Minnesota Statutes 2012, section 256I.05, subdivision 1e, is amended to read:

359.19 Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the
359.20 provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall
359.21 negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to
359.22 exceed \$700 per month, including any legislatively authorized inflationary adjustments,
359.23 for a group residential housing provider that:

359.24 (1) is located in Hennepin County and has had a group residential housing contract
359.25 with the county since June 1996;

359.26 (2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a
359.27 26-bed facility; and

359.28 (3) serves a chemically dependent clientele, providing 24 hours per day supervision
359.29 and limiting a resident's maximum length of stay to 13 months out of a consecutive
359.30 24-month period.

359.31 ~~(b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a~~
359.32 ~~supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700~~
359.33 ~~per month, including any legislatively authorized inflationary adjustments, of a group~~
359.34 ~~residential provider that:~~

360.1 ~~(1) is located in St. Louis County and has had a group residential housing contract~~
360.2 ~~with the county since 2006;~~

360.3 ~~(2) operates a 62-bed facility; and~~

360.4 ~~(3) serves a chemically dependent adult male clientele, providing 24 hours per~~
360.5 ~~day supervision and limiting a resident's maximum length of stay to 13 months out of~~
360.6 ~~a consecutive 24-month period.~~

360.7 ~~(e) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency~~
360.8 ~~shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not~~
360.9 ~~to exceed \$700 per month, including any legislatively authorized inflationary adjustments,~~
360.10 ~~for the group residential provider described under paragraphs (a) and (b), not to exceed~~
360.11 ~~an additional 115 beds.~~

360.12 Sec. 19. Minnesota Statutes 2012, section 256J.35, is amended to read:

360.13 **256J.35 AMOUNT OF ASSISTANCE PAYMENT.**

360.14 Except as provided in paragraphs (a) to ~~(e)~~ (d), the amount of an assistance payment
360.15 is equal to the difference between the MFIP standard of need or the Minnesota family
360.16 wage level in section 256J.24 and countable income.

360.17 (a) When MFIP eligibility exists for the month of application, the amount of the
360.18 assistance payment for the month of application must be prorated from the date of
360.19 application or the date all other eligibility factors are met for that applicant, whichever is
360.20 later. This provision applies when an applicant loses at least one day of MFIP eligibility.

360.21 (b) MFIP overpayments to an assistance unit must be recouped according to section
360.22 256J.38, subdivision 4.

360.23 (c) An initial assistance payment must not be made to an applicant who is not
360.24 eligible on the date payment is made.

360.25 (d) MFIP assistance units whose housing costs exceed 50 percent of their monthly
360.26 cash grant are eligible for an additional cash amount in the form of a housing assistance
360.27 grant. The housing assistance grant must be equal to 50 percent of the difference between
360.28 the assistance unit's cash grant and its housing costs, with a maximum housing assistance
360.29 grant of \$250 per month. MFIP assistance units must report their housing costs to the lead
360.30 agency on the forms and according to the timelines established by the commissioner.

360.31 **EFFECTIVE DATE.** This section is effective December 1, 2013.

360.32 Sec. 20. Minnesota Statutes 2012, section 256K.45, is amended to read:

360.33 **256K.45 ~~RUNAWAY AND HOMELESS YOUTH ACT.~~**

361.1 Subdivision 1. **Mission.** The mission of the Homeless Youth Act is to reduce
361.2 the incidence of homelessness among youth by providing integrated and supportive
361.3 services and housing to homeless youth, youth at risk of homelessness, and runaways.
361.4 The commissioner shall establish a Homeless Youth Act fund and award grants to
361.5 providers who are committed to serving homeless youth, to provide street and community
361.6 outreach and drop-in programs, emergency shelter programs, and supportive housing and
361.7 transitional living programs, consistent with the program descriptions in this act.

361.8 **Subd. 1a. Definitions.** (a) The definitions in this subdivision apply to this section.

361.9 (b) "Commissioner" means the commissioner of human services.

361.10 (c) "Homeless youth" means a person 21 years of age or younger who is
361.11 unaccompanied by a parent or guardian and is without shelter where appropriate care and
361.12 supervision are available, whose parent or legal guardian is unable or unwilling to provide
361.13 shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The
361.14 following are not fixed, regular, or adequate nighttime residences:

361.15 (1) a supervised publicly or privately operated shelter designed to provide temporary
361.16 living accommodations;

361.17 (2) an institution or a publicly or privately operated shelter designed to provide
361.18 temporary living accommodations;

361.19 (3) transitional housing;

361.20 (4) a temporary placement with a peer, friend, or family member that has not offered
361.21 permanent residence, a residential lease, or temporary lodging for more than 30 days; or

361.22 (5) a public or private place not designed for, nor ordinarily used as, a regular
361.23 sleeping accommodation for human beings.

361.24 Homeless youth does not include persons incarcerated or otherwise detained under
361.25 federal or state law.

361.26 (d) "Youth at risk of homelessness" means a person 21 years of age or younger
361.27 whose status or circumstances indicate a significant danger of experiencing homelessness
361.28 in the near future. Status or circumstances that indicate a significant danger may include:

361.29 (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3)
361.30 youth whose parents or primary caregivers are or were previously homeless; (4) youth
361.31 who are exposed to abuse and neglect in their homes; (5) youth who experience conflict
361.32 with parents due to chemical or alcohol dependency, mental health disabilities, or other
361.33 disabilities; and (6) runaways.

361.34 (e) "Runaway" means an unmarried child under the age of 18 years who is absent
361.35 from the home of a parent or guardian or other lawful placement without the consent of
361.36 the parent, guardian, or lawful custodian.

362.1 Subd. 2. **Homeless and runaway youth report.** The commissioner shall develop a
362.2 report for homeless youth, youth at risk of homelessness, and runaways. The report shall
362.3 include coordination of services as defined under subdivisions 3 to 5.

362.4 Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in
362.5 centers must provide walk-in access to crisis intervention and ongoing supportive services
362.6 including one-to-one case management services on a self-referral basis. Street and
362.7 community outreach programs must locate, contact, and provide information, referrals,
362.8 and services to homeless youth, youth at risk of homelessness, and runaways. Information,
362.9 referrals, and services provided may include, but are not limited to:

362.10 (1) family reunification services;

362.11 (2) conflict resolution or mediation counseling;

362.12 (3) assistance in obtaining temporary emergency shelter;

362.13 (4) assistance in obtaining food, clothing, medical care, or mental health counseling;

362.14 (5) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse,
362.15 sexually transmitted diseases, and pregnancy;

362.16 (6) referrals to other agencies that provide support services to homeless youth,
362.17 youth at risk of homelessness, and runaways;

362.18 (7) assistance with education, employment, and independent living skills;

362.19 (8) aftercare services;

362.20 (9) specialized services for highly vulnerable runaways and homeless youth,
362.21 including teen parents, emotionally disturbed and mentally ill youth, and sexually
362.22 exploited youth; and

362.23 (10) homelessness prevention.

362.24 Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must
362.25 provide homeless youth and runaways with referral and walk-in access to emergency,
362.26 short-term residential care. The program shall provide homeless youth and runaways with
362.27 safe, dignified shelter, including private shower facilities, beds, and at least one meal each
362.28 day; and shall assist a runaway and homeless youth with reunification with the family or
362.29 legal guardian when required or appropriate.

362.30 (b) The services provided at emergency shelters may include, but are not limited to:

362.31 (1) family reunification services;

362.32 (2) individual, family, and group counseling;

362.33 (3) assistance obtaining clothing;

362.34 (4) access to medical and dental care and mental health counseling;

362.35 (5) education and employment services;

362.36 (6) recreational activities;

- 363.1 (7) advocacy and referral services;
 363.2 (8) independent living skills training;
 363.3 (9) aftercare and follow-up services;
 363.4 (10) transportation; and
 363.5 (11) homelessness prevention.

363.6 Subd. 5. **Supportive housing and transitional living programs.** Transitional
 363.7 living programs must help homeless youth and youth at risk of homelessness to find and
 363.8 maintain safe, dignified housing. The program may also provide rental assistance and
 363.9 related supportive services, or refer youth to other organizations or agencies that provide
 363.10 such services. Services provided may include, but are not limited to:

- 363.11 (1) educational assessment and referrals to educational programs;
 363.12 (2) career planning, employment, work skill training, and independent living skills
 363.13 training;
 363.14 (3) job placement;
 363.15 (4) budgeting and money management;
 363.16 (5) assistance in securing housing appropriate to needs and income;
 363.17 (6) counseling regarding violence, ~~prostitution~~ sexual exploitation, substance abuse,
 363.18 sexually transmitted diseases, and pregnancy;
 363.19 (7) referral for medical services or chemical dependency treatment;
 363.20 (8) parenting skills;
 363.21 (9) self-sufficiency support services or life skill training;
 363.22 (10) aftercare and follow-up services; and
 363.23 (11) homelessness prevention.

363.24 Subd. 6. **Funding.** ~~Any Funds appropriated for this section may be expended on~~
 363.25 ~~programs described under subdivisions 3 to 5, technical assistance, and capacity building.~~
 363.26 ~~Up to four percent of funds appropriated may be used for the purpose of monitoring and~~
 363.27 ~~evaluating runaway and homeless youth programs receiving funding under this section.~~
 363.28 ~~Funding shall be directed to meet the greatest need, with a significant share of the funding~~
 363.29 ~~focused on homeless youth providers in greater Minnesota to meet the greatest need on~~
 363.30 ~~a statewide basis. Programs funded under this section must submit demographic and~~
 363.31 ~~outcome information to the commissioner. The commissioner must submit a report~~
 363.32 ~~regarding program demographic and outcome information to the legislature upon request.~~

363.33 Sec. 21. Minnesota Statutes 2012, section 257.0755, subdivision 1, is amended to read:

363.34 Subdivision 1. **Creation.** ~~One~~ Each ombudsperson shall operate independently from
 363.35 but in collaboration with ~~each of the following groups~~ the community-specific board that

364.1 appointed the ombudsperson under section 257.0768: the Indian Affairs Council, the
364.2 Council on Affairs of Chicano/Latino people, the Council on Black Minnesotans, and
364.3 the Council on Asian-Pacific Minnesotans.

364.4 Sec. 22. Minnesota Statutes 2012, section 260B.007, subdivision 6, is amended to read:

364.5 Subd. 6. **Delinquent child.** (a) Except as otherwise provided in paragraphs (b)
364.6 and (c), "delinquent child" means a child:

364.7 (1) who has violated any state or local law, except as provided in section 260B.225,
364.8 subdivision 1, and except for juvenile offenders as described in subdivisions 16 to 18;

364.9 (2) who has violated a federal law or a law of another state and whose case has been
364.10 referred to the juvenile court if the violation would be an act of delinquency if committed
364.11 in this state or a crime or offense if committed by an adult;

364.12 (3) who has escaped from confinement to a state juvenile correctional facility after
364.13 being committed to the custody of the commissioner of corrections; or

364.14 (4) who has escaped from confinement to a local juvenile correctional facility after
364.15 being committed to the facility by the court.

364.16 (b) The term delinquent child does not include a child alleged to have committed
364.17 murder in the first degree after becoming 16 years of age, but the term delinquent child
364.18 does include a child alleged to have committed attempted murder in the first degree.

364.19 (c) The term delinquent child does not include a child ~~under the age of 16 years~~
364.20 alleged to have engaged in conduct which would, if committed by an adult, violate any
364.21 federal, state, or local law relating to being hired, offering to be hired, or agreeing to be
364.22 hired by another individual to engage in sexual penetration or sexual conduct.

364.23 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
364.24 offenses committed on or after that date.

364.25 Sec. 23. Minnesota Statutes 2012, section 260B.007, subdivision 16, is amended to read:

364.26 Subd. 16. **Juvenile petty offender; juvenile petty offense.** (a) "Juvenile petty
364.27 offense" includes a juvenile alcohol offense, a juvenile controlled substance offense,
364.28 a violation of section 609.685, or a violation of a local ordinance, which by its terms
364.29 prohibits conduct by a child under the age of 18 years which would be lawful conduct if
364.30 committed by an adult.

364.31 (b) Except as otherwise provided in paragraph (c), "juvenile petty offense" also
364.32 includes an offense that would be a misdemeanor if committed by an adult.

364.33 (c) "Juvenile petty offense" does not include any of the following:

365.1 (1) a misdemeanor-level violation of section 518B.01, 588.20, 609.224, 609.2242,
365.2 609.324, subdivision 2 or 3, 609.5632, 609.576, 609.66, 609.746, 609.748, 609.79,
365.3 or 617.23;

365.4 (2) a major traffic offense or an adult court traffic offense, as described in section
365.5 260B.225;

365.6 (3) a misdemeanor-level offense committed by a child whom the juvenile court
365.7 previously has found to have committed a misdemeanor, gross misdemeanor, or felony
365.8 offense; or

365.9 (4) a misdemeanor-level offense committed by a child whom the juvenile court
365.10 has found to have committed a misdemeanor-level juvenile petty offense on two or
365.11 more prior occasions, unless the county attorney designates the child on the petition
365.12 as a juvenile petty offender notwithstanding this prior record. As used in this clause,
365.13 "misdemeanor-level juvenile petty offense" includes a misdemeanor-level offense that
365.14 would have been a juvenile petty offense if it had been committed on or after July 1, 1995.

365.15 (d) A child who commits a juvenile petty offense is a "juvenile petty offender." The
365.16 term juvenile petty offender does not include a child ~~under the age of 16 years~~ alleged
365.17 to have violated any law relating to being hired, offering to be hired, or agreeing to be
365.18 hired by another individual to engage in sexual penetration or sexual conduct which, if
365.19 committed by an adult, would be a misdemeanor.

365.20 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
365.21 offenses committed on or after that date.

365.22 Sec. 24. Minnesota Statutes 2012, section 260C.007, subdivision 6, is amended to read:

365.23 Subd. 6. **Child in need of protection or services.** "Child in need of protection or
365.24 services" means a child who is in need of protection or services because the child:

365.25 (1) is abandoned or without parent, guardian, or custodian;

365.26 (2)(i) has been a victim of physical or sexual abuse as defined in section 626.556,
365.27 subdivision 2, (ii) resides with or has resided with a victim of child abuse as defined in
365.28 subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or
365.29 would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or
365.30 child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment
365.31 as defined in subdivision 15;

365.32 (3) is without necessary food, clothing, shelter, education, or other required care
365.33 for the child's physical or mental health or morals because the child's parent, guardian,
365.34 or custodian is unable or unwilling to provide that care;

366.1 (4) is without the special care made necessary by a physical, mental, or emotional
366.2 condition because the child's parent, guardian, or custodian is unable or unwilling to
366.3 provide that care;

366.4 (5) is medically neglected, which includes, but is not limited to, the withholding of
366.5 medically indicated treatment from a disabled infant with a life-threatening condition. The
366.6 term "withholding of medically indicated treatment" means the failure to respond to the
366.7 infant's life-threatening conditions by providing treatment, including appropriate nutrition,
366.8 hydration, and medication which, in the treating physician's or physicians' reasonable
366.9 medical judgment, will be most likely to be effective in ameliorating or correcting all
366.10 conditions, except that the term does not include the failure to provide treatment other
366.11 than appropriate nutrition, hydration, or medication to an infant when, in the treating
366.12 physician's or physicians' reasonable medical judgment:

366.13 (i) the infant is chronically and irreversibly comatose;

366.14 (ii) the provision of the treatment would merely prolong dying, not be effective in
366.15 ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be
366.16 futile in terms of the survival of the infant; or

366.17 (iii) the provision of the treatment would be virtually futile in terms of the survival
366.18 of the infant and the treatment itself under the circumstances would be inhumane;

366.19 (6) is one whose parent, guardian, or other custodian for good cause desires to be
366.20 relieved of the child's care and custody, including a child who entered foster care under a
366.21 voluntary placement agreement between the parent and the responsible social services
366.22 agency under section 260C.227;

366.23 (7) has been placed for adoption or care in violation of law;

366.24 (8) is without proper parental care because of the emotional, mental, or physical
366.25 disability, or state of immaturity of the child's parent, guardian, or other custodian;

366.26 (9) is one whose behavior, condition, or environment is such as to be injurious or
366.27 dangerous to the child or others. An injurious or dangerous environment may include, but
366.28 is not limited to, the exposure of a child to criminal activity in the child's home;

366.29 (10) is experiencing growth delays, which may be referred to as failure to thrive, that
366.30 have been diagnosed by a physician and are due to parental neglect;

366.31 (11) ~~has engaged in prostitution as defined in section 609.321, subdivision 9~~ is a
366.32 sexually exploited youth;

366.33 (12) has committed a delinquent act or a juvenile petty offense before becoming
366.34 ten years old;

366.35 (13) is a runaway;

366.36 (14) is a habitual truant;

367.1 (15) has been found incompetent to proceed or has been found not guilty by reason
 367.2 of mental illness or mental deficiency in connection with a delinquency proceeding, a
 367.3 certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a
 367.4 proceeding involving a juvenile petty offense; or

367.5 (16) has a parent whose parental rights to one or more other children were
 367.6 involuntarily terminated or whose custodial rights to another child have been involuntarily
 367.7 transferred to a relative and there is a case plan prepared by the responsible social services
 367.8 agency documenting a compelling reason why filing the termination of parental rights
 367.9 petition under section 260C.301, subdivision 3, is not in the best interests of the child; or

367.10 ~~(17) is a sexually exploited youth.~~

367.11 **EFFECTIVE DATE.** This section is effective August 1, 2014.

367.12 Sec. 25. Minnesota Statutes 2012, section 260C.007, subdivision 31, is amended to read:

367.13 Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an
 367.14 individual who:

367.15 (1) is alleged to have engaged in conduct which would, if committed by an adult,
 367.16 violate any federal, state, or local law relating to being hired, offering to be hired, or
 367.17 agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

367.18 (2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345,
 367.19 609.3451, 609.3453, 609.352, 617.246, or 617.247;

367.20 (3) is a victim of a crime described in United States Code, title 18, section 2260;
 367.21 2421; 2422; 2423; 2425; 2425A; or 2256; or

367.22 (4) is a sex trafficking victim as defined in section 609.321, subdivision 7b.

367.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

367.24 Sec. 26. Laws 1998, chapter 407, article 6, section 116, is amended to read:

367.25 Sec. 116. **EBT TRANSACTION COSTS; ~~APPROVAL FROM LEGISLATURE.~~**

367.26 The commissioner of human services shall ~~request and receive approval from the~~
 367.27 ~~legislature before adjusting the payment to~~ not subsidize retailers for electronic benefit
 367.28 transfer ~~transaction costs~~ Supplemental Nutrition Assistance Program transactions.

367.29 **EFFECTIVE DATE.** This section is effective 30 days after the commissioner
 367.30 notifies retailers of the termination of their agreement with the state. The commissioner of
 367.31 human services must notify the revisor of statutes of that date.

368.1 Sec. 27. Laws 2011, First Special Session chapter 9, article 1, section 3, the effective
368.2 date, is amended to read:

368.3 **EFFECTIVE DATE.** This section is effective ~~January 1, 2013~~ July 1, 2014.

368.4 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2013.

368.5 Sec. 28. **INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO**
368.6 **CRIMINAL BACKGROUND CHECKS.**

368.7 (a) If the Department of Health is not reviewed by the Sunset Advisory Commission
368.8 according to the schedule in Minnesota Statutes, section 3D.21, the commissioner
368.9 of health, as the regulator for occupational therapy practitioners, speech-language
368.10 pathologists, audiologists, and hearing instrument dispensers, shall require applicants
368.11 for licensure or renewal to submit to a criminal history records check as required under
368.12 Minnesota Statutes, section 214.075, for other health-related licensed occupations
368.13 regulated by the health-related licensing boards.

368.14 (b) Any statutory changes necessary to include the commissioner of health to
368.15 Minnesota Statutes, section 214.075, shall be included in the plan required in Minnesota
368.16 Statutes, section 214.075, subdivision 8.

368.17 Sec. 29. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET**
368.18 **EXCLUSION.**

368.19 (a) The commissioner of human services shall not count conditional cash transfers
368.20 made to families participating in a family independence demonstration as income or
368.21 assets for purposes of determining or redetermining eligibility for child care assistance
368.22 programs under Minnesota Statutes, chapter 119B; general assistance under Minnesota
368.23 Statutes, chapter 256D; group residential housing under Minnesota Statutes, chapter 256I;
368.24 the Minnesota family investment program, work benefit program, or diversionary work
368.25 program under Minnesota Statutes, chapter 256J; or the MinnesotaCare program under
368.26 Minnesota Statutes, chapter 256L, during the duration of the demonstration.

368.27 (b) The commissioner of human services shall not count conditional cash transfers
368.28 made to families participating in a family independence demonstration as income or assets
368.29 for purposes of determining or redetermining eligibility for medical assistance under
368.30 Minnesota Statutes, chapter 256B, and MinnesotaCare under Minnesota Statutes, chapter
368.31 256L, except that for enrollees subject to a modified adjusted gross income calculation to
368.32 determine eligibility, the conditional cash transfer payments shall be counted as income if

369.1 they are included on the enrollee's federal tax return as income, or if the payments can be
369.2 taken into account in the month of receipt as a lump sum payment.

369.3 (c) The commissioner of the Minnesota Housing Finance Agency shall not count
369.4 conditional cash transfers made to families participating in a family independence
369.5 demonstration as income or assets for purposes of determining or redetermining eligibility
369.6 for housing assistance programs under Minnesota Statutes, section 462A.201, during
369.7 the duration of the demonstration.

369.8 (d) For the purposes of this section:

369.9 (1) "conditional cash transfer" means a payment made to a participant in a family
369.10 independence demonstration by a sponsoring organization to incent, support, or facilitate
369.11 participation; and

369.12 (2) "family independence demonstration" means an initiative sponsored or
369.13 cosponsored by a governmental or nongovernmental organization, the goal of which is
369.14 to facilitate individualized goal-setting and peer support for cohorts of no more than 12
369.15 families each toward the development of financial and nonfinancial assets that enable the
369.16 participating families to achieve financial independence.

369.17 **Sec. 30. REDUCTION OF YOUTH HOMELESSNESS.**

369.18 (a) The Minnesota Interagency Council on Homelessness established under the
369.19 authority of Minnesota Statutes, section 462A.29, as it updates its statewide plan to
369.20 prevent and end homelessness, shall make recommendations on strategies to reduce the
369.21 number of youth experiencing homelessness and to prevent homelessness for youth who
369.22 are at risk of becoming homeless.

369.23 (b) Recommended strategies must take into consideration, to the extent feasible,
369.24 issues that contribute to or reduce youth homelessness including, but not limited to, mental
369.25 health, chemical dependency, trafficking of youth for sex or other purposes, exiting foster
369.26 care, and involvement in gangs. The recommended strategies must include supportive
369.27 services as outlined in Minnesota Statutes, section 256K.45, subdivision 5.

369.28 (c) The council shall provide an update on the status of its work by December 1,
369.29 2014, to the legislative committees with jurisdiction over housing, homelessness, and
369.30 matters pertaining to youth. If the council determines legislative action is required to
369.31 implement recommended strategies, the council shall submit proposals to the legislature at
369.32 the earliest possible opportunity.

369.33 **Sec. 31. REPEALER.**

370.1 (a) Minnesota Statutes 2012, sections 256J.24, subdivision 6; and 256K.45,
370.2 subdivision 2, are repealed.

370.3 (b) Minnesota Statutes 2012, section 609.093, is repealed.

370.4 **EFFECTIVE DATE.** Paragraph (b) is effective the day following final enactment.

370.5 **ARTICLE 11**

370.6 **HOME CARE PROVIDERS**

370.7 Section 1. Minnesota Statutes 2012, section 144.051, is amended by adding a
370.8 subdivision to read:

370.9 Subd. 3. **Data classification; private data.** For providers regulated pursuant to
370.10 sections 144A.43 to 144A.482, the following data collected, created, or maintained by the
370.11 commissioner are classified as "private data" as defined in section 13.02, subdivision 12:

370.12 (1) data submitted by or on behalf of applicants for licenses prior to issuance of
370.13 the license;

370.14 (2) the identity of complainants who have made reports concerning licensees or
370.15 applicants unless the complainant consents to the disclosure;

370.16 (3) the identity of individuals who provide information as part of surveys and
370.17 investigations;

370.18 (4) Social Security numbers; and

370.19 (5) health record data.

370.20 Sec. 2. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
370.21 to read:

370.22 Subd. 4. **Data classification; public data.** For providers regulated pursuant to
370.23 sections 144A.43 to 144A.482, the following data collected, created, or maintained by the
370.24 commissioner are classified as "public data" as defined in section 13.02, subdivision 15:

370.25 (1) all application data on licensees, license numbers, license status;

370.26 (2) licensing information about licenses previously held under this chapter;

370.27 (3) correction orders, including information about compliance with the order and
370.28 whether the fine was paid;

370.29 (4) final enforcement actions pursuant to chapter 14;

370.30 (5) orders for hearing, findings of fact and conclusions of law; and

370.31 (6) when the licensee and department agree to resolve the matter without a hearing,
370.32 the agreement and specific reasons for the agreement are public data.

371.1 Sec. 3. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
371.2 to read:

371.3 Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to
371.4 sections 144A.43 to 144A.482, the following data collected, created, or maintained by
371.5 the Department of Health are classified as "confidential data" as defined in section 13.02,
371.6 subdivision 3: active investigative data relating to the investigation of potential violations
371.7 of law by licensee including data from the survey process before the correction order is
371.8 issued by the department.

371.9 Sec. 4. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
371.10 to read:

371.11 Subd. 6. **Release of private or confidential data.** For providers regulated pursuant
371.12 to sections 144A.43 to 144A.482, the department may release private or confidential
371.13 data, except Social Security numbers, to the appropriate state, federal, or local agency
371.14 and law enforcement office to enhance investigative or enforcement efforts or further
371.15 public health protective process. Types of offices include, but are not limited to, Adult
371.16 Protective Services, Office of the Ombudsmen for Long-Term Care and Office of the
371.17 Ombudsmen for Mental Health and Developmental Disabilities, the health licensing
371.18 boards, Department of Human Services, county or city attorney's offices, police, and local
371.19 or county public health offices.

371.20 Sec. 5. Minnesota Statutes 2012, section 144A.43, is amended to read:

371.21 **144A.43 DEFINITIONS.**

371.22 Subdivision 1. **Applicability.** The definitions in this section apply to sections
371.23 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.

371.24 Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall
371.25 be served and who is authorized to accept service of notices and orders on behalf of
371.26 the home care provider.

371.27 Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association,
371.28 corporation, unit of government, or other entity that applies for a temporary license,
371.29 license, or renewal of their home care provider license under section 144A.472.

371.30 Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

371.31 Subd. 1d. **Client record.** "Client record" means all records that document
371.32 information about the home care services provided to the client by the home care provider.

371.33 Subd. 1e. **Client representative.** "Client representative" means a person who,
371.34 because of the client's needs, makes decisions about the client's care on behalf of the

372.1 client. A client representative may be a guardian, health care agent, family member, or
 372.2 other agent of the client. Nothing in this section expands or diminishes the rights of
 372.3 persons to act on behalf of clients under other law.

372.4 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

372.5 Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given
 372.6 in section 152.01, subdivision 4.

372.7 Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

372.8 Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken by
 372.9 mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary
 372.10 ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and
 372.11 substances such as enzymes, organ tissue, glandulars, or metabolites.

372.12 Subd. 2d. **Dietitian.** "Dietitian" is a person licensed under sections 148.621 to
 372.13 148.633.

372.14 Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is
 372.15 performed by a licensed dietician or licensed nutritionist and includes the activities of
 372.16 assessment, setting priorities and objectives, providing nutrition counseling, developing
 372.17 and implementing nutrition care services, and evaluating and maintaining appropriate
 372.18 standards of quality of nutrition care under sections 148.621 to 148.633.

372.19 Subd. 3. **Home care service.** "Home care service" means any of the following
 372.20 services when delivered in a place of residence to the home of a person whose illness,
 372.21 disability, or physical condition creates a need for the service:

372.22 ~~(1) nursing services, including the services of a home health aide;~~

372.23 ~~(2) personal care services not included under sections 148.171 to 148.285;~~

372.24 ~~(3) physical therapy;~~

372.25 ~~(4) speech therapy;~~

372.26 ~~(5) respiratory therapy;~~

372.27 ~~(6) occupational therapy;~~

372.28 ~~(7) nutritional services;~~

372.29 ~~(8) home management services when provided to a person who is unable to perform~~
 372.30 ~~these activities due to illness, disability, or physical condition. Home management~~
 372.31 ~~services include at least two of the following services: housekeeping, meal preparation,~~
 372.32 ~~and shopping;~~

372.33 ~~(9) medical social services;~~

372.34 ~~(10) the provision of medical supplies and equipment when accompanied by the~~
 372.35 ~~provision of a home care service; and~~

373.1 ~~(11) other similar medical services and health-related support services identified by~~
 373.2 ~~the commissioner in rule.~~

373.3 ~~"Home care service" does not include the following activities conducted by the~~
 373.4 ~~commissioner of health or a board of health as defined in section 145A.02, subdivision 2:~~
 373.5 ~~communicable disease investigations or testing; administering or monitoring a prescribed~~
 373.6 ~~therapy necessary to control or prevent a communicable disease; or the monitoring~~
 373.7 ~~of an individual's compliance with a health directive as defined in section 144.4172,~~
 373.8 ~~subdivision 6.~~

373.9 (1) assistive tasks provided by unlicensed personnel;

373.10 (2) services provided by a registered nurse or licensed practical nurse, physical
 373.11 therapist, respiratory therapist, occupational therapist, speech-language pathologist,
 373.12 dietitian or nutritionist, or social worker;

373.13 (3) medication and treatment management services; or

373.14 (4) the provision of durable medical equipment services when provided with any of
 373.15 the home care services listed in clauses (1) to (3).

373.16 Subd. 3a. **Hands-on-assistance.** "Hands-on-assistance" means physical help by
 373.17 another person without which the client is not able to perform the activity.

373.18 Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of
 373.19 residence.

373.20 Subd. 4. **Home care provider.** "Home care provider" means an individual,
 373.21 organization, association, corporation, unit of government, or other entity that is regularly
 373.22 engaged in the delivery of at least one home care service, directly or by contractual
 373.23 arrangement, of home care services in a client's home for a fee and who has a valid current
 373.24 temporary license or license issued under sections 144A.43 to 144A.482. At least one
 373.25 home care service must be provided directly, although additional home care services may
 373.26 be provided by contractual arrangements. "Home care provider" does not include:

373.27 (1) any home care or nursing services conducted by and for the adherents of any
 373.28 recognized church or religious denomination for the purpose of providing care and
 373.29 services for those who depend upon spiritual means, through prayer alone, for healing;

373.30 (2) an individual who only provides services to a relative;

373.31 (3) an individual not connected with a home care provider who provides assistance
 373.32 with home management services or personal care needs if the assistance is provided
 373.33 primarily as a contribution and not as a business;

373.34 (4) an individual not connected with a home care provider who shares housing with
 373.35 and provides primarily housekeeping or homemaking services to an elderly or disabled
 373.36 person in return for free or reduced-cost housing;

374.1 ~~(5) an individual or agency providing home-delivered meal services;~~

374.2 ~~(6) an agency providing senior companion services and other older American~~
374.3 ~~volunteer programs established under the Domestic Volunteer Service Act of 1973,~~
374.4 ~~Public Law 98-288;~~

374.5 ~~(7) an employee of a nursing home licensed under this chapter or an employee of a~~
374.6 ~~boarding care home licensed under sections 144.50 to 144.56 who responds to occasional~~
374.7 ~~emergency calls from individuals residing in a residential setting that is attached to or~~
374.8 ~~located on property contiguous to the nursing home or boarding care home;~~

374.9 ~~(8) a member of a professional corporation organized under chapter 319B that does~~
374.10 ~~not regularly offer or provide home care services as defined in subdivision 3;~~

374.11 ~~(9) the following organizations established to provide medical or surgical services~~
374.12 ~~that do not regularly offer or provide home care services as defined in subdivision 3:~~
374.13 ~~a business trust organized under sections 318.01 to 318.04, a nonprofit corporation~~
374.14 ~~organized under chapter 317A, a partnership organized under chapter 323, or any other~~
374.15 ~~entity determined by the commissioner;~~

374.16 ~~(10) an individual or agency that provides medical supplies or durable medical~~
374.17 ~~equipment, except when the provision of supplies or equipment is accompanied by a~~
374.18 ~~home care service;~~

374.19 ~~(11) an individual licensed under chapter 147; or~~

374.20 ~~(12) an individual who provides home care services to a person with a developmental~~
374.21 ~~disability who lives in a place of residence with a family, foster family, or primary caregiver.~~

374.22 ~~Subd. 5. **Medication reminder.** "Medication reminder" means providing a verbal~~
374.23 ~~or visual reminder to a client to take medication. This includes bringing the medication~~
374.24 ~~to the client and providing liquids or nutrition to accompany medication that a client is~~
374.25 ~~self-administering.~~

374.26 ~~Subd. 6. **License.** "License" means a basic or comprehensive home care license~~
374.27 ~~issued by the commissioner to a home care provider.~~

374.28 ~~Subd. 7. **Licensed health professional.** "Licensed health professional" means a~~
374.29 ~~person, other than a registered nurse or licensed practical nurse, who provides home care~~
374.30 ~~services within the scope of practice of the person's health occupation license, registration,~~
374.31 ~~or certification as regulated and who is licensed by the appropriate Minnesota state board~~
374.32 ~~or agency.~~

374.33 ~~Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under~~
374.34 ~~this chapter.~~

375.1 Subd. 9. **Managerial official.** "Managerial official" means an administrator,
375.2 director, officer, trustee, or employee of a home care provider, however designated, who
375.3 has the authority to establish or control business policy.

375.4 Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug.
375.5 For purposes of this chapter only, medication includes dietary supplements.

375.6 Subd. 11. **Medication administration.** "Medication administration" means
375.7 performing a set of tasks to ensure a client takes medications, and includes the following:

375.8 (1) checking the client's medication record;

375.9 (2) preparing the medication as necessary;

375.10 (3) administering the medication to the client;

375.11 (4) documenting the administration or reason for not administering the medication;

375.12 and

375.13 (5) reporting to a nurse any concerns about the medication, the client, or the client's
375.14 refusal to take the medication.

375.15 Subd. 12. **Medication management.** "Medication management" means the
375.16 provision of any of the following medication-related services to a client:

375.17 (1) performing medication setup;

375.18 (2) administering medication;

375.19 (3) storing and securing medications;

375.20 (4) documenting medication activities;

375.21 (5) verifying and monitoring effectiveness of systems to ensure safe handling and
375.22 administration;

375.23 (6) coordinating refills;

375.24 (7) handling and implementing changes to prescriptions;

375.25 (8) communicating with the pharmacy about the client's medications; and

375.26 (9) coordinating and communicating with the prescriber.

375.27 Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a
375.28 nurse, pharmacy, or authorized prescriber for later administration by the client or by
375.29 comprehensive home care staff.

375.30 Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to
375.31 148.285.

375.32 Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is
375.33 licensed under sections 148.6401 to 148.6450.

375.34 Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is
375.35 not required by federal law to bear the symbol "Rx only."

376.1 Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who
376.2 has five percent or more of equity interest in a limited partnership, a person who owns or
376.3 controls voting stock in a corporation in an amount equal to or greater than five percent of
376.4 the shares issued and outstanding, or a corporation that owns equity interest in a licensee
376.5 or applicant for a license.

376.6 Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01,
376.7 subdivision 3.

376.8 Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed
376.9 under sections 148.65 to 148.78.

376.10 Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.

376.11 Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections
376.12 148.235; 151.01, subdivision 23; and 151.37, to prescribe prescription drugs.

376.13 Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01,
376.14 subdivision 16.

376.15 Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned
376.16 to be completed at predetermined times or according to a predetermined routine.

376.17 Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder
376.18 to a client.

376.19 Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who
376.20 is licensed under chapter 147C.

376.21 Subd. 26. **Revenues.** "Revenues" means all money received by a licensee derived
376.22 from the provision of home care services, including fees for services and appropriations
376.23 of public money for home care services.

376.24 Subd. 27. **Service plan.** "Service plan" means the written plan between the client or
376.25 client's representative and the temporary licensee or licensee about the services that will
376.26 be provided to the client.

376.27 Subd. 28. **Social worker.** "Social worker" means a person who is licensed under
376.28 chapter 148D or 148E.

376.29 Subd. 29. **Speech language pathologist.** "Speech language pathologist" has the
376.30 meaning given in section 148.512.

376.31 Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another
376.32 person within arm's reach to minimize the risk of injury while performing daily activities
376.33 through physical intervention or cuing.

376.34 Subd. 31. **Substantial compliance.** "Substantial compliance" means complying
376.35 with the requirements in this chapter sufficiently to prevent unacceptable health or safety
376.36 risks to the home care client.

377.1 Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for
 377.2 licensure for compliance with this chapter.

377.3 Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized
 377.4 to conduct surveys of home care providers and applicants.

377.5 Subd. 34. **Temporary license.** "Temporary license" means the initial basic or
 377.6 comprehensive home care license the department issues after approval of a complete
 377.7 written application and before the department completes the temporary license survey and
 377.8 determines that the temporary licensee is in substantial compliance.

377.9 Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision
 377.10 of care, other than medications, ordered or prescribed by a licensed health professional
 377.11 provided to a client to cure, rehabilitate, or ease symptoms.

377.12 Subd. 36. **Unit of government.** "Unit of government" means every city, county,
 377.13 town, school district, other political subdivisions of the state, and any agency of the state
 377.14 or federal government, which includes any instrumentality of a unit of government.

377.15 Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not
 377.16 otherwise licensed or certified by a governmental health board or agency who provide
 377.17 home care services in the client's home.

377.18 Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

377.19 Sec. 6. Minnesota Statutes 2012, section 144A.44, is amended to read:

377.20 **144A.44 HOME CARE BILL OF RIGHTS.**

377.21 Subdivision 1. **Statement of rights.** A person who receives home care services
 377.22 has these rights:

377.23 (1) the right to receive written information about rights ~~in advance of~~ before
 377.24 ~~receiving care or during the initial evaluation visit before the initiation of treatment~~
 377.25 services, including what to do if rights are violated;

377.26 (2) the right to receive care and services according to a suitable and up-to-date plan,
 377.27 and subject to accepted health care, medical or nursing standards, to take an active part
 377.28 ~~in creating and changing the plan~~ developing, modifying, and evaluating care the plan
 377.29 and services;

377.30 (3) the right to be told ~~in advance of~~ before receiving care ~~about the services that will~~
 377.31 ~~be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will
 377.32 be providing the services, the frequency of visits proposed to be furnished, other choices
 377.33 that are available for addressing home care needs, and ~~the consequences of these choices~~
 377.34 ~~including~~ the potential consequences of refusing these services;

378.1 (4) the right to be told in advance of any ~~change~~ recommended changes by the
 378.2 provider in the service plan of care and to take an active part in any ~~change~~ decisions
 378.3 about changes to the service plan;

378.4 (5) the right to refuse services or treatment;

378.5 (6) the right to know, ~~in advance~~ before receiving services or during the initial
 378.6 visit, any limits to the services available from a home care provider, and the provider's
 378.7 grounds for a termination of services;

378.8 (7) ~~the right to know in advance of receiving care whether the services are covered~~
 378.9 ~~by health insurance, medical assistance, or other health programs, the charges for services~~
 378.10 ~~that will not be covered by Medicare, and the charges that the individual may have to pay;~~

378.11 (8) (7) the right to know be told before services are initiated what the provider
 378.12 charges are for the services, no matter who will be paying the bill and if known to what
 378.13 extent payment may be expected from health insurance, public programs or other sources,
 378.14 and what charges the client may be responsible for paying;

378.15 (9) (8) the right to know that there may be other services available in the community,
 378.16 including other home care services and providers, and to know where to go for find
 378.17 information about these services;

378.18 (10) (9) the right to choose freely among available providers and to change providers
 378.19 after services have begun, within the limits of health insurance, long-term care insurance,
 378.20 medical assistance, or other health programs;

378.21 (11) (10) the right to have personal, financial, and medical information kept private,
 378.22 and to be advised of the provider's policies and procedures regarding disclosure of such
 378.23 information;

378.24 (12) (11) the right to be allowed access to the client's own records and written
 378.25 information from those records in accordance with sections 144.291 to 144.298;

378.26 (13) (12) the right to be served by people who are properly trained and competent
 378.27 to perform their duties;

378.28 (14) (13) the right to be treated with courtesy and respect, and to have the patient's
 378.29 client's property treated with respect;

378.30 (15) (14) the right to be free from physical and verbal abuse, neglect, financial
 378.31 exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and
 378.32 the Maltreatment of Minors Act;

378.33 (16) (15) the right to reasonable, advance notice of changes in services or charges;
 378.34 including;

378.35 (17) the right to know the provider's reason for termination of services;

379.1 (17) the right to at least ten days' advance notice of the termination of a service by a
 379.2 provider, except in cases where:

379.3 (i) the recipient of services client engages in conduct that significantly alters the
 379.4 conditions of employment as specified in the employment contract between terms of
 379.5 the service plan with the home care provider and the individual providing home care
 379.6 services, or creates;

379.7 (ii) the client, person who lives with the client, or others create an abusive or unsafe
 379.8 work environment for the individual person providing home care services; or

379.9 (ii) (iii) an emergency for the informal caregiver or a significant change in the
 379.10 recipient's client's condition has resulted in service needs that exceed the current service
 379.11 provider agreement plan and that cannot be safely met by the home care provider;

379.12 ~~(17)~~ (18) the right to a coordinated transfer when there will be a change in the
 379.13 provider of services;

379.14 ~~(18)~~ (19) the right to voice grievances regarding treatment or care that is complain
 379.15 about services that are provided, or fails to be, furnished, or regarding fail to be provided,
 379.16 and the lack of courtesy or respect to the patient client or the patient's client's property;

379.17 ~~(19)~~ (20) the right to know how to contact an individual associated with the home
 379.18 care provider who is responsible for handling problems and to have the home care provider
 379.19 investigate and attempt to resolve the grievance or complaint;

379.20 ~~(20)~~ (21) the right to know the name and address of the state or county agency to
 379.21 contact for additional information or assistance; and

379.22 ~~(21)~~ (22) the right to assert these rights personally, or have them asserted by
 379.23 the patient's family or guardian when the patient has been judged incompetent, client's
 379.24 representative or by anyone on behalf of the client, without retaliation.

379.25 **Subd. 2. Interpretation and enforcement of rights.** These rights are established
 379.26 for the benefit of persons clients who receive home care services. "Home care services"
 379.27 means home care services as defined in section 144A.43, subdivision 3, and unlicensed
 379.28 personal care assistance services, including services covered by medical assistance under
 379.29 section 256B.0625, subdivision 19a. All home care providers, including those exempted
 379.30 under section 144A.471, must comply with this section. The commissioner shall enforce
 379.31 this section and the home care bill of rights requirement against home care providers
 379.32 exempt from licensure in the same manner as for licensees. A home care provider may
 379.33 not request or require a person client to surrender any of these rights as a condition of
 379.34 receiving services. A guardian or conservator or, when there is no guardian or conservator,
 379.35 a designated person, may seek to enforce these rights. This statement of rights does not
 379.36 replace or diminish other rights and liberties that may exist relative to persons clients

380.1 receiving home care services, persons providing home care services, or providers licensed
 380.2 under ~~Laws 1987, chapter 378. A copy of these rights must be provided to an individual~~
 380.3 ~~at the time home care services, including personal care assistance services, are initiated.~~
 380.4 ~~The copy shall also contain the address and phone number of the Office of Health Facility~~
 380.5 ~~Complaints and the Office of Ombudsman for Long-Term Care and a brief statement~~
 380.6 ~~describing how to file a complaint with these offices. Information about how to contact~~
 380.7 ~~the Office of Ombudsman for Long-Term Care shall be included in notices of change in~~
 380.8 ~~client fees and in notices where home care providers initiate transfer or discontinuation of~~
 380.9 ~~services sections 144A.43 to 144A.482.~~

380.10 Sec. 7. Minnesota Statutes 2012, section 144A.45, is amended to read:

380.11 **144A.45 REGULATION OF HOME CARE SERVICES.**

380.12 Subdivision 1. **Rules Regulations.** The commissioner shall ~~adopt rules for the~~
 380.13 ~~regulation of~~ regulate home care providers pursuant to sections 144A.43 to ~~144A.47~~
 380.14 144A.482. The ~~rules~~ regulations shall include the following:

380.15 (1) provisions to assure, to the extent possible, the health, safety and well-being,
 380.16 and appropriate treatment of persons who receive home care services while respecting
 380.17 clients' autonomy and choice;

380.18 (2) requirements that home care providers furnish the commissioner with specified
 380.19 information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

380.20 (3) standards of training of home care provider personnel, ~~which may vary according~~
 380.21 ~~to the nature of the services provided or the health status of the consumer~~;

380.22 (4) standards for provision of home care services;

380.23 (4) (5) ~~standards for medication management which may vary according to the~~
 380.24 ~~nature of the services provided, the setting in which the services are provided, or the~~
 380.25 ~~status of the consumer. Medication management includes the central storage, handling,~~
 380.26 ~~distribution, and administration of medications~~;

380.27 (5) (6) ~~standards for supervision of home care services requiring supervision by a~~
 380.28 ~~registered nurse or other appropriate health care professional which must occur on site~~
 380.29 ~~at least every 62 days, or more frequently if indicated by a clinical assessment, and in~~
 380.30 ~~accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a~~
 380.31 ~~person performing home care aide tasks for a class B licensee providing paraprofessional~~
 380.32 ~~services does not require nursing supervision~~;

380.33 (6) (7) ~~standards for client evaluation or assessment which may vary according to~~
 380.34 ~~the nature of the services provided or the status of the consumer~~;

381.1 ~~(7)~~ (8) requirements for the involvement of a ~~consumer's physician~~ client's health
 381.2 care provider, the documentation of ~~physicians'~~ health care providers' orders, if required,
 381.3 and the ~~consumer's treatment~~ client's service plan, ~~and~~;

381.4 (9) the maintenance of accurate, current ~~clinical~~ client records;

381.5 ~~(8)~~ (10) the establishment of ~~different classes~~ basic and comprehensive levels of
 381.6 licenses for ~~different types of providers and different standards and requirements for~~
 381.7 ~~different kinds of home care~~ based on services provided; and

381.8 (9) ~~operating procedures required to implement~~ (11) provisions to enforce these
 381.9 regulations and the home care bill of rights.

381.10 Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota
 381.11 Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting
 381.12 toileting, transfers, and ambulation if the client is ambulatory and if the client has no
 381.13 serious acute illness or infectious disease.

381.14 Subd. 1b. **Home health aide qualifications.** Notwithstanding the provisions of
 381.15 Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks
 381.16 if the person maintains current registration as a nursing assistant on the Minnesota nursing
 381.17 assistant registry. ~~Maintaining current registration on the Minnesota nursing assistant~~
 381.18 ~~registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110,~~
 381.19 ~~subpart 3.~~

381.20 Subd. 2. **Regulatory functions.** (a) The commissioner shall:

381.21 ~~(1) evaluate, monitor, and license, survey, and monitor without advance notice,~~ home
 381.22 care providers in accordance with sections ~~144A.45 to 144A.47~~ 144A.43 to 144A.482;

381.23 ~~(2) inspect the office and records of a provider during regular business hours without~~
 381.24 ~~advance notice to the home care provider;~~

381.25 (2) survey every temporary licensee within one year of the temporary license issuance
 381.26 date subject to the temporary licensee providing home care services to a client or clients;

381.27 (3) survey all licensed home care providers on an interval that will promote the
 381.28 health and safety of clients;

381.29 ~~(3)~~ (4) with the consent of the ~~consumer~~ client, visit the home where services are
 381.30 being provided;

381.31 ~~(4)~~ (5) issue correction orders and assess civil penalties in accordance with section
 381.32 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to ~~144A.47~~ or the rules
 381.33 ~~adopted under those sections~~ 144A.482;

381.34 ~~(5)~~ (6) take action as authorized in section ~~144A.46, subdivision 3~~ 144A.475; and

381.35 ~~(6)~~ (7) take other action reasonably required to accomplish the purposes of sections
 381.36 144A.43 to ~~144A.47~~ 144A.482.

382.1 ~~(b) In the exercise of the authority granted in sections 144A.43 to 144A.47, the~~
 382.2 ~~commissioner shall comply with the applicable requirements of section 144.122, the~~
 382.3 ~~Government Data Practices Act, and the Administrative Procedure Act.~~

382.4 ~~Subd. 4. **Medicaid reimbursement.** Notwithstanding the provisions of section~~
 382.5 ~~256B.37 or state plan requirements to the contrary, certification by the federal Medicare~~
 382.6 ~~program must not be a requirement of Medicaid payment for services delivered under~~
 382.7 ~~section 144A.4605.~~

382.8 ~~Subd. 5. **Home care providers; services for Alzheimer's disease or related**~~
 382.9 ~~**disorder.** (a) If a home care provider licensed under section 144A.46 or 144A.4605 markets~~
 382.10 ~~or otherwise promotes services for persons with Alzheimer's disease or related disorders,~~
 382.11 ~~the facility's direct care staff and their supervisors must be trained in dementia care.~~

382.12 ~~(b) Areas of required training include:~~

382.13 ~~(1) an explanation of Alzheimer's disease and related disorders;~~

382.14 ~~(2) assistance with activities of daily living;~~

382.15 ~~(3) problem solving with challenging behaviors; and~~

382.16 ~~(4) communication skills.~~

382.17 ~~(c) The licensee shall provide to consumers in written or electronic form a~~
 382.18 ~~description of the training program, the categories of employees trained, the frequency~~
 382.19 ~~of training, and the basic topics covered.~~

382.20 Sec. 8. [144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.

382.21 Subdivision 1. **License required.** A home care provider may not open, operate,
 382.22 manage, conduct, maintain, or advertise itself as a home care provider or provide home
 382.23 care services in Minnesota without a temporary or current home care provider license
 382.24 issued by the commissioner of health.

382.25 Subd. 2. **Determination of direct home care service.** "Direct home care service"
 382.26 means a home care service provided to a client by the home care provider or its employees,
 382.27 and not by contract. Factors that must be considered in determining whether an individual
 382.28 or a business entity provides at least one home care service directly include, but are not
 382.29 limited to, whether the individual or business entity:

382.30 (1) has the right to control, and does control, the types of services provided;

382.31 (2) has the right to control, and does control, when and how the services are provided;

382.32 (3) establishes the charges;

382.33 (4) collects fees from the clients or receives payment from third-party payers on
 382.34 the clients' behalf;

383.1 (5) pays individuals providing services compensation on an hourly, weekly, or
383.2 similar basis;

383.3 (6) treats the individuals providing services as employees for the purposes of payroll
383.4 taxes and workers' compensation insurance; and

383.5 (7) holds itself out as a provider of home care services or acts in a manner that
383.6 leads clients or potential clients to believe that it is a home care provider providing home
383.7 care services.

383.8 None of the factors listed in this subdivision is solely determinative.

383.9 Subd. 3. **Determination of regularly engaged.** "Regularly engaged" means
383.10 providing, or offering to provide, home care services as a regular part of a business. The
383.11 following factors must be considered by the commissioner in determining whether an
383.12 individual or a business entity is regularly engaged in providing home care services:

383.13 (1) whether the individual or business entity states or otherwise promotes that the
383.14 individual or business entity provides home care services;

383.15 (2) whether persons receiving home care services constitute a substantial part of the
383.16 individual's or the business entity's clientele; and

383.17 (3) whether the home care services provided are other than occasional or incidental
383.18 to the provision of services other than home care services.

383.19 None of the factors listed in this subdivision is solely determinative.

383.20 Subd. 4. **Penalties for operating without license.** A person involved in the
383.21 management, operation, or control of a home care provider that operates without an
383.22 appropriate license is guilty of a misdemeanor. This section does not apply to a person
383.23 who has no legal authority to affect or change decisions related to the management,
383.24 operation, or control of a home care provider.

383.25 Subd. 5. **Basic and comprehensive levels of licensure.** An applicant seeking
383.26 to become a home care provider must apply for either a basic or comprehensive home
383.27 care license.

383.28 Subd. 6. **Basic home care license provider.** Home care services that can be
383.29 provided with a basic home care license are assistive tasks provided by licensed or
383.30 unlicensed personnel that include:

383.31 (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting,
383.32 and bathing;

383.33 (2) providing standby assistance;

383.34 (3) providing verbal or visual reminders to the client to take regularly scheduled
383.35 medication which includes bringing the client previously set-up medication, medication in
383.36 original containers, or liquid or food to accompany the medication;

384.1 (4) providing verbal or visual reminders to the client to perform regularly scheduled
384.2 treatments and exercises;
384.3 (5) preparing modified diets ordered by a licensed health professional; and
384.4 (6) assisting with laundry, housekeeping, meal preparation, shopping, or other
384.5 household chores and services if the provider is also providing at least one of the activities
384.6 in clauses (1) to (5)

384.7 Subd. 7. **Comprehensive home care license provider.** Home care services that
384.8 may be provided with a comprehensive home care license include any of the basic home
384.9 care services listed in subdivision 6, and one or more of the following:

384.10 (1) services of an advanced practice nurse, registered nurse, licensed practical
384.11 nurse, physical therapist, respiratory therapist, occupational therapist, speech-language
384.12 pathologist, dietician or nutritionist, or social worker;

384.13 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a
384.14 licensed health professional within the person's scope of practice;

384.15 (3) medication management services;

384.16 (4) hands-on assistance with transfers and mobility;

384.17 (5) assisting clients with eating when the clients have complicating eating problems
384.18 as identified in the client record or through an assessment such as difficulty swallowing,
384.19 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
384.20 instruments to be fed; or

384.21 (6) providing other complex or specialty health care services.

384.22 Subd. 8. **Exemptions from home care services licensure.** (a) Except as otherwise
384.23 provided in this chapter, home care services that are provided by the state, counties, or
384.24 other units of government must be licensed under this chapter.

384.25 (b) An exemption under this subdivision does not excuse the exempted individual or
384.26 organization from complying with applicable provisions of the home care bill of rights
384.27 in section 144A.44. The following individuals or organizations are exempt from the
384.28 requirement to obtain a home care provider license:

384.29 (1) an individual or organization that offers, provides, or arranges for personal care
384.30 assistance services under the medical assistance program as authorized under sections
384.31 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;

384.32 (2) a provider that is licensed by the commissioner of human services to provide
384.33 semi-independent living services for persons with developmental disabilities under section
384.34 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

385.1 (3) a provider that is licensed by the commissioner of human services to provide
385.2 home and community-based services for persons with developmental disabilities under
385.3 section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

385.4 (4) an individual or organization that provides only home management services, if
385.5 the individual or organization is registered under section 144A.482; or

385.6 (5) an individual who is licensed in this state as a nurse, dietitian, social worker,
385.7 occupational therapist, physical therapist, or speech-language pathologist who provides
385.8 health care services in the home independently and not through any contractual or
385.9 employment relationship with a home care provider or other organization.

385.10 Subd. 9. Exclusions from home care licensure. The following are excluded from
385.11 home care licensure and are not required to provide the home care bill of rights:

385.12 (1) an individual or business entity providing only coordination of home care that
385.13 includes one or more of the following:

385.14 (i) determination of whether a client needs home care services, or assisting a client
385.15 in determining what services are needed;

385.16 (ii) referral of clients to a home care provider;

385.17 (iii) administration of payments for home care services; or

385.18 (iv) administration of a health care home established under section 256B.0751;

385.19 (2) an individual who is not an employee of a licensed home care provider if the
385.20 individual:

385.21 (i) only provides services as an independent contractor to one or more licensed
385.22 home care providers;

385.23 (ii) provides no services under direct agreements or contracts with clients; and

385.24 (iii) is contractually bound to perform services in compliance with the contracting
385.25 home care provider's policies and service plans;

385.26 (3) a business that provides staff to home care providers, such as a temporary
385.27 employment agency, if the business:

385.28 (i) only provides staff under contract to licensed or exempt providers;

385.29 (ii) provides no services under direct agreements with clients; and

385.30 (iii) is contractually bound to perform services under the contracting home care
385.31 provider's direction and supervision;

385.32 (4) any home care services conducted by and for the adherents of any recognized
385.33 church or religious denomination for its members through spiritual means, or by prayer
385.34 for healing;

385.35 (5) an individual who only provides home care services to a relative;

386.1 (6) an individual not connected with a home care provider that provides assistance
386.2 with basic home care needs if the assistance is provided primarily as a contribution and
386.3 not as a business;

386.4 (7) an individual not connected with a home care provider that shares housing with
386.5 and provides primarily housekeeping or homemaking services to an elderly or disabled
386.6 person in return for free or reduced-cost housing;

386.7 (8) an individual or provider providing home-delivered meal services;

386.8 (9) an individual providing senior companion services and other Older American
386.9 Volunteer Programs (OAVP) established under the Domestic Volunteer Service Act of
386.10 1973, United States Code, title 42, chapter 66;

386.11 (10) an employee of a nursing home licensed under this chapter or an employee of a
386.12 boarding care home licensed under sections 144.50 to 144.56 who responds to occasional
386.13 emergency calls from individuals residing in a residential setting that is attached to or
386.14 located on property contiguous to the nursing home or boarding care home;

386.15 (11) a member of a professional corporation organized under chapter 319B that
386.16 does not regularly offer or provide home care services as defined in section 144A.43,
386.17 subdivision 3;

386.18 (12) the following organizations established to provide medical or surgical services
386.19 that do not regularly offer or provide home care services as defined in section 144A.43,
386.20 subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit
386.21 corporation organized under chapter 317A, a partnership organized under chapter 323, or
386.22 any other entity determined by the commissioner;

386.23 (13) an individual or agency that provides medical supplies or durable medical
386.24 equipment, except when the provision of supplies or equipment is accompanied by a
386.25 home care service;

386.26 (14) a physician licensed under chapter 147;

386.27 (15) an individual who provides home care services to a person with a developmental
386.28 disability who lives in a place of residence with a family, foster family, or primary caregiver;

386.29 (16) a business that only provides services that are primarily instructional and not
386.30 medical services or health-related support services;

386.31 (17) an individual who performs basic home care services for no more than 14 hours
386.32 each calendar week to no more than one client;

386.33 (18) an individual or business licensed as hospice as defined in sections 144A.75 to
386.34 144A.755 who is not providing home care services independent of hospice service;

387.1 (19) activities conducted by the commissioner of health or a board of health as
 387.2 defined in section 145A.02, subdivision 2, including communicable disease investigations
 387.3 or testing; or

387.4 (20) administering or monitoring a prescribed therapy necessary to control or
 387.5 prevent a communicable disease, or the monitoring of an individual's compliance with a
 387.6 health directive as defined in section 144.4172, subdivision 6.

387.7 **Sec. 9. [144A.472] HOME CARE PROVIDER LICENSE; APPLICATION AND**
 387.8 **RENEWAL.**

387.9 Subdivision 1. **License applications.** Each application for a home care provider
 387.10 license must include information sufficient to show that the applicant meets the
 387.11 requirements of licensure, including:

387.12 (1) the applicant's name, e-mail address, physical address, and mailing address,
 387.13 including the name of the county in which the applicant resides and has a principal
 387.14 place of business;

387.15 (2) the initial license fee in the amount specified in subdivision 7;

387.16 (3) e-mail address, physical address, mailing address, and telephone number of the
 387.17 principal administrative office;

387.18 (4) e-mail address, physical address, mailing address, and telephone number of
 387.19 each branch office, if any;

387.20 (5) names, e-mail and mailing addresses, and telephone numbers of all owners
 387.21 and managerial officials;

387.22 (6) documentation of compliance with the background study requirements of section
 387.23 144A.476 for all persons involved in the management, operation, or control of the home
 387.24 care provider;

387.25 (7) documentation of a background study as required by section 144.057 for any
 387.26 individual seeking employment, paid or volunteer, with the home care provider;

387.27 (8) evidence of workers' compensation coverage as required by sections 176.181
 387.28 and 176.182;

387.29 (9) documentation of liability coverage, if the provider has it;

387.30 (10) identification of the license level the provider is seeking;

387.31 (11) documentation that identifies the managerial official who is in charge of
 387.32 day-to-day operations and attestation that the person has reviewed and understands the
 387.33 home care provider regulations;

388.1 (12) documentation that the applicant has designated one or more owners,
388.2 managerial officials, or employees as an agent or agents, which shall not affect the legal
388.3 responsibility of any other owner or managerial official under this chapter;

388.4 (13) the signature of the officer or managing agent on behalf of an entity, corporation,
388.5 association, or unit of government;

388.6 (14) verification that the applicant has the following policies and procedures in place
388.7 so that if a license is issued, the applicant will implement the policies and procedures
388.8 and keep them current:

388.9 (i) requirements in sections 626.556, reporting of maltreatment of minors, and
388.10 626.557, reporting of maltreatment of vulnerable adults;

388.11 (ii) conducting and handling background studies on employees;

388.12 (iii) orientation, training, and competency evaluations of home care staff, and a
388.13 process for evaluating staff performance;

388.14 (iv) handling complaints from clients, family members, or client representatives
388.15 regarding staff or services provided by staff;

388.16 (v) conducting initial evaluation of clients' needs and the providers' ability to provide
388.17 those services;

388.18 (vi) conducting initial and ongoing client evaluations and assessments and how
388.19 changes in a client's condition are identified, managed, and communicated to staff and
388.20 other health care providers as appropriate;

388.21 (vii) orientation to and implementation of the home care client bill of rights;

388.22 (viii) infection control practices;

388.23 (ix) reminders for medications, treatments, or exercises, if provided; and

388.24 (x) conducting appropriate screenings, or documentation of prior screenings, to
388.25 show that staff are free of tuberculosis, consistent with current United States Centers for
388.26 Disease Control standards; and

388.27 (15) other information required by the department.

388.28 **Subd. 2. Comprehensive home care license applications.** In addition to the
388.29 information and fee required in subdivision 1, applicants applying for a comprehensive
388.30 home care license must also provide verification that the applicant has the following
388.31 policies and procedures in place so that if a license is issued, the applicant will implement
388.32 the policies and procedures in this subdivision and keep them current:

388.33 (1) conducting initial and ongoing assessments of the client's needs by a registered
388.34 nurse or appropriate licensed health professional, including how changes in the client's
388.35 conditions are identified, managed, and communicated to staff and other health care
388.36 providers, as appropriate;

389.1 (2) ensuring that nurses and licensed health professionals have current and valid
389.2 licenses to practice;

389.3 (3) medication and treatment management;

389.4 (4) delegation of home care tasks by registered nurses or licensed health professionals;

389.5 (5) supervision of registered nurses and licensed health professionals; and

389.6 (6) supervision of unlicensed personnel performing delegated home care tasks.

389.7 Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license
389.8 may be renewed for a period of one year if the licensee satisfies the following:

389.9 (1) submits an application for renewal in the format provided by the commissioner
389.10 at least 30 days before expiration of the license;

389.11 (2) submits the renewal fee in the amount specified in subdivision 7;

389.12 (3) has provided home care services within the past 12 months;

389.13 (4) complies with sections 144A.43 to 144A.4799;

389.14 (5) provides information sufficient to show that the applicant meets the requirements
389.15 of licensure, including items required under subdivision 1;

389.16 (6) provides verification that all policies under subdivision 1, are current; and

389.17 (7) provides any other information deemed necessary by the commissioner.

389.18 (b) A renewal applicant who holds a comprehensive home care license must also
389.19 provide verification that policies listed under subdivision 2 are current.

389.20 Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately
389.21 licensed if the commissioner determines that the units cannot adequately share supervision
389.22 and administration of services from the main office.

389.23 Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license
389.24 issued by the commissioner may not be transferred to another party. Before acquiring
389.25 ownership of a home care provider business, a prospective applicant must apply for a
389.26 new temporary license. A change of ownership is a transfer of operational control to
389.27 a different business entity, and includes:

389.28 (1) transfer of the business to a different or new corporation;

389.29 (2) in the case of a partnership, the dissolution or termination of the partnership under
389.30 chapter 323A, with the business continuing by a successor partnership or other entity;

389.31 (3) relinquishment of control of the provider to another party, including to a contract
389.32 management firm that is not under the control of the owner of the business' assets;

389.33 (4) transfer of the business by a sole proprietor to another party or entity; or

389.34 (5) in the case of a privately held corporation, the change in ownership or control of
389.35 50 percent or more of the outstanding voting stock.

390.1 Subd. 6. Notification of changes of information. The temporary licensee or
 390.2 licensee shall notify the commissioner in writing within ten working days after any
 390.3 change in the information required in subdivision 1, except the information required in
 390.4 subdivision 1, clause (5), is required at the time of license renewal.

390.5 Subd. 7. Fees; application, change of ownership, and renewal. (a) An initial
 390.6 applicant seeking a temporary home care licensure must submit the following application
 390.7 fee to the commissioner along with a completed application:

390.8 (1) basic home care provider, \$2,100; or

390.9 (2) comprehensive home care provider, \$4,200.

390.10 (b) A home care provider who is filing a change of ownership as required under
 390.11 subdivision 5 must submit the following application fee to the commissioner, along with
 390.12 the documentation required for the change of ownership:

390.13 (1) basic home care provider, \$2,100; or

390.14 (2) comprehensive home care provider, \$4,200.

390.15 (c) A home care provider who is seeking to renew the provider's license shall pay a
 390.16 fee to the commissioner based on revenues derived from the provision of home care
 390.17 services during the calendar year prior to the year in which the application is submitted,
 390.18 according to the following schedule:

390.19 **License Renewal Fee**

<u>Provider Annual Revenue</u>	<u>Fee</u>
390.20 <u>greater than \$1,500,000</u>	\$6,625
390.21 <u>greater than \$1,275,000 and no more than</u>	\$5,797
390.22 <u>\$1,500,000</u>	
390.23 <u>greater than \$1,100,000 and no more than</u>	\$4,969
390.24 <u>\$1,275,000</u>	
390.25 <u>greater than \$950,000 and no more than</u>	\$4,141
390.26 <u>\$1,100,000</u>	
390.27 <u>greater than \$850,000 and no more than</u>	\$3,727
390.28 <u>\$950,000</u>	
390.29 <u>greater than \$750,000 and no more than</u>	\$3,313
390.30 <u>\$850,000</u>	
390.31 <u>greater than \$650,000 and no more than</u>	\$2,898
390.32 <u>\$750,000</u>	
390.33 <u>greater than \$550,000 and no more than</u>	\$2,485
390.34 <u>\$650,000</u>	
390.35 <u>greater than \$450,000 and no more than</u>	\$2,070
390.36 <u>\$550,000</u>	
390.37 <u>greater than \$350,000 and no more than</u>	\$1,656
390.38 <u>\$450,000</u>	
390.39 <u>greater than \$250,000 and no more than</u>	\$1,242
390.40 <u>\$350,000</u>	
390.41	

391.1	<u>greater than \$100,000 and no more than</u>	<u>\$828</u>
391.2	<u>\$250,000</u>	
391.3	<u>greater than \$50,000 and no more than \$100,000</u>	<u>\$500</u>
391.4	<u>greater than \$25,000 and no more than \$50,000</u>	<u>\$400</u>
391.5	<u>no more than \$25,000</u>	<u>\$200</u>

391.6 (d) If requested, the home care provider shall provide the commissioner information
 391.7 to verify the provider's annual revenues or other information as needed, including copies
 391.8 of documents submitted to the Department of Revenue.

391.9 (e) At each annual renewal, a home care provider may elect to pay the highest
 391.10 renewal fee for its license category, and not provide annual revenue information to the
 391.11 commissioner.

391.12 (f) A temporary license or license applicant, or temporary licensee or licensee that
 391.13 knowingly provides the commissioner incorrect revenue amounts for the purpose of
 391.14 paying a lower license fee, shall be subject to a civil penalty in the amount of double the
 391.15 fee the provider should have paid.

391.16 (g) Fees and penalties collected under this section shall be deposited in the state
 391.17 treasury and credited to the special state government revenue fund.

391.18 (h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

391.19 **Sec. 10. [144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE**
 391.20 **RENEWAL.**

391.21 Subdivision 1. **Temporary license and renewal of license.** (a) The department
 391.22 shall review each application to determine the applicant's knowledge of and compliance
 391.23 with Minnesota home care regulations. Before granting a temporary license or renewing a
 391.24 license, the commissioner may further evaluate the applicant or licensee by requesting
 391.25 additional information or documentation or by conducting an on-site survey of the
 391.26 applicant to determine compliance with sections 144A.43 to 144A.482.

391.27 (b) Within 14 calendar days after receiving an application for a license,
 391.28 the commissioner shall acknowledge receipt of the application in writing. The
 391.29 acknowledgment must indicate whether the application appears to be complete or whether
 391.30 additional information is required before the application will be considered complete.

391.31 (c) Within 90 days after receiving a complete application, the commissioner shall
 391.32 issue a temporary license, renew the license, or deny the license.

391.33 (d) The commissioner shall issue a license that contains the home care provider's
 391.34 name, address, license level, expiration date of the license, and unique license number. All
 391.35 licenses are valid for one year from the date of issuance.

392.1 Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner
392.2 shall issue a temporary license for either the basic or comprehensive home care level. A
392.3 temporary license is effective for one year from the date of issuance. Temporary licensees
392.4 must comply with sections 144A.43 to 144A.482.

392.5 (b) During the temporary license year, the commissioner shall survey the temporary
392.6 licensee after the commissioner is notified or has evidence that the temporary licensee
392.7 is providing home care services.

392.8 (c) Within five days of beginning the provision of services, the temporary
392.9 licensee must notify the commissioner that it is serving clients. The notification to the
392.10 commissioner may be mailed or e-mailed to the commissioner at the address provided by
392.11 the commissioner. If the temporary licensee does not provide home care services during
392.12 the temporary license year, then the temporary license expires at the end of the year and
392.13 the applicant must reapply for a temporary home care license.

392.14 (d) A temporary licensee may request a change in the level of licensure prior to
392.15 being surveyed and granted a license by notifying the commissioner in writing and
392.16 providing additional documentation or materials required to update or complete the
392.17 changed temporary license application. The applicant must pay the difference between the
392.18 application fees when changing from the basic to the comprehensive level of licensure.
392.19 No refund will be made if the provider chooses to change the license application to the
392.20 basic level.

392.21 (e) If the temporary licensee notifies the commissioner that the licensee has clients
392.22 within 45 days prior to the temporary license expiration, the commissioner may extend the
392.23 temporary license for up to 60 days in order to allow the commissioner to complete the
392.24 on-site survey required under this section and follow-up survey visits.

392.25 Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial
392.26 compliance with the survey, the commissioner shall issue either a basic or comprehensive
392.27 home care license. If the temporary licensee is not in substantial compliance with the
392.28 survey, the commissioner shall not issue a basic or comprehensive license and there will
392.29 be no contested hearing right under chapter 14.

392.30 (b) If the temporary licensee whose basic or comprehensive license has been denied
392.31 disagrees with the conclusions of the commissioner, then the licensee may request a
392.32 reconsideration by the commissioner or commissioner's designee. The reconsideration
392.33 request process will be conducted internally by the commissioner or commissioner's
392.34 designee, and chapter 14 does not apply.

393.1 (c) The temporary licensee requesting reconsideration must make the request in
 393.2 writing and must list and describe the reasons why the licensee disagrees with the decision
 393.3 to deny the basic or comprehensive home care license.

393.4 (d) A temporary licensee whose license is denied must comply with the requirements
 393.5 for notification and transfer of clients in section 144A.475, subdivision 5.

393.6 Sec. 11. **[144A.474] SURVEYS AND INVESTIGATIONS.**

393.7 Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home
 393.8 care provider. By June 30, 2016, the commissioner shall conduct a survey of home care
 393.9 providers on a frequency of at least once every three years. Survey frequency may be
 393.10 based on the license level, the provider's compliance history, number of clients served,
 393.11 or other factors as determined by the department deemed necessary to ensure the health,
 393.12 safety, and welfare of clients and compliance with the law.

393.13 Subd. 2. **Types of home care surveys.** (a) "Initial full survey" is the survey
 393.14 conducted of a new temporary licensee after the department is notified or has evidence that
 393.15 the licensee is providing home care services to determine if the provider is in compliance
 393.16 with home care requirements. Initial surveys must be completed within 14 months after
 393.17 the department's issuance of a temporary basic or comprehensive license.

393.18 (b) "Core survey" means periodic inspection of home care providers to determine
 393.19 ongoing compliance with the home care requirements, focusing on the essential health and
 393.20 safety requirements. Core surveys are available to licensed home care providers who have
 393.21 been licensed for three years and surveyed at least once in the past three years with the
 393.22 latest survey having no widespread violations beyond Level 1 as provided in subdivision
 393.23 11. Providers must also not have had any substantiated licensing complaints, substantiated
 393.24 complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors
 393.25 Act, or an enforcement action as authorized in section 144A.475 in the past three years.

393.26 (1) The core survey for basic license-level providers reviews compliance in the
 393.27 following areas:

393.28 (i) reporting of maltreatment;

393.29 (ii) orientation to and implementation of Home Care Client Bill of Rights;

393.30 (iii) statement of home care services;

393.31 (iv) initial evaluation of clients and initiation of services;

393.32 (v) basic-license level client review and monitoring;

393.33 (vi) service plan implementation and changes to the service plan;

393.34 (vii) client complaint and investigative process;

393.35 (viii) competency of unlicensed personnel; and

394.1 (ix) infection control.

394.2 (2) For comprehensive license-level providers, the core survey will include
394.3 everything in the basic license-level core survey plus these areas:

394.4 (i) delegation to unlicensed personnel;

394.5 (ii) assessment, monitoring, and reassessment of clients; and

394.6 (iii) medication, treatment, and therapy management.

394.7 (c) "Full survey" means the periodic inspection of home care providers to determine
394.8 ongoing compliance with the home care requirements that cover the core survey areas
394.9 and all the legal requirements for home care providers. A full survey is conducted for all
394.10 temporary licensees and for providers who do not meet the requirements needed for a core
394.11 survey, and when a surveyor identifies unacceptable client health or safety risks during a
394.12 core survey. A full survey will include all the tasks identified as part of the core survey
394.13 and any additional review deemed necessary by the department, including additional
394.14 observation, interviewing, or records review of additional clients and staff.

394.15 (d) "Follow-up surveys" are conducted to determine if a home care provider has
394.16 corrected deficient issues and systems identified during a core survey, full survey, or
394.17 complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax,
394.18 mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be
394.19 concluded with an exit conference and written information provided on the process for
394.20 requesting a reconsideration of the survey results.

394.21 (e) Upon receiving information that a home care provider has violated or is currently
394.22 violating a requirement of sections 144A.43 to 144A.482, the commissioner shall
394.23 investigate the complaint according to sections 144A.51 to 144A.54.

394.24 Subd. 3. **Survey process.** (a) The survey process for core surveys shall include the
394.25 following as applicable to the particular licensee and setting surveyed:

394.26 (1) presurvey review of pertinent documents and notification to the ombudsman
394.27 for long-term care;

394.28 (2) an entrance conference with available staff;

394.29 (3) communication with managerial officials or the registered nurse in charge, if
394.30 available, and ongoing communication with key staff throughout the survey regarding
394.31 information needed by the surveyor, clarifications regarding home care requirements, and
394.32 applicable standards of practice;

394.33 (4) presentation of written contact information to the provider about the survey staff
394.34 conducting the survey, the supervisor, and the process for requesting a reconsideration of
394.35 the survey results;

395.1 (5) a brief tour of a sample of the housing with services establishments in which the
395.2 provider is providing home care services;

395.3 (6) a sample selection of home care clients;

395.4 (7) information-gathering through client and staff observations, client and staff
395.5 interviews, and reviews of records, policies, procedures, practices, and other agency
395.6 information;

395.7 (8) interviews of clients' family members, if available, with clients' consent when the
395.8 client can legally give consent;

395.9 (9) except for complaint surveys conducted by the Office of Health Facilities
395.10 Complaints, exit conference, with preliminary findings shared and discussed with the
395.11 provider and written information provided on the process for requesting a reconsideration
395.12 of the survey results; and

395.13 (10) postsurvey analysis of findings and formulation of survey results, including
395.14 correction orders when applicable.

395.15 Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted
395.16 without advance notice to home care providers. Surveyors may contact the home care
395.17 provider on the day of a survey to arrange for someone to be available at the survey site.
395.18 The contact does not constitute advance notice.

395.19 Subd. 5. **Information provided by home care provider.** The home care provider
395.20 shall provide accurate and truthful information to the department during a survey,
395.21 investigation, or other licensing activities.

395.22 Subd. 6. **Providing client records.** Upon request of a surveyor, home care providers
395.23 shall provide a list of current and past clients or client representatives that includes
395.24 addresses and telephone numbers and any other information requested about the services
395.25 to clients within a reasonable period of time.

395.26 Subd. 7. **Contacting and visiting clients.** Surveyors may contact or visit a home
395.27 care provider's clients to gather information without notice to the home care provider.
395.28 Before visiting a client, a surveyor shall obtain the client's or client's representative's
395.29 permission by telephone, mail, or in person. Surveyors shall inform all clients or client's
395.30 representatives of their right to decline permission for a visit.

395.31 Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the
395.32 commissioner finds upon survey or during a complaint investigation that a home care
395.33 provider, a managerial official, or an employee of the provider is not in compliance with
395.34 sections 144A.43 to 144A.482. The correction order shall cite the specific statute and
395.35 document areas of noncompliance and the time allowed for correction.

396.1 (b) The commissioner shall mail copies of any correction order within 30 calendar
396.2 days after exit survey to the last known address of the home care provider. A copy of each
396.3 correction order and copies of any documentation supplied to the commissioner shall be
396.4 kept on file by the home care provider, and public documents shall be made available for
396.5 viewing by any person upon request. Copies may be kept electronically.

396.6 (c) By the correction order date, the home care provider must document in the
396.7 provider's records any action taken to comply with the correction order. The commissioner
396.8 may request a copy of this documentation and the home care provider's action to respond
396.9 to the correction order in future surveys, upon a complaint investigation, and as otherwise
396.10 needed.

396.11 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations
396.12 or any violations determined to be widespread, the department shall conduct a follow-up
396.13 survey within 90 calendar days of the survey. When conducting a follow-up survey, the
396.14 surveyor will focus on whether the previous violations have been corrected and may also
396.15 address any new violations that are observed while evaluating the corrections that have
396.16 been made. If a new violation is identified on a follow-up survey, no fine will be imposed
396.17 unless it is not corrected on the next follow-up survey.

396.18 Subd. 10. **Performance incentive.** A licensee is eligible for a performance
396.19 incentive if there are no violations identified in a core or full survey. The performance
396.20 incentive is a ten percent discount on the licensee's next home care renewal license fee.

396.21 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be
396.22 assessed based on the level and scope of the violations described in paragraph (c) as follows:

396.23 (1) Level 1, no fines or enforcement;

396.24 (2) Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement
396.25 mechanisms authorized in section 144A.475 for widespread violations;

396.26 (3) Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement
396.27 mechanisms authorized in section 144A.475; and

396.28 (4) Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the
396.29 enforcement mechanisms authorized in section 144A.475.

396.30 (b) Correction orders for violations are categorized by both level and scope as
396.31 follows and fines will be assessed accordingly:

396.32 (1) Level of violation:

396.33 (i) Level 1. A violation that has no potential to cause more than a minimal impact on
396.34 the client and does not affect health or safety.

397.1 (ii) Level 2. A violation that did not harm the client's health or safety, but had the
397.2 potential to have harmed a client's health or safety, but was not likely to cause serious
397.3 injury, impairment, or death.

397.4 (iii) Level 3. A violation that harmed a client's health or safety, not including serious
397.5 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
397.6 impairment, or death.

397.7 (iv) Level 4. A violation that results in serious injury, impairment, or death.

397.8 (2) Scope of violation:

397.9 (i) Isolated. When one or a limited number of clients are affected, or one or a limited
397.10 number of staff are involved, or the situation has occurred only occasionally.

397.11 (ii) Pattern. When more than a limited number of clients are affected, more than
397.12 a limited number of staff are involved, or the situation has occurred repeatedly but is
397.13 not found to be pervasive.

397.14 (iii) Widespread. When problems are pervasive or represent a systemic failure that
397.15 has affected or has the potential to affect a large portion or all of the clients.

397.16 (c) If the commissioner finds that the applicant or a home care provider required
397.17 to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the
397.18 date specified in the correction order or conditional license resulting from a survey or
397.19 complaint investigation, the commissioner may impose a fine. A notice of noncompliance
397.20 with a correction order must be mailed to the applicant's or provider's last known address.
397.21 The noncompliance notice must list the violations not corrected.

397.22 (d) The license holder must pay the fines assessed on or before the payment date
397.23 specified. If the license holder fails to fully comply with the order, the commissioner
397.24 may issue a second fine or suspend the license until the license holder complies by
397.25 paying the fine. A timely appeal shall stay payment of the fine until the commissioner
397.26 issues a final order.

397.27 (e) A license holder shall promptly notify the commissioner in writing when a
397.28 violation specified in the order is corrected. If upon reinspection the commissioner
397.29 determines that a violation has not been corrected as indicated by the order, the
397.30 commissioner may issue a second fine. The commissioner shall notify the license holder by
397.31 mail to the last known address in the licensing record that a second fine has been assessed.
397.32 The license holder may appeal the second fine as provided under this subdivision.

397.33 (f) A home care provider that has been assessed a fine under this subdivision has a
397.34 right to a reconsideration or a hearing under this section and chapter 14.

398.1 (g) When a fine has been assessed, the license holder may not avoid payment by
398.2 closing, selling, or otherwise transferring the licensed program to a third party. In such an
398.3 event, the license holder shall be liable for payment of the fine.

398.4 (h) In addition to any fine imposed under this section, the commissioner may assess
398.5 costs related to an investigation that results in a final order assessing a fine or other
398.6 enforcement action authorized by this chapter.

398.7 (i) Fines collected under this subdivision shall be deposited in the state government
398.8 special revenue fund and credited to an account separate from the revenue collected under
398.9 section 144A.472. Subject to an appropriation by the legislature, the revenue from the
398.10 finances collected may be used by the commissioner for special projects to improve home care
398.11 in Minnesota as recommended by the advisory council established in section 144A.4799.

398.12 Subd. 12. **Reconsideration.** The commissioner shall make available to home
398.13 care providers a correction order reconsideration process. This process may be used
398.14 to challenge the correction order issued, including the level and scope described in
398.15 subdivision 9, and any fine assessed. During the correction order reconsideration request,
398.16 the issuance for the correction orders under reconsideration are not stayed, but the
398.17 department will post information on the Web site with the correction order that the
398.18 licensee has requested a reconsideration required and that the review is pending.

398.19 (a) A licensed home care provider may request from the commissioner, in writing,
398.20 a correction order reconsideration regarding any correction order issued to the provider.
398.21 The correction order reconsideration shall not be reviewed by any surveyor, investigator,
398.22 or supervisor that participated in the writing or reviewing of the correction order being
398.23 disputed. The correction order reconsiderations may be conducted in person by telephone,
398.24 by another electronic form, or in writing, as determined by the commissioner. The
398.25 commissioner shall respond in writing to the request from a home care provider for
398.26 a correction order reconsideration within 60 days of the date the provider requests a
398.27 reconsideration. The commissioner's response shall identify the commissioner's decision
398.28 regarding each citation challenged by the home care provider.

398.29 The findings of a correction order reconsideration process shall be one or more of
398.30 the following:

398.31 (1) Supported in full. The correction order is supported in full, with no deletion of
398.32 findings to the citation.

398.33 (2) Supported in substance. The correction order is supported, but one or more
398.34 findings are deleted or modified without any change in the citation.

399.1 (3) Correction order cited an incorrect home care licensing requirement. The
399.2 correction order is amended by changing the correction order to the appropriate statutory
399.3 reference.

399.4 (4) Correction order was issued under an incorrect citation. The correction order is
399.5 amended to be issued under the more appropriate correction order citation.

399.6 (5) The correction order is rescinded.

399.7 (6) Fine is amended. It is determined the fine assigned to the correction order was
399.8 applied incorrectly.

399.9 (7) The level or scope of the citation is modified based on the reconsideration.

399.10 (b) If the correction order findings are changed by the commissioner, the
399.11 commissioner shall update the correction order Web site accordingly.

399.12 Subd. 13. **Home care surveyor training.** Before conducting a home care survey,
399.13 each home care surveyor must receive training on the following topics:

399.14 (1) Minnesota home care licensure requirements;

399.15 (2) Minnesota Home Care Client Bill of Rights;

399.16 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

399.17 (4) principles of documentation;

399.18 (5) survey protocol and processes;

399.19 (6) Offices of the Ombudsman roles;

399.20 (7) Office of Health Facility Complaints;

399.21 (8) Minnesota landlord-tenant and housing with services laws;

399.22 (9) types of payors for home care services; and

399.23 (10) Minnesota Nurse Practice Act for nurse surveyors.

399.24 Materials used for this training will be posted on the department Web site. Requisite
399.25 understanding of these topics will be reviewed as part of the quality improvement plan
399.26 in section 28.

399.27 **Sec. 12. [144A.475] ENFORCEMENT.**

399.28 **Subdivision 1. Conditions.** (a) The commissioner may refuse to grant a temporary
399.29 license, renew a license, suspend or revoke a license, or impose a conditional license if the
399.30 home care provider or owner or managerial official of the home care provider:

399.31 (1) is in violation of, or during the term of the license has violated, any of the
399.32 requirements in sections 144A.471 to 144A.482;

399.33 (2) permits, aids, or abets the commission of any illegal act in the provision of
399.34 home care;

399.35 (3) performs any act detrimental to the health, safety, and welfare of a client;

- 400.1 (4) obtains the license by fraud or misrepresentation;
- 400.2 (5) knowingly made or makes a false statement of a material fact in the application
- 400.3 for a license or in any other record or report required by this chapter;
- 400.4 (6) denies representatives of the department access to any part of the home care
- 400.5 provider's books, records, files, or employees;
- 400.6 (7) interferes with or impedes a representative of the department in contacting the
- 400.7 home care provider's clients;
- 400.8 (8) interferes with or impedes a representative of the department in the enforcement
- 400.9 of this chapter or has failed to fully cooperate with an inspection, survey, or investigation
- 400.10 by the department;
- 400.11 (9) destroys or makes unavailable any records or other evidence relating to the home
- 400.12 care provider's compliance with this chapter;
- 400.13 (10) refuses to initiate a background study under section 144.057 or 245A.04;
- 400.14 (11) fails to timely pay any fines assessed by the department;
- 400.15 (12) violates any local, city, or township ordinance relating to home care services;
- 400.16 (13) has repeated incidents of personnel performing services beyond their
- 400.17 competency level; or
- 400.18 (14) has operated beyond the scope of the home care provider's license level.
- 400.19 (b) A violation by a contractor providing the home care services of the home care
- 400.20 provider is a violation by the home care provider.
- 400.21 **Subd. 2. Terms to suspension or conditional license.** A suspension or conditional
- 400.22 license designation may include terms that must be completed or met before a suspension
- 400.23 or conditional license designation is lifted. A conditional license designation may include
- 400.24 restrictions or conditions that are imposed on the provider. Terms for a suspension or
- 400.25 conditional license may include one or more of the following and the scope of each will be
- 400.26 determined by the commissioner:
- 400.27 (1) requiring a consultant to review, evaluate, and make recommended changes to
- 400.28 the home care provider's practices and submit reports to the commissioner at the cost of
- 400.29 the home care provider;
- 400.30 (2) requiring supervision of the home care provider or staff practices at the cost
- 400.31 of the home care provider by an unrelated person who has sufficient knowledge and
- 400.32 qualifications to oversee the practices and who will submit reports to the commissioner;
- 400.33 (3) requiring the home care provider or employees to obtain training at the cost of
- 400.34 the home care provider;
- 400.35 (4) requiring the home care provider to submit reports to the commissioner;

401.1 (5) prohibiting the home care provider from taking any new clients for a period
401.2 of time; or

401.3 (6) any other action reasonably required to accomplish the purpose of this
401.4 subdivision and section 144A.45, subdivision 2.

401.5 Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license,
401.6 the home care provider shall be entitled to notice and a hearing as provided by sections
401.7 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may,
401.8 without a prior contested case hearing, temporarily suspend a license or prohibit delivery
401.9 of services by a provider for not more than 90 days if the commissioner determines that
401.10 the health or safety of a consumer is in imminent danger, provided:

401.11 (1) advance notice is given to the home care provider;

401.12 (2) after notice, the home care provider fails to correct the problem;

401.13 (3) the commissioner has reason to believe that other administrative remedies are not
401.14 likely to be effective; and

401.15 (4) there is an opportunity for a contested case hearing within the 90 days.

401.16 Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties
401.17 under section 144A.45, subdivision 2, clause (5), and an action against a license under
401.18 this section, a provider must request a hearing no later than 15 days after the provider
401.19 receives notice of the action.

401.20 Subd. 5. **Plan required.** (a) The process of suspending or revoking a license
401.21 must include a plan for transferring affected clients to other providers by the home care
401.22 provider, which will be monitored by the commissioner. Within three business days of
401.23 being notified of the final revocation or suspension action, the home care provider shall
401.24 provide the commissioner, the lead agencies as defined in section 256B.0911, and the
401.25 ombudsman for long-term care with the following information:

401.26 (1) a list of all clients, including full names and all contact information on file;

401.27 (2) a list of each client's representative or emergency contact person, including full
401.28 names and all contact information on file;

401.29 (3) the location or current residence of each client;

401.30 (4) the payor sources for each client, including payor source identification numbers;

401.31 and

401.32 (5) for each client, a copy of the client's service plan, and a list of the types of
401.33 services being provided.

401.34 (b) The revocation or suspension notification requirement is satisfied by mailing the
401.35 notice to the address in the license record. The home care provider shall cooperate with
401.36 the commissioner and the lead agencies during the process of transferring care of clients to

402.1 qualified providers. Within three business days of being notified of the final revocation or
402.2 suspension action, the home care provider must notify and disclose to each of the home
402.3 care provider's clients, or the client's representative or emergency contact persons, that
402.4 the commissioner is taking action against the home care provider's license by providing a
402.5 copy of the revocation or suspension notice issued by the commissioner.

402.6 Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The
402.7 owner and managerial officials of a home care provider whose Minnesota license has not
402.8 been renewed or that has been revoked because of noncompliance with applicable laws or
402.9 rules shall not be eligible to apply for nor will be granted a home care license, including
402.10 other licenses under this chapter, or be given status as an enrolled personal care assistance
402.11 provider agency or personal care assistant by the Department of Human Services under
402.12 section 256B.0659 for five years following the effective date of the nonrenewal or
402.13 revocation. If the owner and managerial officials already have enrollment status, their
402.14 enrollment will be terminated by the Department of Human Services.

402.15 (b) The commissioner shall not issue a license to a home care provider for five
402.16 years following the effective date of license nonrenewal or revocation if the owner or
402.17 managerial official, including any individual who was an owner or managerial official
402.18 of another home care provider, had a Minnesota license that was not renewed or was
402.19 revoked as described in paragraph (a).

402.20 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall
402.21 suspend or revoke, the license of any home care provider that includes any individual
402.22 as an owner or managerial official who was an owner or managerial official of a home
402.23 care provider whose Minnesota license was not renewed or was revoked as described in
402.24 paragraph (a) for five years following the effective date of the nonrenewal or revocation.

402.25 (d) The commissioner shall notify the home care provider 30 days in advance of
402.26 the date of nonrenewal, suspension, or revocation of the license. Within ten days after
402.27 the receipt of the notification, the home care provider may request, in writing, that the
402.28 commissioner stay the nonrenewal, revocation, or suspension of the license. The home
402.29 care provider shall specify the reasons for requesting the stay; the steps that will be taken
402.30 to attain or maintain compliance with the licensure laws and regulations; any limits on the
402.31 authority or responsibility of the owners or managerial officials whose actions resulted in
402.32 the notice of nonrenewal, revocation, or suspension; and any other information to establish
402.33 that the continuing affiliation with these individuals will not jeopardize client health, safety,
402.34 or well-being. The commissioner shall determine whether the stay will be granted within
402.35 30 days of receiving the provider's request. The commissioner may propose additional
402.36 restrictions or limitations on the provider's license and require that the granting of the stay

403.1 be contingent upon compliance with those provisions. The commissioner shall take into
403.2 consideration the following factors when determining whether the stay should be granted:

403.3 (1) the threat that continued involvement of the owners and managerial officials with
403.4 the home care provider poses to client health, safety, and well-being;

403.5 (2) the compliance history of the home care provider; and

403.6 (3) the appropriateness of any limits suggested by the home care provider.

403.7 If the commissioner grants the stay, the order shall include any restrictions or
403.8 limitation on the provider's license. The failure of the provider to comply with any
403.9 restrictions or limitations shall result in the immediate removal of the stay and the
403.10 commissioner shall take immediate action to suspend, revoke, or not renew the license.

403.11 Subd. 7. **Request for hearing.** A request for a hearing must be in writing and must:

403.12 (1) be mailed or delivered to the department or the commissioner's designee;

403.13 (2) contain a brief and plain statement describing every matter or issue contested; and

403.14 (3) contain a brief and plain statement of any new matter that the applicant or home
403.15 care provider believes constitutes a defense or mitigating factor.

403.16 Subd. 8. **Informal conference.** At any time, the applicant or home care provider
403.17 and the commissioner may hold an informal conference to exchange information, clarify
403.18 issues, or resolve issues.

403.19 Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the
403.20 commissioner may bring an action in district court to enjoin a person who is involved in
403.21 the management, operation, or control of a home care provider or an employee of the
403.22 home care provider from illegally engaging in activities regulated by sections 144A.43 to
403.23 144A.482. The commissioner may bring an action under this subdivision in the district
403.24 court in Ramsey County or in the district in which a home care provider is providing
403.25 services. The court may grant a temporary restraining order in the proceeding if continued
403.26 activity by the person who is involved in the management, operation, or control of a home
403.27 care provider, or by an employee of the home care provider, would create an imminent
403.28 risk of harm to a recipient of home care services.

403.29 Subd. 10. **Subpoena.** In matters pending before the commissioner under sections
403.30 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance
403.31 of witnesses and the production of all necessary papers, books, records, documents, and
403.32 other evidentiary material. If a person fails or refuses to comply with a subpoena or
403.33 order of the commissioner to appear or testify regarding any matter about which the
403.34 person may be lawfully questioned or to produce any papers, books, records, documents,
403.35 or evidentiary materials in the matter to be heard, the commissioner may apply to the
403.36 district court in any district, and the court shall order the person to comply with the

404.1 commissioner's order or subpoena. The commissioner of health may administer oaths to
404.2 witnesses or take their affirmation. Depositions may be taken in or outside the state in the
404.3 manner provided by law for the taking of depositions in civil actions. A subpoena or other
404.4 process or paper may be served on a named person anywhere in the state by an officer
404.5 authorized to serve subpoenas in civil actions, with the same fees and mileage and in the
404.6 same manner as prescribed by law for a process issued out of a district court. A person
404.7 subpoenaed under this subdivision shall receive the same fees, mileage, and other costs
404.8 that are paid in proceedings in district court.

404.9 Sec. 13. **[144A.476] BACKGROUND STUDIES.**

404.10 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a)
404.11 Before the commissioner issues a temporary license or renews a license, an owner or
404.12 managerial official is required to complete a background study under section 144.057. No
404.13 person may be involved in the management, operation, or control of a home care provider
404.14 if the person has been disqualified under chapter 245C. If an individual is disqualified
404.15 under section 144.057 or chapter 245C, the individual may request reconsideration of
404.16 the disqualification. If the individual requests reconsideration and the commissioner
404.17 sets aside or rescinds the disqualification, the individual is eligible to be involved in the
404.18 management, operation, or control of the provider. If an individual has a disqualification
404.19 under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's
404.20 disqualification is barred from a set aside, and the individual must not be involved in the
404.21 management, operation, or control of the provider.

404.22 (b) For purposes of this section, owners of a home care provider subject to the
404.23 background check requirement are those individuals whose ownership interest provides
404.24 sufficient authority or control to affect or change decisions related to the operation of the
404.25 home care provider. An owner includes a sole proprietor, a general partner, or any other
404.26 individual whose individual ownership interest can affect the management and direction
404.27 of the policies of the home care provider.

404.28 (c) For the purposes of this section, managerial officials subject to the background
404.29 check requirement are individuals who provide direct contact as defined in section 245C.02,
404.30 subdivision 11, or individuals who have the responsibility for the ongoing management or
404.31 direction of the policies, services, or employees of the home care provider. Data collected
404.32 under this subdivision shall be classified as private data under section 13.02, subdivision 12.

404.33 (d) The department shall not issue any license if the applicant or owner or managerial
404.34 official has been unsuccessful in having a background study disqualification set aside
404.35 under section 144.057 and chapter 245C; if the owner or managerial official, as an owner

405.1 or managerial official of another home care provider, was substantially responsible for
405.2 the other home care provider's failure to substantially comply with sections 144A.43 to
405.3 144A.482; or if an owner that has ceased doing business, either individually or as an
405.4 owner of a home care provider, was issued a correction order for failing to assist clients in
405.5 violation of this chapter.

405.6 Subd. 2. **Employees, contractors, and volunteers.** (a) Employees, contractors,
405.7 and volunteers of a home care provider are subject to the background study required by
405.8 section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall
405.9 be construed to prohibit a home care provider from requiring self-disclosure of criminal
405.10 conviction information.

405.11 (b) Termination of an employee in good faith reliance on information or records
405.12 obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not
405.13 subject the home care provider to civil liability or liability for unemployment benefits.

405.14 Sec. 14. **[144A.477] COMPLIANCE.**

405.15 Subdivision 1. **Medicare-certified providers; coordination of surveys.** If feasible,
405.16 the commissioner shall survey licensees to determine compliance with this chapter at the
405.17 same time as surveys for certification for Medicare if Medicare certification is based on
405.18 compliance with the federal conditions of participation and on survey and enforcement
405.19 by the Department of Health as agent for the United States Department of Health and
405.20 Human Services.

405.21 Subd. 2. **Medicare-certified providers; equivalent requirements.** For home care
405.22 providers licensed to provide comprehensive home care services that are also certified for
405.23 participation in Medicare as a home health agency under Code of Federal Regulations,
405.24 title 42, part 484, the following state licensure regulations are considered equivalent to
405.25 the federal requirements:

405.26 (1) quality management, section 144A.479, subdivision 3;

405.27 (2) personnel records, section 144A.479, subdivision 7;

405.28 (3) acceptance of clients, section 144A.4791, subdivision 4;

405.29 (4) referrals, section 144A.4791, subdivision 5;

405.30 (5) client assessment, sections 144A.4791, subdivision 8, and 144A.4792,

405.31 subdivisions 2 and 3;

405.32 (6) individualized monitoring and reassessment, sections 144A.4791, subdivision
405.33 8, and 144A.4792, subdivisions 2 and 3;

405.34 (7) individualized service plan, sections 144A.4791, subdivision 9, 144A.4792,
405.35 subdivision 5, and 144A.4793, subdivision 3;

406.1 (8) client complaint and investigation process, section 144A.4791, subdivision 11;
406.2 (9) prescription orders, section 144A.4792, subdivisions 13 to 16;
406.3 (10) client records, section 144A.4794, subdivisions 1 to 3;
406.4 (11) qualifications for unlicensed personnel performing delegated tasks, section
406.5 144A.4795;
406.6 (12) training and competency staff, section 144A.4795;
406.7 (13) training and competency for unlicensed personnel, section 144A.4795,
406.8 subdivision 7;
406.9 (14) delegation of home care services, section 144A.4795, subdivision 4;
406.10 (15) availability of contact person, section 144A.4797, subdivision 1; and
406.11 (16) supervision of staff, section 144A.4797, subdivisions 2 and 3.
406.12 Violations of requirements in clauses (1) to (16) may lead to enforcement actions
406.13 under section 144A.474.

406.14 Sec. 15. **[144A.478] INNOVATION VARIANCE.**

406.15 Subdivision 1. **Definition.** For purposes of this section, "innovation variance"
406.16 means a specified alternative to a requirement of this chapter. An innovation variance
406.17 may be granted to allow a home care provider to offer home care services of a type or
406.18 in a manner that is innovative, will not impair the services provided, will not adversely
406.19 affect the health, safety, or welfare of the clients, and is likely to improve the services
406.20 provided. The innovative variance cannot change any of the client's rights under section
406.21 144A.44, home care bill of rights.

406.22 Subd. 2. **Conditions.** The commissioner may impose conditions on the granting of
406.23 an innovation variance that the commissioner considers necessary.

406.24 Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any
406.25 innovation variance and may renew a limited innovation variance.

406.26 Subd. 4. **Applications; innovation variance.** An application for innovation
406.27 variance from the requirements of this chapter may be made at any time, must be made in
406.28 writing to the commissioner, and must specify the following:

406.29 (1) the statute or law from which the innovation variance is requested;

406.30 (2) the time period for which the innovation variance is requested;

406.31 (3) the specific alternative action that the licensee proposes;

406.32 (4) the reasons for the request; and

406.33 (5) justification that an innovation variance will not impair the services provided,
406.34 will not adversely affect the health, safety, or welfare of clients, and is likely to improve
406.35 the services provided.

407.1 The commissioner may require additional information from the home care provider before
407.2 acting on the request.

407.3 Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request
407.4 for an innovation variance in writing within 45 days of receipt of a complete request.
407.5 Notice of a denial shall contain the reasons for the denial. The terms of a requested
407.6 innovation variance may be modified upon agreement between the commissioner and
407.7 the home care provider.

407.8 Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of
407.9 an innovation variance shall be deemed to be a violation of this chapter.

407.10 Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or
407.11 deny renewal of an innovation variance if:

407.12 (1) it is determined that the innovation variance is adversely affecting the health,
407.13 safety, or welfare of the licensee's clients;

407.14 (2) the home care provider has failed to comply with the terms of the innovation
407.15 variance;

407.16 (3) the home care provider notifies the commissioner in writing that it wishes to
407.17 relinquish the innovation variance and be subject to the statute previously varied; or

407.18 (4) the revocation or denial is required by a change in law.

407.19 Sec. 16. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES;**
407.20 **BUSINESS OPERATION.**

407.21 Subdivision 1. **Display of license.** The original current license must be displayed
407.22 in the home care providers' principal business office and copies must be displayed in
407.23 any branch office. The home care provider must provide a copy of the license to any
407.24 person who requests it.

407.25 Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent,
407.26 or misleading advertising in the marketing of services. For purposes of this section,
407.27 advertising includes any verbal, written, or electronic means of communicating to
407.28 potential clients about the availability, nature, or terms of home care services.

407.29 Subd. 3. **Quality management.** The home care provider shall engage in quality
407.30 management appropriate to the size of the home care provider and relevant to the type
407.31 of services the home care provider provides. The quality management activity means
407.32 evaluating the quality of care by periodically reviewing client services, complaints made,
407.33 and other issues that have occurred and determining whether changes in services, staffing,
407.34 or other procedures need to be made in order to ensure safe and competent services to
407.35 clients. Documentation about quality management activity must be available for two

408.1 years. Information about quality management must be available to the commissioner at
408.2 the time of the survey, investigation, or renewal.

408.3 Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licenses
408.4 that are Minnesota counties or other units of government.

408.5 (b) A home care provider or staff cannot accept powers-of-attorney from clients for
408.6 any purpose, and may not accept appointments as guardians or conservators of clients.

408.7 (c) A home care provider cannot serve as a client's representative.

408.8 Subd. 5. **Handling of client's finances and property.** (a) A home care provider
408.9 may assist clients with household budgeting, including paying bills and purchasing
408.10 household goods, but may not otherwise manage a client's property. A home care provider
408.11 must provide a client with receipts for all transactions and purchases paid with the clients'
408.12 funds. When receipts are not available, the transaction or purchase must be documented.
408.13 A home care provider must maintain records of all such transactions.

408.14 (b) A home care provider or staff may not borrow a client's funds or personal or
408.15 real property, nor in any way convert a client's property to the home care provider's or
408.16 staff's possession.

408.17 (c) Nothing in this section precludes a home care provider or staff from accepting
408.18 gifts of minimal value, or precludes the acceptance of donations or bequests made to a
408.19 home care provider that are exempt from income tax under section 501(c) of the Internal
408.20 Revenue Code of 1986.

408.21 Subd. 6. **Reporting maltreatment of vulnerable adults and minors.** (a) All
408.22 home care providers must comply with requirements for the reporting of maltreatment
408.23 of minors in section 626.556 and the requirements for the reporting of maltreatment
408.24 of vulnerable adults in section 626.557. Home care providers must report suspected
408.25 maltreatment of minors and vulnerable adults to the common entry point. Each home
408.26 care provider must establish and implement a written procedure to ensure that all cases
408.27 of suspected maltreatment are reported.

408.28 (b) Each home care provider must develop and implement an individual abuse
408.29 prevention plan for each vulnerable minor or adult for whom home care services are
408.30 provided by a home care provider. The plan shall contain an individualized review or
408.31 assessment of the person's susceptibility to abuse by another individual, including other
408.32 vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors;
408.33 and statements of the specific measures to be taken to minimize the risk of abuse to that
408.34 person and other vulnerable adults or minors. For purposes of the abuse prevention plan,
408.35 the term abuse includes self-abuse.

409.1 Subd. 7. **Employee records.** The home care provider must maintain current records
 409.2 of each paid employee, regularly scheduled volunteers providing home care services, and
 409.3 of each individual contractor providing home care services. The records must include
 409.4 the following information:

409.5 (1) evidence of current professional licensure, registration, or certification, if
 409.6 licensure, registration, or certification is required by this statute, or other rules;

409.7 (2) records of orientation, required annual training and infection control training,
 409.8 and competency evaluations;

409.9 (3) current job description, including qualifications, responsibilities, and
 409.10 identification of staff providing supervision;

409.11 (4) documentation of annual performance reviews which identify areas of
 409.12 improvement needed and training needs;

409.13 (5) for individuals providing home care services, verification that required health
 409.14 screenings under section 144A.4798 have taken place and the dates of those screenings; and

409.15 (6) documentation of the background study as required under section 144.057.

409.16 Each employee record must be retained for at least three years after a paid employee,
 409.17 home care volunteer, or contractor ceases to be employed by or under contract with the
 409.18 home care provider. If a home care provider ceases operation, employee records must be
 409.19 maintained for three years.

409.20 Sec. 17. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH**
 409.21 **RESPECT TO CLIENTS.**

409.22 Subdivision 1. **Home care bill of rights; notification to client.** (a) The home
 409.23 care provider shall provide the client or the client's representative a written notice of the
 409.24 rights under section 144A.44 in a language that the client or the client's representative
 409.25 can understand before the initiation of services to that client. If a written version is not
 409.26 available, the home care bill of rights must be communicated to the client or client's
 409.27 representative in a language they can understand.

409.28 (b) In addition to the text of the home care bill of rights in section 144A.44,
 409.29 subdivision 1, the notice shall also contain the following statement describing how to file
 409.30 a complaint with these offices.

409.31 "If you have a complaint about the provider or the person providing your
 409.32 home care services, you may call, write, or visit the Office of Health Facility
 409.33 Complaints, Minnesota Department of Health. You may also contact the Office of
 409.34 Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health
 409.35 and Developmental Disabilities."

410.1 The statement should include the telephone number, Web site address, e-mail
410.2 address, mailing address, and street address of the Office of Health Facility Complaints at
410.3 the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care,
410.4 and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The
410.5 statement should also include the home care provider's name, address, e-mail, telephone
410.6 number, and name or title of the person at the provider to whom problems or complaints
410.7 may be directed. It must also include a statement that the home care provider will not
410.8 retaliate because of a complaint.

410.9 (c) The home care provider shall obtain written acknowledgment of the client's
410.10 receipt of the home care bill of rights or shall document why an acknowledgment cannot
410.11 be obtained. The acknowledgment may be obtained from the client or the client's
410.12 representative. Acknowledgment of receipt shall be retained in the client's record.

410.13 Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related**
410.14 **disorders.** The home care provider that provides services to clients with dementia shall
410.15 provide in written or electronic form, to clients and families or other persons who request
410.16 it, a description of the training program and related training it provides, including the
410.17 categories of employees trained, the frequency of training, and the basic topics covered.
410.18 This information satisfies the disclosure requirements in section 325F.72, subdivision
410.19 2, clause (4).

410.20 Subd. 3. **Statement of home care services.** Prior to the initiation of services,
410.21 a home care provider must provide to the client or the client's representative a written
410.22 statement which identifies if they have a basic or comprehensive home care license, the
410.23 services they are authorized to provide, and which services they cannot provide under the
410.24 scope of their license. The home care provider shall obtain written acknowledgment
410.25 from the clients that they have provided the statement or must document why they could
410.26 not obtain the acknowledgment.

410.27 Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a
410.28 client unless the home care provider has staff, sufficient in qualifications, competency,
410.29 and numbers, to adequately provide the services agreed to in the service plan and that
410.30 are within the provider's scope of practice.

410.31 Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in
410.32 need of another medical or health service, including a licensed health professional, or
410.33 social service provider, the home care provider shall:

410.34 (1) determine the client's preferences with respect to obtaining the service; and

410.35 (2) inform the client of resources available, if known, to assist the client in obtaining
410.36 services.

411.1 Subd. 6. **Initiation of services.** When a provider initiates services and the
411.2 individualized review or assessment required in subdivisions 7 and 8 has not been
411.3 completed, the provider must complete a temporary plan and agreement with the client for
411.4 services.

411.5 Subd. 7. **Basic individualized client review and monitoring.** (a) When services
411.6 being provided are basic home care services, an individualized initial review of the client's
411.7 needs and preferences must be conducted at the client's residence with the client or client's
411.8 representative. This initial review must be completed within 30 days after the initiation of
411.9 the home care services.

411.10 (b) Client monitoring and review must be conducted as needed based on changes
411.11 in the needs of the client and cannot exceed 90 days from the date of the last review.
411.12 The monitoring and review may be conducted at the client's residence or through the
411.13 utilization of telecommunication methods based on practice standards that meet the
411.14 individual client's needs.

411.15 Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When
411.16 the services being provided are comprehensive home care services, an individualized
411.17 initial assessment must be conducted in-person by a registered nurse. When the services
411.18 are provided by other licensed health professionals, the assessment must be conducted by
411.19 the appropriate health professional. This initial assessment must be completed within five
411.20 days after initiation of home care services.

411.21 (b) Client monitoring and reassessment must be conducted in the client's home no
411.22 more than 14 days after initiation of services.

411.23 (c) Ongoing client monitoring and reassessment must be conducted as needed based
411.24 on changes in the needs of the client and cannot exceed 90 days from the last date of the
411.25 assessment. The monitoring and reassessment may be conducted at the client's residence
411.26 or through the utilization of telecommunication methods based on practice standards that
411.27 meet the individual client's needs.

411.28 Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later
411.29 than 14 days after the initiation of services, a home care provider shall finalize a current
411.30 written service plan.

411.31 (b) The service plan and any revisions must include a signature or other
411.32 authentication by the home care provider and by the client or the client's representative
411.33 documenting agreement on the services to be provided. The service plan must be revised,
411.34 if needed, based on client review or reassessment under subdivisions 7 and 8. The provider
411.35 must provide information to the client about changes to the provider's fee for services and
411.36 how to contact the Office of the Ombudsman for Long-Term Care.

412.1 (c) The home care provider must implement and provide all services required by
412.2 the current service plan.

412.3 (d) The service plan and revised service plan must be entered into the client's record,
412.4 including notice of a change in a client's fees when applicable.

412.5 (e) Staff providing home care services must be informed of the current written
412.6 service plan.

412.7 (f) The service plan must include:

412.8 (1) a description of the home care services to be provided, the fees for services, and
412.9 the frequency of each service, according to the client's current review or assessment and
412.10 client preferences;

412.11 (2) the identification of the staff or categories of staff who will provide the services;

412.12 (3) the schedule and methods of monitoring reviews or assessments of the client;

412.13 (4) the frequency of sessions of supervision of staff and type of personnel who
412.14 will supervise staff; and

412.15 (5) a contingency plan that includes:

412.16 (i) the action to be taken by the home care provider and by the client or client's
412.17 representative if the scheduled service cannot be provided;

412.18 (ii) information and method for a client or client's representative to contact the
412.19 home care provider;

412.20 (iii) names and contact information of persons the client wishes to have notified
412.21 in an emergency or if there is a significant adverse change in the client's condition,
412.22 including identification of and information as to who has authority to sign for the client in
412.23 an emergency; and

412.24 (iv) the circumstances in which emergency medical services are not to be summoned
412.25 consistent with chapters 145B and 145C, and declarations made by the client under those
412.26 chapters.

412.27 **Subd. 10. Termination of service plan.** (a) If a home care provider terminates a
412.28 service plan with a client, and the client continues to need home care services, the home
412.29 care provider shall provide the client and the client's representative, if any, with a written
412.30 notice of termination which includes the following information:

412.31 (1) the effective date of termination;

412.32 (2) the reason for termination;

412.33 (3) a list of known licensed home care providers in the client's immediate geographic
412.34 area;

413.1 (4) a statement that the home care provider will participate in a coordinated transfer
413.2 of care of the client to another home care provider, health care provider, or caregiver, as
413.3 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

413.4 (5) the name and contact information of a person employed by the home care
413.5 provider with whom the client may discuss the notice of termination; and

413.6 (6) if applicable, a statement that the notice of termination of home care services
413.7 does not constitute notice of termination of the housing with services contract with a
413.8 housing with services establishment.

413.9 (b) When the home care provider voluntarily discontinues services to all clients, the
413.10 home care provider must notify the commissioner, lead agencies, and the ombudsman for
413.11 long-term care about its clients and comply with the requirements in this subdivision.

413.12 Subd. 11. **Client complaint and investigative process.** (a) The home care
413.13 provider must have a written policy and system for receiving, investigating, reporting,
413.14 and attempting to resolve complaints from its clients or clients' representatives. The
413.15 policy should clearly identify the process by which clients may file a complaint or concern
413.16 about home care services and an explicit statement that the home care provider will not
413.17 discriminate or retaliate against a client for expressing concerns or complaints. A home
413.18 care provider must have a process in place to conduct investigations of complaints made
413.19 by the client or the client's representative about the services in the client's plan that are or
413.20 are not being provided or other items covered in the client's home care bill of rights. This
413.21 complaint system must provide reasonable accommodations for any special needs of the
413.22 client or client's representative if requested.

413.23 (b) The home care provider must document the complaint, name of the client,
413.24 investigation, and resolution of each complaint filed. The home care provider must
413.25 maintain a record of all activities regarding complaints received, including the date the
413.26 complaint was received, and the home care provider's investigation and resolution of the
413.27 complaint. This complaint record must be kept for each event for at least two years after
413.28 the date of entry and must be available to the commissioner for review.

413.29 (c) The required complaint system must provide for written notice to each client or
413.30 client's representative that includes:

413.31 (1) the client's right to complain to the home care provider about the services received;

413.32 (2) the name or title of the person or persons with the home care provider to contact
413.33 with complaints;

413.34 (3) the method of submitting a complaint to the home care provider; and

413.35 (4) a statement that the provider is prohibited against retaliation according to
413.36 paragraph (d).

414.1 (d) A home care provider must not take any action that negatively affects a client
414.2 in retaliation for a complaint made or a concern expressed by the client or the client's
414.3 representative.

414.4 Subd. 12. **Disaster planning and emergency preparedness plan.** The home care
414.5 provider must have a written plan of action to facilitate the management of the client's care
414.6 and services in response to a natural disaster, such as flood and storms, or other emergencies
414.7 that may disrupt the home care provider's ability to provide care or services. The licensee
414.8 must provide adequate orientation and training of staff on emergency preparedness.

414.9 Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a
414.10 client, family member, or other caregiver of the client requests that an employee or other
414.11 agent of the home care provider discontinue a life-sustaining treatment, the employee or
414.12 agent receiving the request:

414.13 (1) shall take no action to discontinue the treatment; and

414.14 (2) shall promptly inform their supervisor or other agent of the home care provider
414.15 of the client's request.

414.16 (b) Upon being informed of a request for termination of treatment, the home care
414.17 provider shall promptly:

414.18 (1) inform the client that the request will be made known to the physician who
414.19 ordered the client's treatment;

414.20 (2) inform the physician of the client's request; and

414.21 (3) work with the client and the client's physician to comply with the provisions of
414.22 the Health Care Directive Act in chapter 145C.

414.23 (c) This section does not require the home care provider to discontinue treatment,
414.24 except as may be required by law or court order.

414.25 (d) This section does not diminish the rights of clients to control their treatments,
414.26 refuse services, or terminate their relationships with the home care provider.

414.27 (e) This section shall be construed in a manner consistent with chapter 145B or
414.28 145C, whichever applies, and declarations made by clients under those chapters.

414.29 **Sec. 18. [144A.4792] MEDICATION MANAGEMENT.**

414.30 Subdivision 1. **Medication management services; comprehensive home care**
414.31 **license.** (a) This subdivision applies only to home care providers with a comprehensive
414.32 home care license that provides medication management services to clients. Medication
414.33 management services may not be provided by a home care provider that has a basic
414.34 home care license.

415.1 (b) A comprehensive home care provider who provides medication management
415.2 services must develop, implement, and maintain current written medication management
415.3 policies and procedures. The policies and procedures must be developed under the
415.4 supervision and direction of a registered nurse, licensed health professional, or pharmacist
415.5 consistent with current practice standards and guidelines.

415.6 (c) The written policies and procedures must address requesting and receiving
415.7 prescriptions for medications; preparing and giving medications; verifying that
415.8 prescription drugs are administered as prescribed; documenting medication management
415.9 activities; controlling and storing medications; monitoring and evaluating medication use;
415.10 resolving medication errors; communicating with the prescriber, pharmacist, and client
415.11 and client representative, if any; disposing of unused medications; and educating clients
415.12 and client representatives about medications. When controlled substances are being
415.13 managed, the policies and procedures must also identify how the provider will ensure
415.14 security and accountability for the overall management, control, and disposition of those
415.15 substances in compliance with state and federal regulations and with subdivision 22.

415.16 Subd. 2. **Provision of medication management services.** (a) For each client who
415.17 requests medication management services, the comprehensive home care provider shall,
415.18 prior to providing medication management services, have a registered nurse, licensed
415.19 health professional, or authorized prescriber under section 151.37 conduct an assessment
415.20 to determine what medication management services will be provided and how the services
415.21 will be provided. This assessment must be conducted face-to-face with the client. The
415.22 assessment must include an identification and review of all medications the client is known
415.23 to be taking. The review and identification must include indications for medications, side
415.24 effects, contraindications, allergic or adverse reactions, and actions to address these issues.

415.25 (b) The assessment must identify interventions needed in management of
415.26 medications to prevent diversion of medication by the client or others who may have
415.27 access to the medications. Diversion of medications means the misuse, theft, or illegal
415.28 or improper disposition of medications.

415.29 Subd. 3. **Individualized medication monitoring and reassessment.** The
415.30 comprehensive home care provider must monitor and reassess the client's medication
415.31 management services as needed under subdivision 14 when the client presents with
415.32 symptoms or other issues that may be medication-related and, at a minimum, annually.

415.33 Subd. 4. **Client refusal.** The home care provider must document in the client's
415.34 record any refusal for an assessment for medication management by the client. The
415.35 provider must discuss with the client the possible consequences of the client's refusal and
415.36 document the discussion in the client's record.

416.1 Subd. 5. **Individualized medication management plan.** (a) For each client
416.2 receiving medication management services, the comprehensive home care provider must
416.3 prepare and include in the service plan a written statement of the medication management
416.4 services that will be provided to the client. The provider must develop and maintain a
416.5 current individualized medication management record for each client based on the client's
416.6 assessment that must contain the following:

416.7 (1) a statement describing the medication management services that will be provided;

416.8 (2) a description of storage of medications based on the client's needs and
416.9 preferences, risk of diversion, and consistent with the manufacturer's directions;

416.10 (3) documentation of specific client instructions relating to the administration
416.11 of medications;

416.12 (4) identification of persons responsible for monitoring medication supplies and
416.13 ensuring that medication refills are ordered on a timely basis;

416.14 (5) identification of medication management tasks that may be delegated to
416.15 unlicensed personnel;

416.16 (6) procedures for staff notifying a registered nurse or appropriate licensed health
416.17 professional when a problem arises with medication management services; and

416.18 (7) any client-specific requirements relating to documenting medication
416.19 administration, verifications that all medications are administered as prescribed, and
416.20 monitoring of medication use to prevent possible complications or adverse reactions.

416.21 (b) The medication management record must be current and updated when there are
416.22 any changes.

416.23 Subd. 6. **Administration of medication.** Medications may be administered by a
416.24 nurse, physician, or other licensed health practitioner authorized to administer medications
416.25 or by unlicensed personnel who have been delegated medication administration tasks by
416.26 a registered nurse.

416.27 Subd. 7. **Delegation of medication administration.** When administration of
416.28 medications is delegated to unlicensed personnel, the comprehensive home care provider
416.29 must ensure that the registered nurse has:

416.30 (1) instructed the unlicensed personnel in the proper methods to administer the
416.31 medications, and the unlicensed personnel has demonstrated ability to competently follow
416.32 the procedures;

416.33 (2) specified, in writing, specific instructions for each client and documented those
416.34 instructions in the client's records; and

416.35 (3) communicated with the unlicensed personnel about the individual needs of
416.36 the client.

417.1 Subd. 8. Documentation of administration of medications. Each medication
417.2 administered by comprehensive home care provider staff must be documented in the
417.3 client's record. The documentation must include the signature and title of the person
417.4 who administered the medication. The documentation must include the medication
417.5 name, dosage, date and time administered, and method and route of administration. The
417.6 staff must document the reason why medication administration was not completed as
417.7 prescribed and document any follow-up procedures that were provided to meet the client's
417.8 needs when medication was not administered as prescribed and in compliance with the
417.9 client's medication management plan.

417.10 Subd. 9. Documentation of medication set up. Documentation of dates of
417.11 medication set up, name of medication, quantity of dose, times to be administered, route
417.12 of administration, and name of person completing medication set up must be done at
417.13 time of set up.

417.14 Subd. 10. Medications management for clients who will be away from home. (a)
417.15 A home care provider that is providing medication management services to the client and
417.16 controls the client's access to the medications must develop and implement policies and
417.17 procedures for giving accurate and current medications to clients for planned or unplanned
417.18 times away from home according to the client's individualized medication management
417.19 plan. The policy and procedures must state that:

417.20 (1) for planned time away, the medications must be obtained from the pharmacy or
417.21 set up by the registered nurse according to appropriate state and federal laws and nursing
417.22 standards of practice;

417.23 (2) for unplanned time away, when the pharmacy is not able to provide the
417.24 medications, a licensed nurse or unlicensed personnel shall give the client or client's
417.25 representative medications in amounts and dosages needed for the length of the anticipated
417.26 absence, not to exceed 120 hours;

417.27 (3) the client, or the client's representative, must be provided written information
417.28 on medications, including any special instructions for administering or handling the
417.29 medications, including controlled substances;

417.30 (4) the medications must be placed in a medication container or containers
417.31 appropriate to the provider's medication system and must be labeled with the client's name
417.32 and the dates and times that the medications are scheduled; and

417.33 (5) the client or client's representative must be provided in writing the home care
417.34 provider's name and information on how to contact the home care provider.

417.35 (b) For unplanned time away when the licensed nurse is not available, the registered
417.36 nurse may delegate this task to unlicensed personnel if:

418.1 (1) the registered nurse has trained the unlicensed staff and determined the
418.2 unlicensed staff is competent to follow the procedures for giving medications to clients;

418.3 (2) the registered nurse has developed written procedures for the unlicensed
418.4 personnel, including any special instructions or procedures regarding controlled substances
418.5 that are prescribed for the client. The procedures must address:

418.6 (i) the type of container or containers to be used for the medications appropriate to
418.7 the provider's medication system;

418.8 (ii) how the container or containers must be labeled;

418.9 (iii) the written information about the medications to be given to the client or client's
418.10 representative;

418.11 (iv) how the unlicensed staff will document in the client's record that medications
418.12 have been given to the client or the client's representative, including documenting the date
418.13 the medications were given to the client or the client's representative and who received the
418.14 medications, the person who gave the medications to the client, the number of medications
418.15 that were given to the client, and other required information;

418.16 (v) how the registered nurse will be notified that medications have been given to
418.17 the client or client's representative and whether the registered nurse needs to be contacted
418.18 before the medications are given to the client or the client's representative; and

418.19 (vi) a review by the registered nurse of the completion of this task to verify that this
418.20 task was completed accurately by the unlicensed personnel.

418.21 Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home
418.22 care provider must determine whether it will require a prescription for all medications it
418.23 manages. The comprehensive home care provider must inform the client or the client's
418.24 representative whether the comprehensive home care provider requires a prescription
418.25 for all over-the-counter and dietary supplements before the comprehensive home care
418.26 provider will agree to manage those medications.

418.27 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.**

418.28 A comprehensive home care provider providing medication management services for
418.29 over-the-counter drugs or dietary supplements must retain those items in the original labeled
418.30 container with directions for use prior to setting up for immediate or later administration.
418.31 The provider must verify that the medications are up-to-date and stored as appropriate.

418.32 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
418.33 prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed
418.34 medications that the comprehensive home care provider is managing for the client.

419.1 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least
419.2 every 12 months or more frequently as indicated by the assessment in subdivision 2.
419.3 Prescriptions for controlled substances must comply with chapter 152.

419.4 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an
419.5 authorized prescriber must be received by a nurse or pharmacist. The order must be
419.6 handled according to Minnesota Rules, part 6800.6200.

419.7 Subd. 16. **Written or electronic prescription.** When a written or electronic
419.8 prescription is received, it must be communicated to the registered nurse in charge and
419.9 recorded or placed in the client's record.

419.10 Subd. 17. **Records confidential.** A prescription or order received verbally, in
419.11 writing, or electronically must be kept confidential according to sections 144.291 to
419.12 144.298 and 144A.44.

419.13 Subd. 18. **Medications provided by client or family members.** When the
419.14 comprehensive home care provider is aware of any medications or dietary supplements
419.15 that are being used by the client and are not included in the assessment for medication
419.16 management services, the staff must advise the registered nurse and document that in
419.17 the client's record.

419.18 Subd. 19. **Storage of drugs.** A comprehensive home care provider providing
419.19 storage of medications outside of the client's private living space must store all prescription
419.20 drugs in securely locked and substantially constructed compartments according to the
419.21 manufacturer's directions and permit only authorized personnel to have access.

419.22 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for
419.23 immediate or later administration, must be kept in the original container in which it was
419.24 dispensed by the pharmacy bearing the original prescription label with legible information
419.25 including the expiration or beyond-use date of a time-dated drug.

419.26 Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or
419.27 saved for use by anyone other than the client.

419.28 Subd. 22. **Disposition of drugs.** (a) Any current medications being managed by the
419.29 comprehensive home care provider must be given to the client or the client's representative
419.30 when the client's service plan ends or medication management services are no longer part
419.31 of the service plan. Medications that have been stored in the client's private living space
419.32 for a client that is deceased or that have been discontinued or that have expired may be
419.33 given to the client or the client's representative for disposal.

419.34 (b) The comprehensive home care provider will dispose of any medications
419.35 remaining with the comprehensive home care provider that are discontinued or expired or

420.1 upon the termination of the service contract or the client's death according to state and
420.2 federal regulations for disposition of drugs and controlled substances.

420.3 (c) Upon disposition, the comprehensive home care provider must document in the
420.4 client's record the disposition of the medications including the medication's name, strength,
420.5 prescription number as applicable, quantity, to whom the medications were given, date of
420.6 disposition, and names of staff and other individuals involved in the disposition.

420.7 Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing
420.8 medication management must develop and implement procedures for loss or spillage of all
420.9 controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must
420.10 require that when a spillage of a controlled substance occurs, a notation must be made
420.11 in the client's record explaining the spillage and the actions taken. The notation must
420.12 be signed by the person responsible for the spillage and include verification that any
420.13 contaminated substance was disposed of according to state or federal regulations.

420.14 (b) The procedures must require the comprehensive home care provider of
420.15 medication management to investigate any known loss or unaccounted for prescription
420.16 drugs and take appropriate action required under state or federal regulations and document
420.17 the investigation in required records.

420.18 Sec. 19. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT**
420.19 **SERVICES.**

420.20 Subdivision 1. **Providers with a comprehensive home care license.** This section
420.21 applies only to home care providers with a comprehensive home care license that provide
420.22 treatment or therapy management services to clients. Treatment or therapy management
420.23 services cannot be provided by a home care provider that has a basic home care license.

420.24 Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who
420.25 provides treatment and therapy management services must develop, implement, and
420.26 maintain up-to-date written treatment or therapy management policies and procedures.
420.27 The policies and procedures must be developed under the supervision and direction of
420.28 a registered nurse or appropriate licensed health professional consistent with current
420.29 practice standards and guidelines.

420.30 (b) The written policies and procedures must address requesting and receiving
420.31 orders or prescriptions for treatments or therapies, providing the treatment or therapy,
420.32 documenting of treatment or therapy activities, educating and communicating with clients
420.33 about treatments or therapy they are receiving, monitoring and evaluating the treatment
420.34 and therapy, and communicating with the prescriber.

421.1 Subd. 3. **Individualized treatment or therapy management plan.** For each
421.2 client receiving management of ordered or prescribed treatments or therapy services, the
421.3 comprehensive home care provider must prepare and include in the service plan a written
421.4 statement of the treatment or therapy services that will be provided to the client. The
421.5 provider must also develop and maintain a current individualized treatment and therapy
421.6 management record for each client which must contain at least the following:

421.7 (1) a statement of the type of services that will be provided;

421.8 (2) documentation of specific client instructions relating to the treatments or therapy
421.9 administration;

421.10 (3) identification of treatment or therapy tasks that will be delegated to unlicensed
421.11 personnel;

421.12 (4) procedures for notifying a registered nurse or appropriate licensed health
421.13 professional when a problem arises with treatments or therapy services; and

421.14 (5) any client-specific requirements relating to documentation of treatment
421.15 and therapy received, verification that all treatment and therapy was administered as
421.16 prescribed, and monitoring of treatment or therapy to prevent possible complications or
421.17 adverse reactions. The treatment or therapy management record must be current and
421.18 updated when there are any changes.

421.19 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed
421.20 treatments or therapies must be administered by a nurse, physician, or other licensed health
421.21 professional authorized to perform the treatment or therapy, or may be delegated or assigned
421.22 to unlicensed personnel by the licensed health professional according to the appropriate
421.23 practice standards for delegation or assignment. When administration of a treatment or
421.24 therapy is delegated or assigned to unlicensed personnel, the home care provider must
421.25 ensure that the registered nurse or authorized licensed health professional has:

421.26 (1) instructed the unlicensed personnel in the proper methods with respect to each
421.27 client and has demonstrated their ability to competently follow the procedures;

421.28 (2) specified, in writing, specific instructions for each client and documented those
421.29 instructions in the client's record; and

421.30 (3) communicated with the unlicensed personnel about the individual needs of
421.31 the client.

421.32 Subd. 5. **Documentation of administration of treatments and therapies.** Each
421.33 treatment or therapy administered by a comprehensive home care provider must be
421.34 documented in the client's record. The documentation must include the signature and title
421.35 of the person who administered the treatment or therapy and must include the date and
421.36 time of administration. When treatment or therapies are not administered as ordered or

422.1 prescribed, the provider must document the reason why it was not administered and any
422.2 follow-up procedures that were provided to meet the client's needs.

422.3 Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or
422.4 electronically recorded order or prescription for all treatments and therapies. The order
422.5 must contain the name of the client, description of the treatment or therapy to be provided,
422.6 and the frequency and other information needed to administer the treatment or therapy.

422.7 Sec. 20. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

422.8 Subdivision 1. **Client record.** (a) The home care provider must maintain records
422.9 for each client for whom it is providing services. Entries in the client records must be
422.10 current, legible, permanently recorded, dated, and authenticated with the name and title
422.11 of the person making the entry.

422.12 (b) Client records, whether written or electronic, must be protected against loss,
422.13 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
422.14 relevant federal and state laws. The home care provider shall establish and implement
422.15 written procedures to control use, storage, and security of client's records and establish
422.16 criteria for release of client information.

422.17 (c) The home care provider may not disclose to any other person any personal,
422.18 financial, medical, or other information about the client, except:

422.19 (1) as may be required by law;

422.20 (2) to employees or contractors of the home care provider, another home care
422.21 provider, other health care practitioner or provider, or inpatient facility needing
422.22 information in order to provide services to the client, but only such information that
422.23 is necessary for the provision of services;

422.24 (3) to persons authorized in writing by the client or the client's representative to
422.25 receive the information, including third-party payers; and

422.26 (4) to representatives of the commissioner authorized to survey or investigate home
422.27 care providers under this chapter or federal laws.

422.28 Subd. 2. **Access to records.** The home care provider must ensure that the
422.29 appropriate records are readily available to employees or contractors authorized to access
422.30 the records. Client records must be maintained in a manner that allows for timely access,
422.31 printing, or transmission of the records.

422.32 Subd. 3. **Contents of client record.** Contents of a client record include the
422.33 following for each client:

422.34 (1) identifying information, including the client's name, date of birth, address, and
422.35 telephone number;

- 423.1 (2) the name, address, and telephone number of an emergency contact, family
423.2 members, client's representative, if any, or others as identified;
- 423.3 (3) names, addresses, and telephone numbers of the client's health and medical
423.4 service providers and other home care providers, if known;
- 423.5 (4) health information, including medical history, allergies, and when the provider
423.6 is managing medications, treatments or therapies that require documentation, and other
423.7 relevant health records;
- 423.8 (5) client's advance directives, if any;
- 423.9 (6) the home care provider's current and previous assessments and service plans;
- 423.10 (7) all records of communications pertinent to the client's home care services;
- 423.11 (8) documentation of significant changes in the client's status and actions taken in
423.12 response to the needs of the client including reporting to the appropriate supervisor or
423.13 health care professional;
- 423.14 (9) documentation of incidents involving the client and actions taken in response
423.15 to the needs of the client including reporting to the appropriate supervisor or health
423.16 care professional;
- 423.17 (10) documentation that services have been provided as identified in the service plan;
- 423.18 (11) documentation that the client has received and reviewed the home care bill
423.19 of rights;
- 423.20 (12) documentation that the client has been provided the statement of disclosure on
423.21 limitations of services under section 144A.4791, subdivision 3;
- 423.22 (13) documentation of complaints received and resolution;
- 423.23 (14) discharge summary, including service termination notice and related
423.24 documentation, when applicable; and
- 423.25 (15) other documentation required under this chapter and relevant to the client's
423.26 services or status.
- 423.27 Subd. 4. **Transfer of client records.** If a client transfers to another home care
423.28 provider or other health care practitioner or provider, or is admitted to an inpatient facility,
423.29 the home care provider, upon request of the client or the client's representative, shall take
423.30 steps to ensure a coordinated transfer including sending a copy or summary of the client's
423.31 record to the new home care provider, facility, or the client, as appropriate.
- 423.32 Subd. 5. **Record retention.** Following the client's discharge or termination of
423.33 services, a home care provider must retain a client's record for at least five years, or as
423.34 otherwise required by state or federal regulations. Arrangements must be made for secure
423.35 storage and retrieval of client records if the home care provider ceases business.

424.1 Sec. 21. [144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.

424.2 Subdivision 1. **Qualifications, training, and competency.** All staff providing
424.3 home care services must be trained and competent in the provision of home care services
424.4 consistent with current practice standards appropriate to the client's needs.

424.5 Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health
424.6 professionals and nurses providing home care services as an employee of a licensed home
424.7 care provider must possess current Minnesota license or registration to practice.

424.8 (b) Licensed health professionals and registered nurses must be competent in
424.9 assessing client needs, planning appropriate home care services to meet client needs,
424.10 implementing services, and supervising staff if assigned.

424.11 (c) Nothing in this section limits or expands the rights of nurses or licensed health
424.12 professionals to provide services within the scope of their licenses or registrations, as
424.13 provided by law.

424.14 Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home
424.15 care services must have:

424.16 (1) successfully completed a training and competency evaluation appropriate to
424.17 the services provided by the home care provider and the topics listed in subdivision 7,
424.18 paragraph (b); or

424.19 (2) demonstrated competency by satisfactorily completing a written or oral test on
424.20 the tasks the unlicensed personnel will perform and in the topics listed in subdivision
424.21 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7,
424.22 paragraph (b), clauses (5), (7), and (8), by a practical skills test.

424.23 Unlicensed personnel providing home care services for a basic home care provider may
424.24 not perform delegated nursing or therapy tasks.

424.25 (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive
424.26 home care provider must:

424.27 (1) have successfully completed training and demonstrated competency by
424.28 successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b)
424.29 and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5)
424.30 and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

424.31 (2) satisfy the current requirements of Medicare for training or competency of home
424.32 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
424.33 section 483 or section 484.36; or

424.34 (3) have, before April 19, 1993, completed a training course for nursing assistants
424.35 that was approved by the commissioner.

425.1 (c) Unlicensed personnel performing therapy or treatment tasks delegated or
425.2 assigned by a licensed health professional must meet the requirements for delegated
425.3 tasks in subdivision 4 and any other training or competency requirements within the
425.4 licensed health professional scope of practice relating to delegation or assignment of tasks
425.5 to unlicensed personnel.

425.6 Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health
425.7 professional may delegate tasks only to staff that are competent and possess the knowledge
425.8 and skills consistent with the complexity of the tasks and according to the appropriate
425.9 Minnesota Practice Act. The comprehensive home care provider must establish and
425.10 implement a system to communicate up-to-date information to the registered nurse or
425.11 licensed health professional regarding the current available staff and their competency so
425.12 the registered nurse or licensed health professional has sufficient information to determine
425.13 the appropriateness of delegating tasks to meet individual client needs and preferences.

425.14 Subd. 5. **Individual contractors.** When a home care provider contracts with an
425.15 individual contractor excluded from licensure under section 144A.471 to provide home
425.16 care services, the contractor must meet the same requirements required by this section for
425.17 personnel employed by the home care provider.

425.18 Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary
425.19 staffing agency excluded from licensure under section 144A.471, those individuals must
425.20 meet the same requirements required by this section for personnel employed by the home
425.21 care provider and shall be treated as if they are staff of the home care provider.

425.22 Subd. 7. **Requirements for instructors, training content, and competency**
425.23 **evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must
425.24 meet the following requirements:

425.25 (1) training and competency evaluations of unlicensed personnel providing basic
425.26 home care services must be conducted by individuals with work experience and training in
425.27 providing home care services listed in section 144A.471, subdivisions 6 and 7; and

425.28 (2) training and competency evaluations of unlicensed personnel providing
425.29 comprehensive home care services must be conducted by a registered nurse, or another
425.30 instructor may provide training in conjunction with the registered nurse. If the home care
425.31 provider is providing services by licensed health professionals only, then that specific
425.32 training and competency evaluation may be conducted by the licensed health professionals
425.33 as appropriate.

425.34 (b) Training and competency evaluations for all unlicensed personnel must include
425.35 the following:

425.36 (1) documentation requirements for all services provided;

- 426.1 (2) reports of changes in the client's condition to the supervisor designated by the
426.2 home care provider;
- 426.3 (3) basic infection control, including blood-borne pathogens;
426.4 (4) maintenance of a clean and safe environment;
426.5 (5) appropriate and safe techniques in personal hygiene and grooming, including:
426.6 (i) hair care and bathing;
426.7 (ii) care of teeth, gums, and oral prosthetic devices;
426.8 (iii) care and use of hearing aids; and
426.9 (iv) dressing and assisting with toileting;
- 426.10 (6) training on the prevention of falls for providers working with the elderly or
426.11 individuals at risk of falls;
- 426.12 (7) standby assistance techniques and how to perform them;
426.13 (8) medication, exercise, and treatment reminders;
426.14 (9) basic nutrition, meal preparation, food safety, and assistance with eating;
426.15 (10) preparation of modified diets as ordered by a licensed health professional;
426.16 (11) communication skills that include preserving the dignity of the client and
426.17 showing respect for the client and the client's preferences, cultural background, and family;
- 426.18 (12) awareness of confidentiality and privacy;
426.19 (13) understanding appropriate boundaries between staff and clients and the client's
426.20 family;
- 426.21 (14) procedures to utilize in handling various emergency situations; and
426.22 (15) awareness of commonly used health technology equipment and assistive devices.
- 426.23 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
426.24 personnel providing comprehensive home care services must include:
- 426.25 (1) observation, reporting, and documenting of client status;
426.26 (2) basic knowledge of body functioning and changes in body functioning, injuries,
426.27 or other observed changes that must be reported to appropriate personnel;
- 426.28 (3) reading and recording temperature, pulse, and respirations of the client;
426.29 (4) recognizing physical, emotional, cognitive, and developmental needs of the client;
426.30 (5) safe transfer techniques and ambulation;
426.31 (6) range of motioning and positioning; and
426.32 (7) administering medications or treatments as required.
- 426.33 (d) When the registered nurse or licensed health professional delegates tasks, they
426.34 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
426.35 methods to perform the tasks or procedures for each client and are able to demonstrate
426.36 the ability to competently follow the procedures and perform the tasks. If an unlicensed

427.1 personnel has not regularly performed the delegated home care task for a period of 24
427.2 consecutive months, the unlicensed personnel must demonstrate competency in the task
427.3 to the registered nurse or appropriate licensed health professional. The registered nurse
427.4 or licensed health professional must document instructions for the delegated tasks in
427.5 the client's record.

427.6 Sec. 22. **[144A.4796] ORIENTATION AND ANNUAL TRAINING**
427.7 **REQUIREMENTS.**

427.8 Subdivision 1. **Orientation of staff and supervisors to home care.** All staff
427.9 providing and supervising direct home care services must complete an orientation to home
427.10 care licensing requirements and regulations before providing home care services to clients.
427.11 The orientation may be incorporated into the training required under subdivision 6. The
427.12 orientation need only be completed once for each staff person and is not transferable
427.13 to another home care provider.

427.14 Subd. 2. **Content.** The orientation must contain the following topics:

427.15 (1) an overview of sections 144A.43 to 144A.4798;

427.16 (2) introduction and review of all the provider's policies and procedures related to
427.17 the provision of home care services;

427.18 (3) handling of emergencies and use of emergency services;

427.19 (4) compliance with and reporting the maltreatment of minors or vulnerable adults
427.20 under sections 626.556 and 626.557;

427.21 (5) home care bill of rights, under section 144A.44;

427.22 (6) handling of clients' complaints; reporting of complaints and where to report
427.23 complaints including information on the Office of Health Facility Complaints and the
427.24 Common Entry Point;

427.25 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
427.26 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
427.27 Ombudsman at the Department of Human Services, county managed care advocates,
427.28 or other relevant advocacy services; and

427.29 (8) review of the types of home care services the employee will be providing and
427.30 the provider's scope of licensure.

427.31 Subd. 3. **Verification and documentation of orientation.** Each home care provider
427.32 shall retain evidence in the employee record of each staff person having completed the
427.33 orientation required by this section.

428.1 Subd. 4. **Orientation to client.** Staff providing home care services must be oriented
428.2 specifically to each individual client and the services to be provided. This orientation may
428.3 be provided in person, orally, in writing, or electronically.

428.4 Subd. 5. **Training required relating to Alzheimer's disease and related disorders.**
428.5 For home care providers that provide services for persons with Alzheimer's or related
428.6 disorders, all direct care staff and supervisors working with those clients must receive
428.7 training that includes a current explanation of Alzheimer's disease and related disorders
428.8 effective approaches to use to problem solve when working with a client's challenging
428.9 behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

428.10 Subd. 6. **Required annual training.** All staff that perform direct home care
428.11 services must complete at least eight hours of annual training for each 12 months of
428.12 employment. The training may be obtained from the home care provider or another source
428.13 and must include topics relevant to the provision of home care services. The annual
428.14 training must include:

428.15 (1) training on reporting of maltreatment of minors under section 626.556 and
428.16 maltreatment of vulnerable adults under section 626.557, whichever is applicable to the
428.17 services provided;

428.18 (2) review of the home care bill of rights in section 144A.44;

428.19 (3) review of infection control techniques used in the home and implementation of
428.20 infection control standards including a review of hand washing techniques; the need for
428.21 and use of protective gloves, gowns, and masks; appropriate disposal of contaminated
428.22 materials and equipment, such as dressings, needles, syringes, and razor blades;
428.23 disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of
428.24 communicable diseases; and

428.25 (4) review of the provider's policies and procedures relating to the provision of home
428.26 care services and how to implement those policies and procedures.

428.27 Subd. 7. **Documentation.** A home care provider must retain documentation in the
428.28 employee records of the staff that have satisfied the orientation and training requirements
428.29 of this section.

428.30 **Sec. 23. [144A.4797] PROVISION OF SERVICES.**

428.31 Subdivision 1. **Availability of contact person to staff.** (a) A home care provider
428.32 with a basic home care license must have a person available to staff for consultation on
428.33 items relating to the provision of services or about the client.

428.34 (b) A home care provider with a comprehensive home care license must have a
428.35 registered nurse available for consultation to staff performing delegated nursing tasks

429.1 and must have an appropriate licensed health professional available if performing other
429.2 delegated services such as therapies.

429.3 (c) The appropriate contact person must be readily available either in person, by
429.4 telephone, or by other means to the staff at times when the staff is providing services.

429.5 Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform
429.6 basic home care services must be supervised periodically where the services are being
429.7 provided to verify that the work is being performed competently and to identify problems
429.8 and solutions to address issues relating to the staff's ability to provide the services. The
429.9 supervision of the unlicensed personnel must be done by staff of the home care provider
429.10 having the authority, skills, and ability to provide the supervision of unlicensed personnel
429.11 and who can implement changes as needed, and train staff.

429.12 (b) Supervision includes direct observation of unlicensed personnel while they
429.13 are providing the services and may also include indirect methods of gaining input such
429.14 as gathering feedback from the client. Supervisory review of staff must be provided at a
429.15 frequency based on the staff person's competency and performance.

429.16 (c) For an individual who is licensed as a home care provider, this section does
429.17 not apply.

429.18 Subd. 3. **Supervision of staff providing delegated nursing or therapy home**
429.19 **care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be
429.20 supervised by an appropriate licensed health professional or a registered nurse periodically
429.21 where the services are being provided to verify that the work is being performed
429.22 competently and to identify problems and solutions related to the staff person's ability to
429.23 perform the tasks. Supervision of staff performing medication or treatment administration
429.24 shall be provided by a registered nurse or appropriate licensed health professional and
429.25 must include observation of the staff administering the medication or treatment and the
429.26 interaction with the client.

429.27 (b) The direct supervision of staff performing delegated tasks must be provided
429.28 within 30 days after the individual begins working for the home care provider and
429.29 thereafter as needed based on performance. This requirement also applies to staff who
429.30 have not performed delegated tasks for one year or longer.

429.31 Subd. 4. **Documentation.** A home care provider must retain documentation of
429.32 supervision activities in the personnel records.

429.33 Subd. 5. **Exemption.** This section does not apply to an individual licensed under
429.34 sections 144A.43 to 144A.4799.

429.35 Sec. 24. **[144A.4798] EMPLOYEE HEALTH STATUS.**

430.1 Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider
 430.2 must establish and maintain a TB prevention and control program based on the most
 430.3 current guidelines issued by the Centers for Disease Control and Prevention (CDC).
 430.4 Components of a TB prevention and control program include screening all staff providing
 430.5 home care services, both paid and unpaid, at the time of hire for active TB disease and
 430.6 latent TB infection, and developing and implementing a written TB infection control plan.
 430.7 The commissioner shall make the most recent CDC standards available to home care
 430.8 providers on the department's Web site.

430.9 Subd. 2. **Communicable diseases.** A home care provider must follow
 430.10 current federal or state guidelines for prevention, control, and reporting of human
 430.11 immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other
 430.12 communicable diseases as defined in Minnesota Rules, part 4605.7040.

430.13 Sec. 25. **[144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE**
 430.14 **PROVIDER ADVISORY COUNCIL.**

430.15 Subdivision 1. **Membership.** The commissioner of health shall appoint eight
 430.16 persons to a home care provider advisory council consisting of the following:

430.17 (1) three public members as defined in section 214.02 who shall be either persons
 430.18 who are currently receiving home care services or have family members receiving home
 430.19 care services, or persons who have family members who have received home care services
 430.20 within five years of the application date;

430.21 (2) three Minnesota home care licensees representing basic and comprehensive
 430.22 levels of licensure who may be a managerial official, an administrator, a supervising
 430.23 registered nurse, or an unlicensed personnel performing home care tasks;

430.24 (3) one member representing the Minnesota Board of Nursing; and

430.25 (4) one member representing the ombudsman for long-term care.

430.26 Subd. 2. **Organizations and meetings.** The advisory council shall be organized
 430.27 and administered under section 15.059 with per diems and costs paid within the limits of
 430.28 available appropriations. Meetings will be held quarterly and hosted by the department.
 430.29 Subcommittees may be developed as necessary by the commissioner. Advisory council
 430.30 meetings are subject to the Open Meeting Law under chapter 13D.

430.31 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide
 430.32 advice regarding regulations of Department of Health licensed home care providers in
 430.33 this chapter such as:

430.34 (1) advice to the commissioner regarding community standards for home care
 430.35 practices;

431.1 (2) advice to the commissioner on enforcement of licensing standards and whether
431.2 certain disciplinary actions are appropriate;

431.3 (3) advice to the commissioner about ways of distributing information to licensees
431.4 and consumers of home care;

431.5 (4) advice to the commissioner about training standards;

431.6 (5) identify emerging issues and opportunities in the home care field, including the
431.7 use of technology in home and telehealth capabilities; and

431.8 (6) perform other duties as directed by the commissioner.

431.9 **Sec. 26. [144A.481] HOME CARE LICENSING IMPLEMENTATION FOR**
431.10 **NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

431.11 **Subdivision 1. Temporary home care licenses and changes of ownership. (a)**
431.12 **Beginning January 1, 2014, all temporary license applicants must apply for either a**
431.13 **temporary basic or comprehensive home care license.**

431.14 **(b) Temporary home care temporary licenses issued beginning January 1, 2014,**
431.15 **will be issued according to the provisions in sections 144A.43 to 144A.4799 and fees in**
431.16 **section 144A.472 and will be required to comply with this chapter.**

431.17 **(c) No temporary licenses or licenses will be accepted or issued between October 1,**
431.18 **2013, and December 31, 2013.**

431.19 **(d) Beginning October 1, 2013, changes in ownership applications will require**
431.20 **payment of the new fees listed in section 144A.472.**

431.21 **Subd. 2. Current home care licensees with licenses prior to July 1, 2013. (a)**
431.22 **Beginning July 1, 2014, department licensed home care providers must apply for either**
431.23 **the basic or comprehensive home care license on their regularly scheduled renewal date.**

431.24 **(b) By June 30, 2015, all home care providers must either have a basic or**
431.25 **comprehensive home care license or temporary license.**

431.26 **Subd. 3. Renewal application of home care licensure during transition period.**
431.27 **Renewal of home care licenses issued beginning July 1, 2014, will be issued according to**
431.28 **sections 144A.43 to 144A.4799 and, upon license renewal, providers must comply with**
431.29 **sections 144A.43 to 144A.4799. Prior to renewal, providers must comply with the home**
431.30 **care licensure law in effect on June 30, 2013.**

431.31 **The fees charged for licenses renewed between July 1, 2014, and June 30, 2016,**
431.32 **shall be the lesser of 200 percent or \$1,000, except where the 200 percent or \$1,000**
431.33 **increase exceeds the actual renewal fee charged, with a maximum renewal fee of \$6,625.**

432.1 For fiscal year 2014 only, the fees for providers with revenues greater than \$25,000
432.2 and no more than \$100,000 will be \$313 and for providers with revenues no more than
432.3 \$25,000 the fee will be \$125.

432.4 Sec. 27. **[144A.482] REGISTRATION OF HOME MANAGEMENT**
432.5 **PROVIDERS.**

432.6 (a) For purposes of this section, a home management provider is an individual or
432.7 organization that provides at least two of the following services: housekeeping, meal
432.8 preparation, and shopping, to a person who is unable to perform these activities due to
432.9 illness, disability, or physical condition.

432.10 (b) A person or organization that provides only home management services may not
432.11 operate in the state without a current certificate of registration issued by the commissioner
432.12 of health. To obtain a certificate of registration, the person or organization must annually
432.13 submit to the commissioner the name, mailing and physical address, e-mail address, and
432.14 telephone number of the individual or organization and a signed statement declaring that
432.15 the individual or organization is aware that the home care bill of rights applies to their
432.16 clients and that the person or organization will comply with the home care bill of rights
432.17 provisions contained in section 144A.44. An individual or organization applying for a
432.18 certificate must also provide the name, business address, and telephone number of each of
432.19 the individuals responsible for the management or direction of the organization.

432.20 (c) The commissioner shall charge an annual registration fee of \$20 for individuals
432.21 and \$50 for organizations. The registration fee shall be deposited in the state treasury and
432.22 credited to the state government special revenue fund.

432.23 (d) A home care provider that provides home management services and other home
432.24 care services must be licensed, but licensure requirements other than the home care bill of
432.25 rights do not apply to those employees or volunteers who provide only home management
432.26 services to clients who do not receive any other home care services from the provider.
432.27 A licensed home care provider need not be registered as a home management service
432.28 provider, but must provide an orientation on the home care bill of rights to its employees
432.29 or volunteers who provide home management services.

432.30 (e) An individual who provides home management services under this section must,
432.31 within 120 days after beginning to provide services, attend an orientation session approved
432.32 by the commissioner that provides training on the home care bill of rights and an orientation
432.33 on the aging process and the needs and concerns of elderly and disabled persons.

432.34 (f) The commissioner may suspend or revoke a provider's certificate of registration
432.35 or assess fines for violation of the home care bill of rights. Any fine assessed for a

433.1 violation of the home care bill of rights by a provider registered under this section shall be
433.2 in the amount established in the licensure rules for home care providers. As a condition
433.3 of registration, a provider must cooperate fully with any investigation conducted by the
433.4 commissioner, including providing specific information requested by the commissioner on
433.5 clients served and the employees and volunteers who provide services. Fines collected
433.6 under this paragraph shall be deposited in the state treasury and credited to the fund
433.7 specified in the statute or rule in which the penalty was established.

433.8 (g) The commissioner may use any of the powers granted in sections 144A.43 to
433.9 144A.4799 to administer the registration system and enforce the home care bill of rights
433.10 under this section.

433.11 Sec. 28. **AGENCY QUALITY IMPROVEMENT PROGRAM.**

433.12 **Subdivision 1. Annual legislative report on home care licensing.** The
433.13 commissioner shall establish a quality improvement program for the home care survey
433.14 and home care complaint investigation processes. The commissioner shall submit to the
433.15 legislature an annual report, beginning October 1, 2015, and each October 1 thereafter.
433.16 Each report will review the previous state fiscal year of home care licensing and regulatory
433.17 activities. The report must include, but is not limited to, an analysis of:

433.18 (1) the number of FTE's in the Division of Compliance Monitoring, including the
433.19 Office of Health Facility Complaints units assigned to home care licensing, survey,
433.20 investigation and enforcement process;

433.21 (2) numbers of and descriptive information about licenses issued, complaints
433.22 received and investigated, including allegations made and correction orders issued,
433.23 surveys completed and timelines, and correction order reconsiderations and results;

433.24 (3) descriptions of emerging trends in home care provision and areas of concern
433.25 identified by the department in its regulation of home care providers;

433.26 (4) information and data regarding performance improvement projects underway
433.27 and planned by the commissioner in the area of home care surveys; and

433.28 (5) work of the Department of Health Home Care Advisory Council.

433.29 **Subd. 2. Study of correction order appeal process.** Starting July 1, 2015, the
433.30 commissioner shall study whether to add a correction order appeal process conducted by
433.31 an independent reviewer such as an administrative law judge or other office and submit a
433.32 report to the legislature by February 1, 2016. The commissioner shall review home care
433.33 regulatory systems in other states as part of that study. The commissioner shall consult
433.34 with the home care providers and representatives.

434.1 Sec. 29. INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME
434.2 AND COMMUNITY-BASED SERVICES.

434.3 (a) The Department of Health Compliance Monitoring Division and the Department
434.4 of Human Services Licensing Division shall jointly develop an integrated licensing system
434.5 for providers of both home care services subject to licensure under Minnesota Statutes,
434.6 chapter 144A, and for home and community-based services subject to licensure under
434.7 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

434.8 (1) require only one license of any provider of services under Minnesota Statutes,
434.9 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

434.10 (2) promote quality services that recognize a person's individual needs and protect
434.11 the person's health, safety, rights, and well-being;

434.12 (3) promote provider accountability through application requirements, compliance
434.13 inspections, investigations, and enforcement actions;

434.14 (4) reference other applicable requirements in existing state and federal laws,
434.15 including the federal Affordable Care Act;

434.16 (5) establish internal procedures to facilitate ongoing communications between the
434.17 agencies, and with providers and services recipients about the regulatory activities;

434.18 (6) create a link between the agency Web sites so that providers and the public can
434.19 access the same information regardless of which Web site is accessed initially; and

434.20 (7) collect data on identified outcome measures as necessary for the agencies to
434.21 report to the Centers for Medicare and Medicaid Services.

434.22 (b) The joint recommendations for legislative changes to implement the integrated
434.23 licensing system are due to the legislature by February 15, 2014.

434.24 (c) Before implementation of the integrated licensing system, providers licensed as
434.25 home care providers under Minnesota Statutes, chapter 144A, may also provide home
434.26 and community-based services subject to licensure under Minnesota Statutes, chapter
434.27 245D, without obtaining a home and community-based services license under Minnesota
434.28 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
434.29 apply to these providers:

434.30 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
434.31 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

434.32 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
434.33 enforced by the Department of Health under the enforcement authority set forth in
434.34 Minnesota Statutes, section 144A.475; and

434.35 (3) the Department of Health will provide information to the Department of Human
434.36 Services about each provider licensed under this section, including the provider's license

435.1 application, licensing documents, inspections, information about complaints received, and
 435.2 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

435.3 Sec. 30. **REPEALER.**

435.4 (a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

435.5 (b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
 435.6 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040;
 435.7 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
 435.8 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170;
 435.9 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240;
 435.10 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830;
 435.11 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
 435.12 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

435.13 Sec. 31. **EFFECTIVE DATE.**

435.14 Sections 1 to 30 are effective the day following final enactment.

435.15 **ARTICLE 12**

435.16 **HEALTH DEPARTMENT**

435.17 Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 2, is amended to read:

435.18 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available
 435.19 resources in the health care access fund exceed expenditures in that fund, effective for
 435.20 the biennium beginning July 1, 2007, the commissioner of management and budget shall
 435.21 transfer the excess funds from the health care access fund to the general fund on June 30
 435.22 of each year, provided that the amount transferred in any fiscal biennium shall not exceed
 435.23 \$96,000,000. The purpose of this transfer is to meet the rate increase required under Laws
 435.24 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

435.25 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,
 435.26 if necessary, the commissioner shall reduce these transfers from the health care access
 435.27 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,
 435.28 transfer sufficient funds from the general fund to the health care access fund to meet
 435.29 annual MinnesotaCare expenditures.

435.30 (c) Notwithstanding section 295.581, to the extent available resources in the health
 435.31 care access fund exceed expenditures in that fund, effective for the biennium beginning
 435.32 July 1, 2013, the commissioner of management and budget shall transfer \$1,000,000 each
 435.33 fiscal year from the health access fund to the medical education and research costs fund

436.1 established under section 62J.692, for distribution under section 62J.692, subdivision 4,
436.2 paragraph (b).

436.3 **Sec. 2. [62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

436.4 **Subdivision 1. Definitions.** (a) For purposes of this section, the terms defined in
436.5 paragraphs (b) to (e) have the meanings given.

436.6 (b) "Autism spectrum disorders" means the conditions as determined by criteria
436.7 set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental
436.8 Disorders of the American Psychiatric Association.

436.9 (c) "Health plan" has the meaning given in section 62Q.01, subdivision 3.

436.10 (d) "Medically necessary care" means health care services appropriate, in terms of
436.11 type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic
436.12 testing and preventative services. Medically necessary care must be consistent with
436.13 generally accepted practice parameters as determined by physicians and licensed
436.14 psychologists who typically manage patients who have autism spectrum disorders.

436.15 (e) "Mental health professional" has the meaning given in section 245.4871,
436.16 subdivision 27.

436.17 **Subd. 2. Optional coverage required.** (a) A health plan must provide:

436.18 (1) all health benefits related to the treatment of autism spectrum disorders required
436.19 by the essential health benefits required under section 1302 of the Affordable Care Act;

436.20 (2) all health benefits required by this section or any other section of Minnesota
436.21 Statutes as of December 31, 2012; and

436.22 (3) an offer of one or more options for the purchase of supplemental autism coverage
436.23 for young children for children under age 18 for the diagnosis, evaluation, assessment,
436.24 and medically necessary care of autism spectrum disorders, including but not limited to
436.25 the following:

436.26 (i) early intensive behavioral and developmental therapy based in behavioral and
436.27 developmental science, including but not limited to applied behavior analysis, intensive
436.28 early intervention behavior therapy, intensive behavior intervention, and Lovaas therapy
436.29 and developmental approaches;

436.30 (ii) neurodevelopmental and behavioral health treatments and management;

436.31 (iii) speech therapy;

436.32 (iv) occupational therapy;

436.33 (v) physical therapy; and

436.34 (vi) medications.

437.1 (b) The diagnosis, evaluation, and assessment must include an assessment of the
437.2 child's developmental skills, functional behavior, needs, and capacities.

437.3 (c) The coverage option required under this section shall include treatment that is
437.4 in accordance with an individualized treatment plan prescribed by the insured's treating
437.5 physician or mental health professional.

437.6 (d) A health plan may not refuse to renew or reissue, or otherwise terminate or
437.7 restrict, coverage of an individual solely because the individual is diagnosed with an
437.8 autism spectrum disorder.

437.9 (e) A health plan may request an updated treatment plan only once every six months,
437.10 unless the health plan and the treating physician or mental health professional agree that a
437.11 more frequent review is necessary due to emerging circumstances.

437.12 (f) An independent progress evaluation conducted by a mental health professional
437.13 with expertise and training in autism spectrum disorder and child development must
437.14 be completed to determine if progress toward functional and generalizable gains, as
437.15 determined in the treatment plan, is being made.

437.16 (g) A health plan may cap the dollar value of the supplemental coverage offered
437.17 under this subdivision, but may not cap the value at less than \$50,000 per calendar year
437.18 per individual receiving a diagnosis of autism spectrum disorder.

437.19 Subd. 3. **No effect on other law.** Nothing in this section limits in any way the
437.20 coverage required under section 62Q.47.

437.21 Subd. 4. **State health care programs.** This section does not affect benefits available
437.22 under the medical assistance and MinnesotaCare programs and does not limit, restrict, or
437.23 otherwise reduce coverage under these programs.

437.24 **EFFECTIVE DATE.** This section is effective January 1, 2014, and sunsets effective
437.25 December 31, 2015, and applies to coverage offered, issued, sold, renewed, or continued
437.26 as defined in Minnesota Statutes, section 60A.02, subdivision 2a, on or after that date.

437.27 Sec. 3. **[62D.0425] NET WORTH LIMIT.**

437.28 (a) Between July 1, 2013, and June 30, 2018, no health maintenance organization
437.29 shall have a net worth of more than 25 percent of the sum of all expenses incurred during
437.30 the most recent calendar year, except as provided in paragraph (b).

437.31 (b) A health maintenance organization may have a net worth of more than 25 percent
437.32 of the sum of all expenses incurred during the most recent calendar year if necessary to
437.33 maintain capital reserves at the level of the product of 2.0 and its authorized control
437.34 level risk-based capital, as required pursuant to sections 60A.50 to 60A.592 and 62D.04.
437.35 Paragraphs (c) and (d) do not apply to health maintenance organizations permitted, under

438.1 this paragraph, to have a net worth greater than 25 percent of the sum of all expenses
438.2 incurred during the most recent calendar year.

438.3 (c) By June 15, 2013, and annually thereafter until June 15, 2017, for a health
438.4 maintenance organization that has a net worth of more than 25 percent of the sum of all
438.5 expenses incurred during the most recent calendar year, the commissioner of health, in
438.6 consultation with the commissioners of commerce and human services, shall determine:

438.7 (1) capital reserves using the National Association of Insurance Commissioners
438.8 definitions of admitted assets, which shall be used in clauses (2) to (5);

438.9 (2) the proportion of capital reserves that are reasonably attributable to net
438.10 underwriting gains in Minnesota public health care programs based on annual financial
438.11 filings for calendar years 2003 through 2012;

438.12 (3) the proportion of capital reserves that are reasonably attributable to investment
438.13 gains associated with net underwriting gains in Minnesota public health care programs
438.14 based on annual financial filings for calendar years 2003 through 2012;

438.15 (4) any adjustments needed to clause (1) or (2) based on corporate reorganizations,
438.16 since 2003; and

438.17 (5) any adjustments needed to account for the impact of annual financial filings for
438.18 calendar years 2013 through 2016.

438.19 (d) A health maintenance organization that has a net worth of more than 25 percent
438.20 of the sum of all expenses incurred during the most recent calendar year shall reduce its
438.21 capital reserves as follows:

438.22 (1) as determined by paragraph (c), the proportion of capital reserves that are greater
438.23 than 25 percent of the sum of all expenses incurred during the most recent calendar
438.24 year and that are reasonably attributable to net underwriting gains and investment gains
438.25 associated with net underwriting gains in Minnesota public health care programs shall be
438.26 spent down. The health maintenance organization shall place excess capital reserves in a
438.27 special restricted account under the control of the health maintenance organization. The
438.28 special restricted account may only be used to pay for a portion of the health maintenance
438.29 organization's current public program enrollee premiums. The health maintenance
438.30 organization shall spend no less than 50 percent of this special restricted account in any
438.31 state fiscal year beginning on or after July 1, 2013; and

438.32 (2) the proportion of capital reserves that are greater than 25 percent of the
438.33 sum of all expenses incurred during the most recent calendar year and that are not
438.34 reasonably attributable to net underwriting gains and investment gains associated with net
438.35 underwriting gains in Minnesota public health care programs shall be spent down. The
438.36 health maintenance organization shall place these excess capital reserves in a second

439.1 special restricted account under the control of the health maintenance organization. The
439.2 health maintenance organization may use this special restricted account to benefit current
439.3 enrollees by moderating variation in premium increases, assisting enrollees in accessing
439.4 new benefits, reducing health disparities, promoting health, wellness and preventive
439.5 services, and improving care coordination. Prior to spending down excess reserves from
439.6 this special revenue account, the health maintenance organization's spenddown plan must
439.7 be approved by the commissioner of health. The health maintenance organization shall
439.8 spend no less than 33 percent of this special restricted account in any state fiscal year
439.9 beginning July 1, 2013.

439.10 (e) The health maintenance organization must spend down all of the reserves placed
439.11 in its special restricted accounts by July 1, 2018. All reserves placed in a special account
439.12 must be spent according to paragraph (d), unless the reserves are necessary for the health
439.13 maintenance organization to maintain capital reserves at the level of the product of 2.0 and
439.14 its authorized control level risk-based capital, as required pursuant to sections 60A.50 to
439.15 60A.592 and 62D.04, in which case the health maintenance organization may transfer funds
439.16 out of its special restricted accounts in a manner approved by the commissioner of health.

439.17 (f) The commissioner of health must approve all health maintenance organization
439.18 expenditures for the acquisition of any asset that is not an admitted asset under National
439.19 Association of Insurance Commissioners definitions. The commissioner shall disapprove
439.20 any acquisition unless the health maintenance organization demonstrates that the
439.21 acquisition is: (1) consistent with its long-standing business practices; or (2) more
439.22 beneficial to enrollees than benefits to enrollees under paragraph (d).

439.23 Sec. 4. Minnesota Statutes 2012, section 62J.692, subdivision 4, is amended to read:

439.24 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the
439.25 available medical education funds to all qualifying applicants based on a distribution
439.26 formula that reflects a summation of two factors:

439.27 (1) a public program volume factor, which is determined by the total volume of
439.28 public program revenue received by each training site as a percentage of all public
439.29 program revenue received by all training sites in the fund pool; and

439.30 (2) a supplemental public program volume factor, which is determined by providing
439.31 a supplemental payment of 20 percent of each training site's grant to training sites whose
439.32 public program revenue accounted for at least 0.98 percent of the total public program
439.33 revenue received by all eligible training sites. Grants to training sites whose public
439.34 program revenue accounted for less than 0.98 percent of the total public program revenue

440.1 received by all eligible training sites shall be reduced by an amount equal to the total
440.2 value of the supplemental payment.

440.3 Public program revenue for the distribution formula includes revenue from medical
440.4 assistance, prepaid medical assistance, general assistance medical care, and prepaid
440.5 general assistance medical care. Training sites that receive no public program revenue
440.6 are ineligible for funds available under this subdivision. For purposes of determining
440.7 training-site level grants to be distributed under paragraph (a), total statewide average
440.8 costs per trainee for medical residents is based on audited clinical training costs per trainee
440.9 in primary care clinical medical education programs for medical residents. Total statewide
440.10 average costs per trainee for dental residents is based on audited clinical training costs
440.11 per trainee in clinical medical education programs for dental students. Total statewide
440.12 average costs per trainee for pharmacy residents is based on audited clinical training costs
440.13 per trainee in clinical medical education programs for pharmacy students. Training sites
440.14 whose training site level grant is less than \$1,000, based on the formula described in this
440.15 paragraph, are ineligible for funds available under this subdivision.

440.16 (b) Of available medical education funds, \$1,000,000 shall be distributed each year
440.17 for grants to family medicine residency programs located outside of the seven-county
440.18 metropolitan area, as defined in section 473.121, subdivision 4, focused on education and
440.19 training of family medicine physicians to serve communities outside the metropolitan area.
440.20 To be eligible for a grant under this paragraph, a family medicine residency program must
440.21 demonstrate that over the most recent three calendar years, at least 25 percent of its residents
440.22 practice in Minnesota communities outside of the metropolitan area. Grant funds must be
440.23 allocated proportionally based on the number of residents per eligible residency program.

440.24 (c) Funds distributed shall not be used to displace current funding appropriations
440.25 from federal or state sources.

440.26 (e) (d) Funds shall be distributed to the sponsoring institutions indicating the amount
440.27 to be distributed to each of the sponsor's clinical medical education programs based on
440.28 the criteria in this subdivision and in accordance with the commissioner's approval letter.
440.29 Each clinical medical education program must distribute funds allocated under paragraph
440.30 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring
440.31 institutions, which are accredited through an organization recognized by the Department
440.32 of Education or the Centers for Medicare and Medicaid Services, may contract directly
440.33 with training sites to provide clinical training. To ensure the quality of clinical training,
440.34 those accredited sponsoring institutions must:

440.35 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
440.36 training conducted at sites; and

441.1 (2) take necessary action if the contract requirements are not met. Action may include
441.2 the withholding of payments under this section or the removal of students from the site.

441.3 ~~(d)~~ (e) Any funds not distributed in accordance with the commissioner's approval
441.4 letter must be returned to the medical education and research fund within 30 days of
441.5 receiving notice from the commissioner. The commissioner shall distribute returned funds
441.6 to the appropriate training sites in accordance with the commissioner's approval letter.

441.7 ~~(e)~~ (f) A maximum of \$150,000 of the funds dedicated to the commissioner
441.8 under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for
441.9 administrative expenses associated with implementing this section.

441.10 Sec. 5. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

441.11 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
441.12 community providers. The criteria for essential community provider designation shall be
441.13 the following:

441.14 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
441.15 with medical care for uninsured persons and high-risk and special needs populations,
441.16 underserved, and other special needs populations; and

441.17 (2) a commitment to serve low-income and underserved populations by meeting the
441.18 following requirements:

441.19 (i) has nonprofit status in accordance with chapter 317A;

441.20 (ii) has tax-exempt status in accordance with the Internal Revenue Service Code,
441.21 section 501(c)(3);

441.22 (iii) charges for services on a sliding fee schedule based on current poverty income
441.23 guidelines; and

441.24 (iv) does not restrict access or services because of a client's financial limitation;

441.25 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
441.26 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
441.27 government, an Indian health service unit, or a community health board as defined in
441.28 chapter 145A;

441.29 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
441.30 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
441.31 conditions;

441.32 (5) a sole community hospital. For these rural hospitals, the essential community
441.33 provider designation applies to all health services provided, including both inpatient and
441.34 outpatient services. For purposes of this section, "sole community hospital" means a
441.35 rural hospital that:

442.1 (i) is eligible to be classified as a sole community hospital according to Code
442.2 of Federal Regulations, title 42, section 412.92, or is located in a community with a
442.3 population of less than 5,000 and located more than 25 miles from a like hospital currently
442.4 providing acute short-term services;

442.5 (ii) has experienced net operating income losses in two of the previous three
442.6 most recent consecutive hospital fiscal years for which audited financial information is
442.7 available; and

442.8 (iii) consists of 40 or fewer licensed beds; ~~or~~

442.9 (6) a birth center licensed under section 144.615.; or

442.10 (7) a hospital, and its affiliated specialty clinics, whose inpatients are predominantly
442.11 under 21 years of age and that meets the following criteria:

442.12 (i) provides intensive specialty pediatric services that are routinely provided in
442.13 only four or fewer hospitals in the state; and

442.14 (ii) serves children from at least one-half of the counties in the state.

442.15 (b) Prior to designation, the commissioner shall publish the names of all applicants
442.16 in the State Register. The public shall have 30 days from the date of publication to submit
442.17 written comments to the commissioner on the application. No designation shall be made
442.18 by the commissioner until the 30-day period has expired.

442.19 (c) The commissioner may designate an eligible provider as an essential community
442.20 provider for all the services offered by that provider or for specific services designated by
442.21 the commissioner.

442.22 (d) For the purpose of this subdivision, supportive and stabilizing services include at
442.23 a minimum, transportation, child care, cultural, and linguistic services where appropriate.

442.24 Sec. 6. Minnesota Statutes 2012, section 103I.005, is amended by adding a subdivision
442.25 to read:

442.26 Subd. 1a. **Bored geothermal heat exchanger.** "Bored geothermal heat exchanger"
442.27 means an earth-coupled heating or cooling device consisting of a sealed closed-loop
442.28 pipng system installed in a boring in the ground to transfer heat to or from the surrounding
442.29 earth with no discharge.

442.30 Sec. 7. Minnesota Statutes 2012, section 103I.521, is amended to read:

442.31 **103I.521 FEES DEPOSITED WITH COMMISSIONER OF MANAGEMENT**
442.32 **AND BUDGET.**

443.1 Unless otherwise specified, fees collected for licenses or registration by the
443.2 commissioner under this chapter shall be deposited in the state treasury and credited to
443.3 the state government special revenue fund.

443.4 Sec. 8. Minnesota Statutes 2012, section 144.0724, subdivision 6, is amended to read:

443.5 Subd. 6. **Penalties for late or nonsubmission.** A facility that fails to complete or
443.6 submit an assessment for a RUG-III or RUG-IV classification within seven days of the
443.7 time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident.
443.8 The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on
443.9 the day of admission for new admission assessments or on the day that the assessment
443.10 was due for all other assessments and continues in effect until the first day of the month
443.11 following the date of submission of the resident's assessment. If loss of revenue due to
443.12 penalties incurred by a facility for any period of 92 days are equal to or greater than 1.0
443.13 percent of the total operating costs on the facility's most recent annual statistical and cost
443.14 report, a facility may apply to the commissioner of human services for a reduction in
443.15 the total penalty amount. The commissioner of human services in consultation with the
443.16 commissioner of health may, at the sole discretion of the commissioner of human services,
443.17 limit the penalty for residents covered by medical assistance to 15 days.

443.18 Sec. 9. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

443.19 ~~Subdivision 1. **Who must pay.** Except for the limitation contained in this section,~~
443.20 ~~the commissioner of health shall charge a handling fee may enter into a contractual~~
443.21 ~~agreement to recover costs incurred for analysis for diagnostic purposes for each specimen~~
443.22 ~~submitted to the Department of Health for analysis for diagnostic purposes by any hospital,~~
443.23 ~~private laboratory, private clinic, or physician. No fee shall be charged to any entity which~~
443.24 ~~receives direct or indirect financial assistance from state or federal funds administered by~~
443.25 ~~the Department of Health, including any public health department, nonprofit community~~
443.26 ~~clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged. The~~
443.27 commissioner shall not charge for any biological materials submitted to the Department
443.28 of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological
443.29 materials requested by the department to gather information for disease prevention or
443.30 control purposes. The commissioner of health may establish other exceptions to the
443.31 handling fee as may be necessary to protect the public's health. ~~All fees collected pursuant~~
443.32 ~~to this section shall be deposited in the state treasury and credited to the state government~~
443.33 ~~special revenue fund. Funds generated in a contractual agreement made pursuant to this~~
443.34 section shall be deposited in a special account and are appropriated to the commissioner

444.1 for purposes of providing the services specified in the contracts. All such contractual
444.2 agreements shall be processed in accordance with the provisions of chapter 16C.

444.3 **EFFECTIVE DATE.** This section is effective July 1, 2014.

444.4 Sec. 10. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

444.5 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative
444.6 officer or other person in charge of each institution caring for infants 28 days or less
444.7 of age, (2) the person required in pursuance of the provisions of section 144.215, to
444.8 register the birth of a child, or (3) the nurse midwife or midwife in attendance at the
444.9 birth, to arrange to have administered to every infant or child in its care tests for heritable
444.10 and congenital disorders according to subdivision 2 and rules prescribed by the state
444.11 commissioner of health.

444.12 (b) Testing and the, recording and of test results, reporting of test results, and
444.13 follow-up of infants with heritable congenital disorders, including hearing loss detected
444.14 through the early hearing detection and intervention program in section 144.966, shall be
444.15 performed at the times and in the manner prescribed by the commissioner of health. The
444.16 commissioner shall charge a fee so that the total of fees collected will approximate the
444.17 costs of conducting the tests and implementing and maintaining a system to follow-up
444.18 infants with heritable or congenital disorders, including hearing loss detected through the
444.19 early hearing detection and intervention program under section 144.966.

444.20 (c) The fee is \$101 per specimen. Effective July 1, 2010, the fee shall be increased
444.21 to \$106 to support the newborn screening program, including tests administered under
444.22 this section and section 144.966, shall be \$145 per specimen. The increased fee amount
444.23 shall be deposited in the general fund. Costs associated with capital expenditures and
444.24 the development of new procedures may be prorated over a three-year period when
444.25 calculating the amount of the fees. This fee amount shall be deposited in the state treasury
444.26 and credited to the state government special revenue fund.

444.27 (d) The fee to offset the cost of the support services provided under section 144.966,
444.28 subdivision 3a, shall be \$15 per specimen. This fee shall be deposited in the state treasury
444.29 and credited to the general fund.

444.30 Sec. 11. [144.1251] NEWBORN SCREENING FOR CRITICAL CONGENITAL
444.31 HEART DISEASE (CCHD).

444.32 Subdivision 1. **Required testing and reporting.** Each licensed hospital or
444.33 state-licensed birthing center or facility that provides maternity and newborn care services
444.34 shall provide screening for congenital heart disease to all newborns prior to discharge

445.1 using pulse oximetry screening. This screening should occur before discharge from the
445.2 nursery, after the infant turns 24 hours of age. If discharge prior to 24 hours after birth
445.3 occurs, screening should occur as close as possible to the time of discharge. Results of this
445.4 screening must be reported to the Department of Health.

445.5 For premature infants (less than 36 weeks of gestation) and infants admitted to a
445.6 higher-level nursery (special care or intensive care), pulse oximetry should be performed
445.7 when medically appropriate, but always prior to discharge.

445.8 Subd. 2. **Implementation.** The Department of Health shall:

445.9 (1) communicate the screening protocol requirements;

445.10 (2) make information and forms available to the persons with a duty to perform
445.11 testing and reporting, health care providers, parents of newborns, and the public on
445.12 screening and parental options;

445.13 (3) provide training to ensure compliance with and appropriate implementation of
445.14 the screening;

445.15 (4) establish the mechanism for the required data collection and reporting of
445.16 screening and follow-up diagnostic results to the Department of Health according to the
445.17 Department of Health's recommendations;

445.18 (5) coordinate the implementation of universal standardized screening;

445.19 (6) act as a resource for providers as the screening program is implemented, and in
445.20 consultation with the Advisory Committee on Heritable and Congenital Disorders, develop
445.21 and implement policies for early medical and developmental intervention services and
445.22 long-term follow-up services for children and their families identified with a CCHD; and

445.23 (7) comply with sections 144.125 to 144.128.

445.24 Sec. 12. **[144.492] DEFINITIONS.**

445.25 Subdivision 1. **Applicability.** For the purposes of sections 144.492 to 144.494, the
445.26 terms defined in this section have the meanings given them.

445.27 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

445.28 Subd. 3. **Stroke.** "Stroke" means the sudden death of brain cells in a localized
445.29 area due to inadequate blood flow.

445.30 Sec. 13. **[144.493] CRITERIA.**

445.31 Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a
445.32 comprehensive stroke center if the hospital has been certified as a comprehensive stroke
445.33 center by the joint commission or another nationally recognized accreditation entity.

446.1 Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke
446.2 center if the hospital has been certified as a primary stroke center by the joint commission
446.3 or another nationally recognized accreditation entity.

446.4 Subd. 3. **Acute stroke ready hospital.** A hospital meets the criteria for an acute
446.5 stroke ready hospital if the hospital has the following elements of an acute stroke ready
446.6 hospital:

446.7 (1) an acute stroke team available and/or on-call 24 hours a days, seven days a week;

446.8 (2) written stroke protocols, including triage, stabilization of vital functions, initial
446.9 diagnostic tests, and use of medications;

446.10 (3) a written plan and letter of cooperation with emergency medical services regarding
446.11 triage and communication that are consistent with regional patient care procedures;

446.12 (4) emergency department personnel who are trained in diagnosing and treating
446.13 acute stroke;

446.14 (5) the capacity to complete basic laboratory tests, electrocardiograms, and chest
446.15 x-rays 24 hours a day, seven days a week;

446.16 (6) the capacity to perform and interpret brain injury imaging studies 24 hours a
446.17 days, seven days a week;

446.18 (7) written protocols that detail available emergent therapies and reflect current
446.19 treatment guidelines, which include performance measures and are revised at least annually;

446.20 (8) a neurosurgery coverage plan, call schedule, and a triage and transportation plan;

446.21 (9) transfer protocols and agreements for stroke patients; and

446.22 (10) a designated medical director with experience and expertise in acute stroke care.

446.23 Sec. 14. **[144.494] DESIGNATING STROKE CENTERS AND STROKE**
446.24 **HOSPITALS.**

446.25 Subdivision 1. **Naming privileges.** Unless it has been designated as a stroke center
446.26 or stroke hospital pursuant to section 144.493, no hospital shall use the term "stroke
446.27 center" or "stroke hospital" in its name or its advertising or shall otherwise indicate it
446.28 has stroke treatment capabilities.

446.29 Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a
446.30 comprehensive stroke center, primary stroke center, or acute stroke ready hospital may
446.31 apply to the commissioner for designation, and upon the commissioner's review and
446.32 approval of the application, shall be designated as a comprehensive stroke center, a
446.33 primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital
446.34 loses its certification as a comprehensive stroke center or primary stroke center from
446.35 the joint commission or other nationally recognized accreditation entity, its Minnesota

448.1	<u>\$1,150,001 - \$1,200,000</u>	<u>\$3,600</u>
448.2	<u>\$1,200,001 - \$1,250,000</u>	<u>\$3,750</u>
448.3	<u>\$1,250,001 - \$1,300,000</u>	<u>\$3,900</u>
448.4	<u>\$1,300,001 - \$1,350,000</u>	<u>\$4,050</u>
448.5	<u>\$1,350,001 - \$1,400,000</u>	<u>\$4,200</u>
448.6	<u>\$1,400,001 - \$1,450,000</u>	<u>\$4,350</u>
448.7	<u>\$1,450,001 - \$1,500,000</u>	<u>\$4,500</u>
448.8	<u>\$1,500,001 and over</u>	<u>\$4,800</u>

448.9 Sec. 16. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:

448.10 Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The
 448.11 commissioner of health shall establish a Newborn Hearing Screening Advisory Committee
 448.12 to advise and assist the Department of Health and the Department of Education in:

448.13 (1) developing protocols and timelines for screening, rescreening, and diagnostic
 448.14 audiological assessment and early medical, audiological, and educational intervention
 448.15 services for children who are deaf or hard-of-hearing;

448.16 (2) designing protocols for tracking children from birth through age three that may
 448.17 have passed newborn screening but are at risk for delayed or late onset of permanent
 448.18 hearing loss;

448.19 (3) designing a technical assistance program to support facilities implementing the
 448.20 screening program and facilities conducting rescreening and diagnostic audiological
 448.21 assessment;

448.22 (4) designing implementation and evaluation of a system of follow-up and tracking;
 448.23 and

448.24 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
 448.25 culturally appropriate services for children with a confirmed hearing loss and their families.

448.26 (b) The commissioner of health shall appoint at least one member from each of the
 448.27 following groups with no less than two of the members being deaf or hard-of-hearing:

448.28 (1) a representative from a consumer organization representing culturally deaf
 448.29 persons;

448.30 (2) a parent with a child with hearing loss representing a parent organization;

448.31 (3) a consumer from an organization representing oral communication options;

448.32 (4) a consumer from an organization representing cued speech communication
 448.33 options;

448.34 (5) an audiologist who has experience in evaluation and intervention of infants
 448.35 and young children;

449.1 (6) a speech-language pathologist who has experience in evaluation and intervention
449.2 of infants and young children;

449.3 (7) two primary care providers who have experience in the care of infants and young
449.4 children, one of which shall be a pediatrician;

449.5 (8) a representative from the early hearing detection intervention teams;

449.6 (9) a representative from the Department of Education resource center for the deaf
449.7 and hard-of-hearing or the representative's designee;

449.8 (10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing
449.9 Minnesotans;

449.10 (11) a representative from the Department of Human Services Deaf and
449.11 Hard-of-Hearing Services Division;

449.12 (12) one or more of the Part C coordinators from the Department of Education, the
449.13 Department of Health, or the Department of Human Services or the department's designees;

449.14 (13) the Department of Health early hearing detection and intervention coordinators;

449.15 (14) two birth hospital representatives from one rural and one urban hospital;

449.16 (15) a pediatric geneticist;

449.17 (16) an otolaryngologist;

449.18 (17) a representative from the Newborn Screening Advisory Committee under
449.19 this subdivision; and

449.20 (18) a representative of the Department of Education regional low-incidence
449.21 facilitators.

449.22 The commissioner must complete the appointments required under this subdivision by
449.23 September 1, 2007.

449.24 (c) The Department of Health member shall chair the first meeting of the committee.
449.25 At the first meeting, the committee shall elect a chair from its membership. The committee
449.26 shall meet at the call of the chair, at least four times a year. The committee shall adopt
449.27 written bylaws to govern its activities. The Department of Health shall provide technical
449.28 and administrative support services as required by the committee. These services shall
449.29 include technical support from individuals qualified to administer infant hearing screening,
449.30 rescreening, and diagnostic audiological assessments.

449.31 Members of the committee shall receive no compensation for their service, but
449.32 shall be reimbursed as provided in section 15.059 for expenses incurred as a result of
449.33 their duties as members of the committee.

449.34 (d) This subdivision expires June 30, ~~2013~~ 2019.

449.35 Sec. 17. Minnesota Statutes 2012, section 144.966, subdivision 3a, is amended to read:

450.1 Subd. 3a. **Support services to families.** The commissioner shall contract with a
450.2 nonprofit organization to provide support and assistance to families with children who are
450.3 deaf or have a hearing loss. The family support provided must include:

450.4 (1) direct hearing loss specific parent-to-parent assistance and unbiased information
450.5 on communication, educational, and medical options, preferably provided by a program
450.6 that is part of a national organization; and

450.7 (2) individualized deaf or hard of hearing mentors who provide education, including
450.8 instruction in American Sign Language.

450.9 The commissioner shall give preference to a nonprofit organization that has the ability to
450.10 provide these services throughout the state.

450.11 Sec. 18. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

450.12 Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must
450.13 be accompanied by the annual fees specified in this subdivision. The annual fees include:

450.14 (1) base accreditation fee, ~~\$1,500~~ \$600;

450.15 (2) sample preparation techniques fee, \$200 per technique;

450.16 (3) an administrative fee for laboratories located outside this state, ~~\$3,750~~ \$2,000; and

450.17 (4) test category fees.

450.18 (b) For the programs in subdivision 3a, the commissioner may accredit laboratories
450.19 for fields of testing under the categories listed in clauses (1) to (10) upon completion of
450.20 the application requirements provided by subdivision 6 and receipt of the fees for each
450.21 category under each program that accreditation is requested. The categories offered and
450.22 related fees include:

450.23 (1) microbiology, ~~\$450~~ \$200;

450.24 (2) inorganics, ~~\$450~~ \$200;

450.25 (3) metals, ~~\$1,000~~ \$500;

450.26 (4) volatile organics, ~~\$1,300~~ \$1,000;

450.27 (5) other organics, ~~\$1,300~~ \$1,000;

450.28 (6) radiochemistry, ~~\$1,500~~ \$750;

450.29 (7) emerging contaminants, ~~\$1,500~~ \$1,000;

450.30 (8) agricultural contaminants, ~~\$1,250~~ \$1,000;

450.31 (9) toxicity (bioassay), ~~\$1,000~~ \$500; and

450.32 (10) physical characterization, \$250.

450.33 (c) The total annual fee includes the base fee, the sample preparation techniques
450.34 fees, the test category fees per program, and, when applicable, an administrative fee for
450.35 out-of-state laboratories.

451.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

451.2 Sec. 19. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

451.3 Subd. 5. **State government special revenue fund.** Fees collected by the
451.4 commissioner under this section must be deposited in the state treasury and credited to
451.5 the state government special revenue fund.

451.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

451.7 Sec. 20. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
451.8 to read:

451.9 Subd. 10. **Establishing a selection committee.** (a) The commissioner shall
451.10 establish a selection committee for the purpose of recommending approval of qualified
451.11 laboratory assessors and assessment bodies. Committee members shall demonstrate
451.12 competence in assessment practices. The committee shall initially consist of seven
451.13 members appointed by the commissioner as follows:

451.14 (1) one member from a municipal laboratory accredited by the commissioner;

451.15 (2) one member from an industrial treatment laboratory accredited by the
451.16 commissioner;

451.17 (3) one member from a commercial laboratory located in this state and accredited by
451.18 the commissioner;

451.19 (4) one member from a commercial laboratory located outside the state and
451.20 accredited by the commissioner;

451.21 (5) one member from a nongovernmental client of environmental laboratories;

451.22 (6) one member from a professional organization with a demonstrated interest in
451.23 environmental laboratory data and accreditation; and

451.24 (7) one employee of the laboratory accreditation program administered by the
451.25 department.

451.26 (b) Committee appointments begin on January 1 and end on December 31 of the
451.27 same year.

451.28 (c) The commissioner shall appoint persons to fill vacant committee positions,
451.29 expand the total number of appointed positions, or change the designated positions upon
451.30 the advice of the committee.

451.31 (d) The commissioner shall rescind the appointment of a selection committee
451.32 member for sufficient cause as the commissioner determines, such as:

451.33 (1) neglect of duty;

451.34 (2) failure to notify the commissioner of a real or perceived conflict of interest;

- 452.1 (3) nonconformance with committee procedures;
452.2 (4) failure to demonstrate competence in assessment practices; or
452.3 (5) official misconduct.
452.4 (e) Members of the selection committee shall be compensated according to the
452.5 provisions in section 15.059, subdivision 3.

452.6 Sec. 21. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
452.7 to read:

452.8 Subd. 11. **Activities of the selection committee.** (a) The selection committee
452.9 will determine assessor and assessment body application requirements, the frequency
452.10 of application submittal, and the application review schedule. The commissioner shall
452.11 publish the application requirements and procedures on the accreditation program Web site.

452.12 (b) In its selection process, the committee shall ensure its application requirements
452.13 and review process:

452.14 (1) meet the standards implemented in subdivision 2a;

452.15 (2) ensure assessors have demonstrated competence in technical disciplines offered
452.16 for accreditation by the commissioner; and

452.17 (3) consider any history of repeated nonconformance or complaints regarding
452.18 assessors or assessment bodies.

452.19 (c) The selection committee shall consider an application received from qualified
452.20 applicants and shall supply a list of recommended assessors and assessment bodies to
452.21 the commissioner of health no later than 90 days after the commissioner notifies the
452.22 committee of the need for review of applications.

452.23 Sec. 22. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
452.24 to read:

452.25 Subd. 12. **Commissioner approval of assessors and scheduling of assessments.**

452.26 (a) The commissioner shall approve assessors who:

452.27 (1) are employed by the commissioner for the purpose of accrediting laboratories
452.28 and demonstrate competence in assessment practices for environmental laboratories; or

452.29 (2) are employed by a state or federal agency with established agreements for
452.30 mutual assistance or recognition with the commissioner and demonstrate competence in
452.31 assessment practices for environmental laboratories.

452.32 (b) The commissioner may approve other assessors or assessment bodies who are
452.33 recommended by the selection committee according to subdivision 11, paragraph (c). The

453.1 commissioner shall publish the list of assessors and assessment bodies approved from the
453.2 recommendations.

453.3 (c) The commissioner shall rescind approval for an assessor or assessment body for
453.4 sufficient cause as the commissioner determines, such as:

453.5 (1) failure to meet the minimum qualifications for performing assessments;

453.6 (2) lack of availability;

453.7 (3) nonconformance with the applicable laws, rules, standards, policies, and
453.8 procedures;

453.9 (4) misrepresentation of application information regarding qualifications and
453.10 training; or

453.11 (5) excessive cost to perform the assessment activities.

453.12 Sec. 23. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
453.13 to read:

453.14 Subd. 13. **Laboratory requirements for assessor selection and scheduling**

453.15 **assessments.** (a) A laboratory accredited or seeking accreditation that requires an

453.16 assessment by the commissioner must select an assessor, group of assessors, or an

453.17 assessment body from the published list specified in subdivision 12, paragraph (b). An

453.18 accredited laboratory must complete an assessment and make all corrective actions at least

453.19 once every 24 months. Unless the commissioner grants interim accreditation, a laboratory

453.20 seeking accreditation must complete an assessment and make all corrective actions

453.21 prior to, but no earlier than, 18 months prior to the date the application is submitted to

453.22 the commissioner.

453.23 (b) A laboratory shall not select the same assessor more than twice in succession

453.24 for assessments of the same facility unless the laboratory receives written approval

453.25 from the commissioner for the selection. The laboratory must supply a written request

453.26 to the commissioner for approval and must justify the reason for the request and provide

453.27 the alternate options considered.

453.28 (c) A laboratory must select assessors appropriate to the size and scope of the

453.29 laboratory's application or existing accreditation.

453.30 (d) A laboratory must enter into its own contract for direct payment of the assessors

453.31 or assessment body. The contract must authorize the assessor, assessment body, or

453.32 subcontractors to release all records to the commissioner regarding the assessment activity,

453.33 when the assessment is performed in compliance with this statute.

453.34 (e) A laboratory must agree to permit other assessors as selected by the commissioner

453.35 to participate in the assessment activities.

454.1 (f) If the laboratory determines no approved assessor is available to perform
454.2 the assessment, the laboratory must notify the commissioner in writing and provide a
454.3 justification for the determination. If the commissioner confirms no approved assessor
454.4 is available, the commissioner may designate an alternate assessor from those approved
454.5 in subdivision 12, paragraph (a), or the commissioner may delay the assessment until
454.6 an assessor is available. If an approved alternate assessor performs the assessment, the
454.7 commissioner may collect fees equivalent to the cost of performing the assessment
454.8 activities.

454.9 (g) Fees collected under this section are deposited in a special account and are
454.10 annually appropriated to the commissioner for the purpose of performing assessment
454.11 activities.

454.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

454.13 Sec. 24. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:

454.14 Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an
454.15 order requiring violations to be corrected and administratively assessing monetary
454.16 penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The
454.17 procedures in section 144.991 must be followed when issuing administrative penalty
454.18 orders. Except in the case of repeated or serious violations, the penalty assessed in the
454.19 order must be forgiven if the person who is subject to the order demonstrates in writing
454.20 to the commissioner before the 31st day after receiving the order that the person has
454.21 corrected the violation or has developed a corrective plan acceptable to the commissioner.
454.22 The maximum amount of an administrative penalty order is \$10,000 for each violator for
454.23 all violations by that violator identified in an inspection or review of compliance.

454.24 (b) Notwithstanding paragraph (a), the commissioner may issue to a large public
454.25 water supply, serving a population of more than 10,000 persons, an administrative penalty
454.26 order imposing a penalty of at least \$1,000 per day per violation, not to exceed \$10,000
454.27 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

454.28 (c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead
454.29 firm or person performing regulated lead work, an administrative penalty order imposing a
454.30 penalty of at least \$5,000 per violation per day, not to exceed \$10,000 for each violation of
454.31 sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from
454.32 monetary penalties in this section shall be deposited in the state treasury and credited to
454.33 the state government special revenue fund.

454.34 Sec. 25. Minnesota Statutes 2012, section 144A.53, subdivision 2, is amended to read:

455.1 Subd. 2. **Complaints.** The director may receive a complaint from any source
455.2 concerning an action of an administrative agency, a health care provider, a home care
455.3 provider, a residential care home, or a health facility. The director may require a
455.4 complainant to pursue other remedies or channels of complaint open to the complainant
455.5 before accepting or investigating the complaint. Investigators are required to interview
455.6 at least one family member of the vulnerable adult identified in the complaint. If the
455.7 vulnerable adult is directing the vulnerable adult's own care and does not want the
455.8 investigator to contact the family, this information shall be documented in the investigative
455.9 file.

455.10 The director shall keep written records of all complaints and any action upon
455.11 them. After completing an investigation of a complaint, the director shall inform the
455.12 complainant, the administrative agency having jurisdiction over the subject matter, the
455.13 health care provider, the home care provider, the residential care home, and the health
455.14 facility of the action taken. Complainants must be provided a copy of the public report
455.15 upon completion of the investigation.

455.16 Sec. 26. **[145.4716] SAFE HARBOR FOR SEXUALLY EXPLOITED YOUTH.**

455.17 Subdivision 1. **Director.** The commissioner of health shall establish a position for a
455.18 director of child sex trafficking prevention.

455.19 Subd. 2. **Duties of director.** The director of child sex trafficking prevention is
455.20 responsible for the following:

455.21 (1) developing and providing comprehensive training on sexual exploitation of
455.22 youth for social service professionals, medical professionals, public health workers, and
455.23 criminal justice professionals;

455.24 (2) collecting, organizing, maintaining, and disseminating information on sexual
455.25 exploitation and services across the state, including maintaining a list of resources on the
455.26 Department of Health Web site;

455.27 (3) monitoring and applying for federal funding for antitrafficking efforts that may
455.28 benefit victims in the state;

455.29 (4) managing grant programs established under this act;

455.30 (5) identifying best practices in serving sexually exploited youth, as defined in
455.31 section 260C.007, subdivision 31;

455.32 (6) providing oversight of and technical support to regional navigators pursuant to
455.33 section 145.4717;

455.34 (7) conducting a comprehensive evaluation of the statewide program for safe harbor
455.35 of sexually exploited youth; and

456.1 (8) developing a policy, consistent with the requirements of chapter 13, for sharing
456.2 data related to sexually exploited youth, as defined in section 260C.007, subdivision 31,
456.3 among regional navigators and community-based advocates.

456.4 Sec. 27. **[145.4717] REGIONAL NAVIGATOR GRANTS.**

456.5 The commissioner of health, through its director of child sex trafficking prevention,
456.6 established in section 145.4716, shall provide grants to regional navigators serving six
456.7 regions of the state to be determined by the commissioner. Each regional navigator must
456.8 develop and annually submit a work plan to the director of child sex trafficking prevention.
456.9 The work plans must include, but are not limited to, the following information:

456.10 (1) a needs statement specific to the region, including an examination of the
456.11 population at risk;

456.12 (2) regional resources available to sexually exploited youth, as defined in section
456.13 260C.007, subdivision 31;

456.14 (3) grant goals and measurable outcomes; and

456.15 (4) grant activities including timelines.

456.16 Sec. 28. **[145.4718] PROGRAM EVALUATION.**

456.17 (a) The director of child sex trafficking prevention, established under section
456.18 145.4716, must conduct, or contract for, comprehensive evaluation of the statewide
456.19 program for safe harbor for sexually exploited youth. The first evaluation must be
456.20 completed by June 30, 2015, and must be submitted to the commissioner of health by
456.21 September 1, 2015, and every two years thereafter. The evaluation must consider whether
456.22 the program is reaching intended victims and whether support services are available,
456.23 accessible, and adequate for sexually exploited youth, as defined in section 260C.007,
456.24 subdivision 31.

456.25 (b) In conducting the evaluation, the director of child sex trafficking prevention must
456.26 consider evaluation of outcomes, including whether the program increases identification
456.27 of sexually exploited youth, coordination of investigations, access to services and housing
456.28 available for sexually exploited youth, and improved effectiveness of services. The
456.29 evaluation must also include examination of the ways in which penalties under section
456.30 609.3241 are assessed, collected, and distributed to ensure funding for investigation,
456.31 prosecution, and victim services to combat sexual exploitation of youth.

456.32 Sec. 29. Minnesota Statutes 2012, section 145.986, is amended to read:

456.33 **145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

457.1 Subdivision 1. **Grants to local communities Purpose.** The purpose of the statewide
457.2 health improvement program is to:

457.3 (1) address the top three leading preventable causes of illness, preventable health
457.4 costs, and death: tobacco use and exposure, poor diet, and lack of regular physical activity;

457.5 (2) promote the development, availability, and use of evidence-based, community
457.6 level, comprehensive strategies to create healthy communities; and

457.7 (3) measure the impact of the evidence-based, community health improvement
457.8 practices which over time work to contain health care costs and reduce chronic diseases.

457.9 Subd. 1a. Grants to local communities. (a) Beginning July 1, ~~2009~~ 2013,
457.10 the commissioner of health shall award ~~competitive~~ grants to all community health
457.11 boards established pursuant to section 145A.09 and tribal governments to convene,
457.12 coordinate, and implement evidence-based strategies targeted at reducing the percentage
457.13 of Minnesotans who are obese or overweight and to reduce the use of tobacco.

457.14 (b) Grantee activities shall:

457.15 (1) be based on scientific evidence;

457.16 (2) be based on community input;

457.17 (3) address behavior change at the individual, community, and systems levels;

457.18 (4) occur in community, school, worksite, and health care settings; ~~and~~

457.19 (5) be focused on policy, systems, and environmental changes that support healthy
457.20 behaviors; and

457.21 (6) address the health disparities and inequities that exist in the grantee's community.

457.22 (c) To receive a grant under this section, community health boards and tribal
457.23 governments must submit proposals to the commissioner. A local match of ten percent
457.24 of the total funding allocation is required. This local match may include funds donated
457.25 by community partners.

457.26 (d) In order to receive a grant, community health boards and tribal governments
457.27 must submit a health improvement plan to the commissioner of health for approval. The
457.28 commissioner may require the plan to identify a community leadership team, community
457.29 partners, and a community action plan that includes an assessment of area strengths and
457.30 needs, proposed action strategies, technical assistance needs, and a staffing plan.

457.31 (e) The grant recipient must implement the health improvement plan, evaluate the
457.32 effectiveness of the ~~interventions~~ strategies, and modify or discontinue ~~interventions~~
457.33 strategies found to be ineffective.

457.34 ~~(f) By January 15, 2011, the commissioner of health shall recommend whether any~~
457.35 ~~funding should be distributed to community health boards and tribal governments based~~
457.36 ~~on health disparities demonstrated in the populations served.~~

458.1 ~~(g)~~ (f) Grant recipients shall report their activities and their progress toward the
458.2 outcomes established under subdivision 2 to the commissioner in a format and at a time
458.3 specified by the commissioner.

458.4 ~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward
458.5 the measurable outcomes established in subdivision 2. The commissioner shall require a
458.6 corrective action plan and may reduce the funding level of grant recipients that do not
458.7 make adequate progress toward the measurable outcomes.

458.8 Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet
458.9 the goals specified in subdivision 1, and annually review the progress of grant recipients
458.10 in meeting the outcomes.

458.11 (b) The commissioner shall measure current public health status, using existing
458.12 measures and data collection systems when available, to determine baseline data against
458.13 which progress shall be monitored.

458.14 Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide
458.15 content expertise, technical expertise, and training to grant recipients and advice on
458.16 evidence-based strategies, including those based on populations and types of communities
458.17 served. The commissioner shall ensure that the statewide health improvement program
458.18 meets the outcomes established under subdivision 2 by conducting a comprehensive
458.19 statewide evaluation and assisting grant recipients to modify or discontinue interventions
458.20 found to be ineffective.

458.21 (b) In carrying out its responsibilities for administration, technical assistance, and
458.22 oversight, the commissioner may contract out its responsibilities within the limits of the
458.23 administrative budget given for those purposes.

458.24 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision
458.25 3, the commissioner shall conduct ~~a biennial~~ an evaluation of the statewide health
458.26 improvement program funded under this section. Grant recipients shall cooperate with
458.27 the commissioner in the evaluation and provide the commissioner with the information
458.28 necessary to conduct the evaluation.

458.29 (b) Grant recipients will collect, monitor, and submit to the Department of Health
458.30 baseline and annual data, and provide information to improve the quality and impact of
458.31 community health improvement strategies.

458.32 Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature
458.33 on the statewide health improvement program funded under this section. These reports
458.34 must include information on grant recipients, activities that were conducted using grant
458.35 funds, evaluation data, and outcome measures, if available. In addition, the commissioner
458.36 shall provide recommendations on future areas of focus for health improvement. These

459.1 reports are due by January 15 of every other year, beginning in 2010. ~~In the report due~~
459.2 ~~on January 15, 2010, the commissioner shall include recommendations on a sustainable~~
459.3 ~~funding source for the statewide health improvement program other than the health care~~
459.4 ~~access fund.~~

459.5 Subd. 6. **Supplantation of existing funds.** Community health boards and tribal
459.6 governments must use funds received under this section to develop new programs, expand
459.7 current programs that work to reduce the percentage of Minnesotans who are obese or
459.8 overweight or who use tobacco, or replace discontinued state or federal funds previously
459.9 used to reduce the percentage of Minnesotans who are obese or overweight or who use
459.10 tobacco. Funds must not be used to supplant current state or local funding to community
459.11 health boards or tribal governments used to reduce the percentage of Minnesotans who are
459.12 obese or overweight or to reduce tobacco use.

459.13 Sec. 30. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

459.14 Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead
459.15 human body to essential elements through ~~exposure to a combination of heat and alkaline~~
459.16 ~~hydrolysis and the repositioning or movement of the body during the process to facilitate~~
459.17 ~~reduction~~; a water-based dissolution process using alkaline chemicals, heat, agitation, and
459.18 pressure to accelerate natural decomposition; the processing of the hydrolyzed remains
459.19 after removal from the alkaline hydrolysis ~~chamber, vessel~~; placement of the processed
459.20 remains in a hydrolyzed remains container; and release of the hydrolyzed remains to an
459.21 appropriate party. Alkaline hydrolysis is a form of final disposition.

459.22 Sec. 31. Minnesota Statutes 2012, section 149A.02, is amended by adding a
459.23 subdivision to read:

459.24 Subd. 1b. **Alkaline hydrolysis container.** "Alkaline hydrolysis container" means a
459.25 hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily
459.26 fluids that encases the body and into which a dead human body is placed prior to insertion
459.27 into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or
459.28 biodegradable alternative containers or caskets.

459.29 Sec. 32. Minnesota Statutes 2012, section 149A.02, is amended by adding a
459.30 subdivision to read:

459.31 Subd. 1c. **Alkaline hydrolysis facility.** "Alkaline hydrolysis facility" means a
459.32 building or structure containing one or more alkaline hydrolysis vessels for the alkaline
459.33 hydrolysis of dead human bodies.

460.1 Sec. 33. Minnesota Statutes 2012, section 149A.02, is amended by adding a
460.2 subdivision to read:

460.3 Subd. 1d. **Alkaline hydrolysis vessel.** "Alkaline hydrolysis vessel" means the
460.4 container in which the alkaline hydrolysis of a dead human body is performed.

460.5 Sec. 34. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:

460.6 Subd. 2. **Alternative container.** "Alternative container" means a nonmetal
460.7 receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed
460.8 for the encasement of dead human bodies and is made of hydrolyzable or biodegradable
460.9 materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

460.10 Sec. 35. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:

460.11 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means
460.12 any action normally taken by a funeral provider in anticipation of or preparation for the
460.13 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

460.14 Sec. 36. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:

460.15 Subd. 4. **Cash advance item.** "Cash advance item" means any item of service
460.16 or merchandise described to a purchaser as a "cash advance," "accommodation," "cash
460.17 disbursement," or similar term. A cash advance item is also any item obtained from a
460.18 third party and paid for by the funeral provider on the purchaser's behalf. Cash advance
460.19 items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services,
460.20 pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary
460.21 notices, gratuities, and death records.

460.22 Sec. 37. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:

460.23 Subd. 5. **Casket.** "Casket" means a rigid container which is designed for the
460.24 encasement of a dead human body and is usually constructed of hydrolyzable or
460.25 biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented
460.26 and lined with fabric.

460.27 Sec. 38. Minnesota Statutes 2012, section 149A.02, is amended by adding a
460.28 subdivision to read:

460.29 Subd. 12a. **Crypt.** "Crypt" means a space in a mausoleum of sufficient size, used or
460.30 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

461.1 Sec. 39. Minnesota Statutes 2012, section 149A.02, is amended by adding a
461.2 subdivision to read:

461.3 Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a
461.4 final disposition of a dead human body by alkaline hydrolysis, without formal viewing,
461.5 visitation, or ceremony with the body present.

461.6 Sec. 40. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:

461.7 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
461.8 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

461.9 Sec. 41. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:

461.10 Subd. 23. **Funeral services.** "Funeral services" means any services which may
461.11 be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis,
461.12 cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral
461.13 ceremony or the final disposition of dead human bodies.

461.14 Sec. 42. Minnesota Statutes 2012, section 149A.02, is amended by adding a
461.15 subdivision to read:

461.16 Subd. 24b. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a
461.17 dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not
461.18 include pacemakers, prostheses, or similar foreign materials.

461.19 Sec. 43. Minnesota Statutes 2012, section 149A.02, is amended by adding a
461.20 subdivision to read:

461.21 Subd. 24c. **Hydrolyzed remains container.** "Hydrolyzed remains container" means
461.22 a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a
461.23 hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage
461.24 jewelry.

461.25 Sec. 44. Minnesota Statutes 2012, section 149A.02, is amended by adding a
461.26 subdivision to read:

461.27 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains
461.28 in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

461.29 Sec. 45. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:

462.1 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued
462.2 a license to practice mortuary science, to operate a funeral establishment, to operate an
462.3 alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner
462.4 of health.

462.5 Sec. 46. Minnesota Statutes 2012, section 149A.02, is amended by adding a
462.6 subdivision to read:

462.7 Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be
462.8 used, for the placement of hydrolyzed or cremated remains.

462.9 Sec. 47. Minnesota Statutes 2012, section 149A.02, is amended by adding a
462.10 subdivision to read:

462.11 Subd. 32a. **Placement.** "Placement" means the placing of a container holding
462.12 hydrolyzed or cremated remains in a crypt, vault, or niche.

462.13 Sec. 48. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:

462.14 Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of
462.15 the body into an appropriate cremation or alkaline hydrolysis container, embalming of
462.16 the body or such items of care as washing, disinfecting, shaving, positioning of features,
462.17 restorative procedures, application of cosmetics, dressing, and casketing.

462.18 Sec. 49. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:

462.19 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
462.20 cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means
462.21 including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance
462.22 appropriate for final disposition.

462.23 Sec. 50. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:

462.24 Subd. 37. **Public transportation.** "Public transportation" means all manner of
462.25 transportation via common carrier available to the general public including airlines, buses,
462.26 railroads, and ships. For purposes of this chapter, a livery service providing transportation
462.27 to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public
462.28 transportation.

462.29 Sec. 51. Minnesota Statutes 2012, section 149A.02, is amended by adding a
462.30 subdivision to read:

463.1 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed
463.2 or cremated remains in a defined area of a dedicated cemetery or in areas where no local
463.3 prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable
463.4 to the public, are not in a container, and that the person who has control over disposition
463.5 of the hydrolyzed or cremated remains has obtained written permission of the property
463.6 owner or governing agency to scatter on the property.

463.7 Sec. 52. Minnesota Statutes 2012, section 149A.02, is amended by adding a
463.8 subdivision to read:

463.9 Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or
463.10 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.
463.11 Vault may also mean a sealed and lined casket enclosure.

463.12 Sec. 53. Minnesota Statutes 2012, section 149A.03, is amended to read:

463.13 **149A.03 DUTIES OF COMMISSIONER.**

463.14 The commissioner shall:

463.15 (1) enforce all laws and adopt and enforce rules relating to the:

463.16 (i) removal, preparation, transportation, arrangements for disposition, and final
463.17 disposition of dead human bodies;

463.18 (ii) licensure and professional conduct of funeral directors, morticians, interns,
463.19 practicum students, and clinical students;

463.20 (iii) licensing and operation of a funeral establishment; ~~and~~

463.21 (iv) licensing and operation of an alkaline hydrolysis facility; and

463.22 ~~(iv)~~ (v) licensing and operation of a crematory;

463.23 (2) provide copies of the requirements for licensure and permits to all applicants;

463.24 (3) administer examinations and issue licenses and permits to qualified persons
463.25 and other legal entities;

463.26 (4) maintain a record of the name and location of all current licensees and interns;

463.27 (5) perform periodic compliance reviews and premise inspections of licensees;

463.28 (6) accept and investigate complaints relating to conduct governed by this chapter;

463.29 (7) maintain a record of all current preneed arrangement trust accounts;

463.30 (8) maintain a schedule of application, examination, permit, and licensure fees,
463.31 initial and renewal, sufficient to cover all necessary operating expenses;

463.32 (9) educate the public about the existence and content of the laws and rules for
463.33 mortuary science licensing and the removal, preparation, transportation, arrangements

464.1 for disposition, and final disposition of dead human bodies to enable consumers to file
 464.2 complaints against licensees and others who may have violated those laws or rules;

464.3 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary
 464.4 science in order to refine the standards for licensing and to improve the regulatory and
 464.5 enforcement methods used; and

464.6 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in
 464.7 the laws, rules, or procedures governing the practice of mortuary science and the removal,
 464.8 preparation, transportation, arrangements for disposition, and final disposition of dead
 464.9 human bodies.

464.10 Sec. 54. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS**
 464.11 **FACILITY.**

464.12 Subdivision 1. License requirement. Except as provided in section 149A.01,
 464.13 subdivision 3, a place or premise shall not be maintained, managed, or operated which
 464.14 is devoted to or used in the holding and alkaline hydrolysis of a dead human body
 464.15 without possessing a valid license to operate an alkaline hydrolysis facility issued by the
 464.16 commissioner of health.

464.17 Subd. 2. Requirements for an alkaline hydrolysis facility. (a) An alkaline
 464.18 hydrolysis facility licensed under this section must consist of:

464.19 (1) a building or structure that complies with applicable local and state building
 464.20 codes, zoning laws and ordinances, wastewater management and environmental standards,
 464.21 containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead
 464.22 human bodies;

464.23 (2) a method approved by the commissioner of health to dry the hydrolyzed remains
 464.24 and which is located within the licensed facility;

464.25 (3) a means approved by the commissioner of health for refrigeration of dead human
 464.26 bodies awaiting alkaline hydrolysis;

464.27 (4) an appropriate means of processing hydrolyzed remains to a granulated
 464.28 appearance appropriate for final disposition; and

464.29 (5) an appropriate holding facility for dead human bodies awaiting alkaline
 464.30 hydrolysis.

464.31 (b) An alkaline hydrolysis facility licensed under this section may also contain a
 464.32 display room for funeral goods.

464.33 Subd. 3. Application procedure; documentation; initial inspection. An
 464.34 application to license and operate an alkaline hydrolysis facility shall be submitted to the
 464.35 commissioner of health. A completed application includes:

- 465.1 (1) a completed application form, as provided by the commissioner;
465.2 (2) proof of business form and ownership;
465.3 (3) proof of liability insurance coverage or other financial documentation, as
465.4 determined by the commissioner, that demonstrates the applicant's ability to respond in
465.5 damages for liability arising from the ownership, maintenance management, or operation
465.6 of an alkaline hydrolysis facility; and
465.7 (4) copies of wastewater and other environmental regulatory permits and
465.8 environmental regulatory licenses necessary to conduct operations.

465.9 Upon receipt of the application and appropriate fee, the commissioner shall review and
465.10 verify all information. Upon completion of the verification process and resolution of any
465.11 deficiencies in the application information, the commissioner shall conduct an initial
465.12 inspection of the premises to be licensed. After the inspection and resolution of any
465.13 deficiencies found and any reinspections as may be necessary, the commissioner shall
465.14 make a determination, based on all the information available, to grant or deny licensure. If
465.15 the commissioner's determination is to grant the license, the applicant shall be notified and
465.16 the license shall issue and remain valid for a period prescribed on the license, but not to
465.17 exceed one calendar year from the date of issuance of the license. If the commissioner's
465.18 determination is to deny the license, the commissioner must notify the applicant in writing
465.19 of the denial and provide the specific reason for denial.

465.20 Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis
465.21 facility is not assignable or transferable and shall not be valid for any entity other than the
465.22 one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the
465.23 location identified on the license. A 50 percent or more change in ownership or location of
465.24 the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall
465.25 be required of two or more persons or other legal entities operating from the same location.

465.26 Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis
465.27 facility must be conspicuously displayed in the alkaline hydrolysis facility at all times.
465.28 Conspicuous display means in a location where a member of the general public within the
465.29 alkaline hydrolysis facility will be able to observe and read the license.

465.30 Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility
465.31 issued by the commissioner are valid for a period of one calendar year beginning on July 1
465.32 and ending on June 30, regardless of the date of issuance.

465.33 Subd. 7. **Reporting changes in license information.** Any change of license
465.34 information must be reported to the commissioner, on forms provided by the
465.35 commissioner, no later than 30 calendar days after the change occurs. Failure to report
465.36 changes is grounds for disciplinary action.

466.1 Subd. 8. **Notification to the commissioner.** If the licensee is operating under a
466.2 wastewater or an environmental permit or license that is subsequently revoked, denied,
466.3 or terminated, the licensee shall notify the commissioner.

466.4 Subd. 9. **Application information.** All information submitted to the commissioner
466.5 for a license to operate an alkaline hydrolysis facility is classified as licensing data under
466.6 section 13.41, subdivision 5.

466.7 Sec. 55. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE**
466.8 **HYDROLYSIS FACILITY.**

466.9 Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis
466.10 facility issued by the commissioner expire on June 30 following the date of issuance of the
466.11 license and must be renewed to remain valid.

466.12 Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew
466.13 their licenses must submit to the commissioner a completed renewal application no later
466.14 than June 30 following the date the license was issued. A completed renewal application
466.15 includes:

466.16 (1) a completed renewal application form, as provided by the commissioner; and
466.17 (2) proof of liability insurance coverage or other financial documentation, as
466.18 determined by the commissioner, that demonstrates the applicant's ability to respond in
466.19 damages for liability arising from the ownership, maintenance, management, or operation
466.20 of an alkaline hydrolysis facility.

466.21 Upon receipt of the completed renewal application, the commissioner shall review and
466.22 verify the information. Upon completion of the verification process and resolution of
466.23 any deficiencies in the renewal application information, the commissioner shall make a
466.24 determination, based on all the information available, to reissue or refuse to reissue the
466.25 license. If the commissioner's determination is to reissue the license, the applicant shall
466.26 be notified and the license shall issue and remain valid for a period prescribed on the
466.27 license, but not to exceed one calendar year from the date of issuance of the license. If
466.28 the commissioner's determination is to refuse to reissue the license, section 149A.09,
466.29 subdivision 2, applies.

466.30 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration
466.31 date of a license will result in the assessment of a late filing penalty. The late filing penalty
466.32 must be paid before the reissuance of the license and received by the commissioner no
466.33 later than 31 calendar days after the expiration date of the license.

466.34 Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities
466.35 shall automatically lapse when a completed renewal application is not received by the

467.1 commissioner within 31 calendar days after the expiration date of a license, or a late
467.2 filing penalty assessed under subdivision 3 is not received by the commissioner within 31
467.3 calendar days after the expiration of a license.

467.4 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom
467.5 the license was issued is no longer licensed to operate an alkaline hydrolysis facility in
467.6 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
467.7 license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue
467.8 any additional lawful remedies as justified by the case.

467.9 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed
467.10 license upon receipt and review of a completed renewal application, receipt of the late
467.11 filing penalty, and reinspection of the premises, provided that the receipt is made within
467.12 one calendar year from the expiration date of the lapsed license and the cease and desist
467.13 order issued by the commissioner has not been violated. If a lapsed license is not restored
467.14 within one calendar year from the expiration date of the lapsed license, the holder of the
467.15 lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

467.16 Subd. 7. **Reporting changes in license information.** Any change of license
467.17 information must be reported to the commissioner, on forms provided by the
467.18 commissioner, no later than 30 calendar days after the change occurs. Failure to report
467.19 changes is grounds for disciplinary action.

467.20 Subd. 8. **Application information.** All information submitted to the commissioner
467.21 by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is
467.22 classified as licensing data under section 13.41, subdivision 5.

467.23 Sec. 56. Minnesota Statutes 2012, section 149A.65, is amended by adding a
467.24 subdivision to read:

467.25 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline
467.26 hydrolysis facility is \$300. The late fee charge for a license renewal is \$25.

467.27 Sec. 57. Minnesota Statutes 2012, section 149A.65, is amended by adding a
467.28 subdivision to read:

467.29 Subd. 7. **State government special revenue fund.** Fees collected by the
467.30 commissioner under this section must be deposited in the state treasury and credited to
467.31 the state government special revenue fund.

467.32 Sec. 58. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:

468.1 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice
468.2 mortuary science issued by the commissioner may use the title of mortician, funeral
468.3 director, or any other title implying that the licensee is engaged in the business or practice
468.4 of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis
468.5 facility issued by the commissioner may use the title of alkaline hydrolysis facility, water
468.6 cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or
468.7 any other title, word, or term implying that the licensee operates an alkaline hydrolysis
468.8 facility. Only the holder of a valid license to operate a funeral establishment issued by the
468.9 commissioner may use the title of funeral home, funeral chapel, funeral service, or any
468.10 other title, word, or term implying that the licensee is engaged in the business or practice
468.11 of mortuary science. Only the holder of a valid license to operate a crematory issued by
468.12 the commissioner may use the title of crematory, crematorium, green-cremation, or any
468.13 other title, word, or term implying that the licensee operates a crematory or crematorium.

468.14 Sec. 59. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:

468.15 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or
468.16 crematory shall not do business in a location that is not licensed as a funeral establishment,
468.17 alkaline hydrolysis facility, or crematory and shall not advertise a service that is available
468.18 from an unlicensed location.

468.19 Sec. 60. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:

468.20 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern
468.21 shall publish or disseminate false, misleading, or deceptive advertising. False, misleading,
468.22 or deceptive advertising includes, but is not limited to:

468.23 (1) identifying, by using the names or pictures of, persons who are not licensed to
468.24 practice mortuary science in a way that leads the public to believe that those persons will
468.25 provide mortuary science services;

468.26 (2) using any name other than the names under which the funeral establishment,
468.27 alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

468.28 (3) using a surname not directly, actively, or presently associated with a licensed
468.29 funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had
468.30 been previously and continuously used by the licensed funeral establishment, alkaline
468.31 hydrolysis facility, or crematory; and

468.32 (4) using a founding or establishing date or total years of service not directly or
468.33 continuously related to a name under which the funeral establishment, alkaline hydrolysis
468.34 facility, or crematory is currently or was previously licensed.

469.1 Any advertising or other printed material that contains the names or pictures of
469.2 persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory
469.3 shall state the position held by the persons and shall identify each person who is licensed
469.4 or unlicensed under this chapter.

469.5 Sec. 61. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:

469.6 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum
469.7 student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other
469.8 reimbursement in consideration for recommending or causing a dead human body to
469.9 be disposed of by a specific body donation program, funeral establishment, alkaline
469.10 hydrolysis facility, crematory, mausoleum, or cemetery.

469.11 Sec. 62. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:

469.12 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or
469.13 practices, the requirements of this subdivision must be met.

469.14 (b) Funeral providers must tell persons who ask by telephone about the funeral
469.15 provider's offerings or prices any accurate information from the price lists described in
469.16 paragraphs (c) to (e) and any other readily available information that reasonably answers
469.17 the questions asked.

469.18 (c) Funeral providers must make available for viewing to people who inquire in
469.19 person about the offerings or prices of funeral goods or burial site goods, separate printed
469.20 or typewritten price lists using a ten-point font or larger. Each funeral provider must have a
469.21 separate price list for each of the following types of goods that are sold or offered for sale:

469.22 (1) caskets;

469.23 (2) alternative containers;

469.24 (3) outer burial containers;

469.25 (4) alkaline hydrolysis containers;

469.26 ~~(4)~~ (5) cremation containers;

469.27 (6) hydrolyzed remains containers;

469.28 ~~(5)~~ (7) cremated remains containers;

469.29 ~~(6)~~ (8) markers; and

469.30 ~~(7)~~ (9) headstones.

469.31 (d) Each separate price list must contain the name of the funeral provider's place
469.32 of business, address, and telephone number and a caption describing the list as a price
469.33 list for one of the types of funeral goods or burial site goods described in paragraph (c),
469.34 clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion

470.1 of, but in any event before showing, the specific funeral goods or burial site goods and
470.2 must provide a photocopy of the price list, for retention, if so asked by the consumer. The
470.3 list must contain, at least, the retail prices of all the specific funeral goods and burial site
470.4 goods offered which do not require special ordering, enough information to identify each,
470.5 and the effective date for the price list. However, funeral providers are not required to
470.6 make a specific price list available if the funeral providers place the information required
470.7 by this paragraph on the general price list described in paragraph (e).

470.8 (e) Funeral providers must give a printed price list, for retention, to persons who
470.9 inquire in person about the funeral goods, funeral services, burial site goods, or burial site
470.10 services or prices offered by the funeral provider. The funeral provider must give the list
470.11 upon beginning discussion of either the prices of or the overall type of funeral service or
470.12 disposition or specific funeral goods, funeral services, burial site goods, or burial site
470.13 services offered by the provider. This requirement applies whether the discussion takes
470.14 place in the funeral establishment or elsewhere. However, when the deceased is removed
470.15 for transportation to the funeral establishment, an in-person request for authorization to
470.16 embalm does not, by itself, trigger the requirement to offer the general price list. If the
470.17 provider, in making an in-person request for authorization to embalm, discloses that
470.18 embalming is not required by law except in certain special cases, the provider is not
470.19 required to offer the general price list. Any other discussion during that time about prices
470.20 or the selection of funeral goods, funeral services, burial site goods, or burial site services
470.21 triggers the requirement to give the consumer a general price list. The general price list
470.22 must contain the following information:

470.23 (1) the name, address, and telephone number of the funeral provider's place of
470.24 business;

470.25 (2) a caption describing the list as a "general price list";

470.26 (3) the effective date for the price list;

470.27 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per
470.28 hour, mile, or other unit of computation, and other information described as follows:

470.29 (i) forwarding of remains to another funeral establishment, together with a list of
470.30 the services provided for any quoted price;

470.31 (ii) receiving remains from another funeral establishment, together with a list of
470.32 the services provided for any quoted price;

470.33 (iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral
470.34 provider, with the price including an alternative container or alkaline hydrolysis or
470.35 cremation container, any alkaline hydrolysis or crematory charges, and a description of the

471.1 services and container included in the price, where applicable, and the price of alkaline
471.2 hydrolysis or cremation where the purchaser provides the container;

471.3 (iv) separate prices for each immediate burial offered by the funeral provider,
471.4 including a casket or alternative container, and a description of the services and container
471.5 included in that price, and the price of immediate burial where the purchaser provides the
471.6 casket or alternative container;

471.7 (v) transfer of remains to the funeral establishment or other location;

471.8 (vi) embalming;

471.9 (vii) other preparation of the body;

471.10 (viii) use of facilities, equipment, or staff for viewing;

471.11 (ix) use of facilities, equipment, or staff for funeral ceremony;

471.12 (x) use of facilities, equipment, or staff for memorial service;

471.13 (xi) use of equipment or staff for graveside service;

471.14 (xii) hearse or funeral coach;

471.15 (xiii) limousine; and

471.16 (xiv) separate prices for all cemetery-specific goods and services, including all goods
471.17 and services associated with interment and burial site goods and services and excluding
471.18 markers and headstones;

471.19 (5) the price range for the caskets offered by the funeral provider, together with the
471.20 statement "A complete price list will be provided at the funeral establishment or casket
471.21 sale location." or the prices of individual caskets, as disclosed in the manner described
471.22 in paragraphs (c) and (d);

471.23 (6) the price range for the alternative containers offered by the funeral provider,
471.24 together with the statement "A complete price list will be provided at the funeral
471.25 establishment or alternative container sale location." or the prices of individual alternative
471.26 containers, as disclosed in the manner described in paragraphs (c) and (d);

471.27 (7) the price range for the outer burial containers offered by the funeral provider,
471.28 together with the statement "A complete price list will be provided at the funeral
471.29 establishment or outer burial container sale location." or the prices of individual outer
471.30 burial containers, as disclosed in the manner described in paragraphs (c) and (d);

471.31 (8) the price range for the alkaline hydrolysis container offered by the funeral
471.32 provider, together with the statement: "A complete price list will be provided at the funeral
471.33 establishment or alkaline hydrolysis container sale location.", or the prices of individual
471.34 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c)
471.35 and (d);

472.1 (9) the price range for the hydrolyzed remains container offered by the funeral
472.2 provider, together with the statement: "A complete price list will be provided at the
472.3 funeral establishment or hydrolyzed remains container sale location.", or the prices
472.4 of individual hydrolyzed remains container, as disclosed in the manner described in
472.5 paragraphs (c) and (d);

472.6 ~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider,
472.7 together with the statement "A complete price list will be provided at the funeral
472.8 establishment or cremation container sale location." or the prices of individual cremation
472.9 containers ~~and cremated remains containers~~, as disclosed in the manner described in
472.10 paragraphs (c) and (d);

472.11 ~~(9)~~ (11) the price range for the cremated remains containers offered by the funeral
472.12 provider, together with the statement, "A complete price list will be provided at the funeral
472.13 establishment or ~~cremation~~ cremated remains container sale location," or the prices of
472.14 individual cremation containers as disclosed in the manner described in paragraphs (c)
472.15 and (d);

472.16 ~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a
472.17 list of the principal basic services provided for any quoted price and, if the charge cannot
472.18 be declined by the purchaser, the statement "This fee for our basic services will be added
472.19 to the total cost of the funeral arrangements you select. (This fee is already included in
472.20 our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding
472.21 or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted
472.22 price shall include all charges for the recovery of unallocated funeral provider overhead,
472.23 and funeral providers may include in the required disclosure the phrase "and overhead"
472.24 after the word "services." This services fee is the only funeral provider fee for services,
472.25 facilities, or unallocated overhead permitted by this subdivision to be nondeclinable,
472.26 unless otherwise required by law;

472.27 ~~(11)~~ (13) the price range for the markers and headstones offered by the funeral
472.28 provider, together with the statement "A complete price list will be provided at the funeral
472.29 establishment or marker or headstone sale location." or the prices of individual markers
472.30 and headstones, as disclosed in the manner described in paragraphs (c) and (d); and

472.31 ~~(12)~~ (14) any package priced funerals offered must be listed in addition to and
472.32 following the information required in paragraph (e) and must clearly state the funeral
472.33 goods and services being offered, the price being charged for those goods and services,
472.34 and the discounted savings.

472.35 (f) Funeral providers must give an itemized written statement, for retention, to each
472.36 consumer who arranges an at-need funeral or other disposition of human remains at the

473.1 conclusion of the discussion of the arrangements. The itemized written statement must be
473.2 signed by the consumer selecting the goods and services as required in section 149A.80.
473.3 If the statement is provided by a funeral establishment, the statement must be signed by
473.4 the licensed funeral director or mortician planning the arrangements. If the statement is
473.5 provided by any other funeral provider, the statement must be signed by an authorized
473.6 agent of the funeral provider. The statement must list the funeral goods, funeral services,
473.7 burial site goods, or burial site services selected by that consumer and the prices to be paid
473.8 for each item, specifically itemized cash advance items (these prices must be given to the
473.9 extent then known or reasonably ascertainable if the prices are not known or reasonably
473.10 ascertainable, a good faith estimate shall be given and a written statement of the actual
473.11 charges shall be provided before the final bill is paid), and the total cost of goods and
473.12 services selected. At the conclusion of an at-need arrangement, the funeral provider is
473.13 required to give the consumer a copy of the signed itemized written contract that must
473.14 contain the information required in this paragraph.

473.15 (g) Upon receiving actual notice of the death of an individual with whom a funeral
473.16 provider has entered a preneed funeral agreement, the funeral provider must provide
473.17 a copy of all preneed funeral agreement documents to the person who controls final
473.18 disposition of the human remains or to the designee of the person controlling disposition.
473.19 The person controlling final disposition shall be provided with these documents at the time
473.20 of the person's first in-person contact with the funeral provider, if the first contact occurs
473.21 in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place
473.22 of business of the funeral provider. If the contact occurs by other means or at another
473.23 location, the documents must be provided within 24 hours of the first contact.

473.24 Sec. 63. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

473.25 Subd. 4. **Casket, alternate container, alkaline hydrolysis containers, and**
473.26 **cremation container sales; records; required disclosures.** Any funeral provider who
473.27 sells or offers to sell a casket, alternate container, alkaline hydrolysis container, hydrolyzed
473.28 remains container, or cremation container, or cremated remains container to the public
473.29 must maintain a record of each sale that includes the name of the purchaser, the purchaser's
473.30 mailing address, the name of the decedent, the date of the decedent's death, and the place
473.31 of death. These records shall be open to inspection by the regulatory agency. Any funeral
473.32 provider selling a casket, alternate container, or cremation container to the public, and not
473.33 having charge of the final disposition of the dead human body, shall provide a copy of the
473.34 statutes and rules controlling the removal, preparation, transportation, arrangements for
473.35 disposition, and final disposition of a dead human body. This subdivision does not apply to

474.1 morticians, funeral directors, funeral establishments, crematories, or wholesale distributors
474.2 of caskets, alternate containers, alkaline hydrolysis containers, or cremation containers.

474.3 Sec. 64. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:

474.4 Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts**
474.5 **or practices.** In selling or offering to sell funeral goods or funeral services to the public, it
474.6 is a deceptive act or practice for a funeral provider to represent that a casket is required for
474.7 alkaline hydrolysis or cremations by state or local law or otherwise.

474.8 Sec. 65. Minnesota Statutes 2012, section 149A.72, is amended by adding a
474.9 subdivision to read:

474.10 Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To
474.11 prevent deceptive acts or practices, funeral providers must place the following disclosure
474.12 in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota
474.13 law does not require you to purchase a casket for alkaline hydrolysis. If you want to
474.14 arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline
474.15 hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant
474.16 to leakage of bodily fluids that encases the body and into which a dead human body is
474.17 placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide
474.18 are (specify containers provided)." This disclosure is required only if the funeral provider
474.19 arranges alkaline hydrolysis.

474.20 Sec. 66. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:

474.21 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods,
474.22 funeral services, burial site goods, or burial site services to the public, it is a deceptive act
474.23 or practice for a funeral provider to represent that federal, state, or local laws, or particular
474.24 cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral
474.25 goods, funeral services, burial site goods, or burial site services when that is not the case.

474.26 Sec. 67. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

474.27 Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive**
474.28 **acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site
474.29 goods, or burial site services to the public, it is a deceptive act or practice for a funeral
474.30 provider to require that a casket be purchased for alkaline hydrolysis or cremation.

474.31 Sec. 68. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

475.1 Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.**
475.2 To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline
475.3 hydrolysis or cremations, they must make a an alkaline hydrolysis container or cremation
475.4 container available for alkaline hydrolysis or cremations.

475.5 Sec. 69. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

475.6 Subd. 4. **Required purchases of funeral goods or services; preventive**
475.7 **requirements.** To prevent unfair or deceptive acts or practices, funeral providers must
475.8 place the following disclosure in the general price list, immediately above the prices
475.9 required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods
475.10 and services shown below are those we can provide to our customers. You may choose
475.11 only the items you desire. If legal or other requirements mean that you must buy any items
475.12 you did not specifically ask for, we will explain the reason in writing on the statement we
475.13 provide describing the funeral goods, funeral services, burial site goods, and burial site
475.14 services you selected." However, if the charge for "services of funeral director and staff"
475.15 cannot be declined by the purchaser, the statement shall include the sentence "However,
475.16 any funeral arrangements you select will include a charge for our basic services." between
475.17 the second and third sentences of the sentences specified in this subdivision. The statement
475.18 may include the phrase "and overhead" after the word "services" if the fee includes a
475.19 charge for the recovery of unallocated funeral overhead. If the funeral provider does
475.20 not include this disclosure statement, then the following disclosure statement must be
475.21 placed in the statement of funeral goods, funeral services, burial site goods, and burial site
475.22 services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges
475.23 are only for those items that you selected or that are required. If we are required by law or
475.24 by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain
475.25 the reasons in writing below." A funeral provider is not in violation of this subdivision by
475.26 failing to comply with a request for a combination of goods or services which would be
475.27 impossible, impractical, or excessively burdensome to provide.

475.28 Sec. 70. Minnesota Statutes 2012, section 149A.74, is amended to read:

475.29 **149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.**

475.30 Subdivision 1. **Services provided without prior approval; deceptive acts or**
475.31 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it
475.32 is a deceptive act or practice for any funeral provider to embalm a dead human body
475.33 unless state or local law or regulation requires embalming in the particular circumstances
475.34 regardless of any funeral choice which might be made, or prior approval for embalming

476.1 has been obtained from an individual legally authorized to make such a decision. In
476.2 seeking approval to embalm, the funeral provider must disclose that embalming is not
476.3 required by law except in certain circumstances; that a fee will be charged if a funeral
476.4 is selected which requires embalming, such as a funeral with viewing; and that no
476.5 embalming fee will be charged if the family selects a service which does not require
476.6 embalming, such as direct alkaline hydrolysis, direct cremation, or immediate burial.

476.7 **Subd. 2. Services provided without prior approval; preventive requirement.**

476.8 To prevent unfair or deceptive acts or practices, funeral providers must include on
476.9 the itemized statement of funeral goods or services, as described in section 149A.71,
476.10 subdivision 2, paragraph (f), the statement "If you selected a funeral that may require
476.11 embalming, such as a funeral with viewing, you may have to pay for embalming. You do
476.12 not have to pay for embalming you did not approve if you selected arrangements such
476.13 as direct alkaline hydrolysis, direct cremation, or immediate burial. If we charged for
476.14 embalming, we will explain why below."

476.15 Sec. 71. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:

476.16 **Subd. 9. Embalmed Bodies awaiting final disposition.** All embalmed bodies
476.17 awaiting final disposition shall be kept in an appropriate holding facility or preparation
476.18 and embalming room. The holding facility must be secure from access by anyone except
476.19 the authorized personnel of the funeral establishment, preserve the dignity and integrity of
476.20 the body, and protect the health and safety of the personnel of the funeral establishment.

476.21 Sec. 72. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:

476.22 **Subd. 3. Disposition permit.** A disposition permit is required before a body can
476.23 be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be
476.24 issued until a fact of death record has been completed and filed with the local or state
476.25 registrar of vital statistics.

476.26 Sec. 73. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:

476.27 **Subd. 6. Conveyances permitted for transportation.** A dead human body may be
476.28 transported by means of private vehicle or private aircraft, provided that the body must be
476.29 encased in an appropriate container, that meets the following standards:

476.30 (1) promotes respect for and preserves the dignity of the dead human body;

476.31 (2) shields the body from being viewed from outside of the conveyance;

477.1 (3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket,
477.2 alternative container, alkaline hydrolysis container, or cremation container in a horizontal
477.3 position;

477.4 (4) is designed to permit loading and unloading of the body without excessive tilting
477.5 of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container,
477.6 or cremation container; and

477.7 (5) if used for the transportation of more than one dead human body at one time,
477.8 the vehicle must be designed so that a body or container does not rest directly on top of
477.9 another body or container and that each body or container is secured to prevent the body
477.10 or container from excessive movement within the conveyance.

477.11 A vehicle that is a dignified conveyance and was specified for use by the deceased
477.12 or by the family of the deceased may be used to transport the body to the place of final
477.13 disposition.

477.14 Sec. 74. Minnesota Statutes 2012, section 149A.94, is amended to read:

477.15 **149A.94 FINAL DISPOSITION.**

477.16 Subdivision 1. **Generally.** Every dead human body lying within the state, except
477.17 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
477.18 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
477.19 the state for the purpose of disposition elsewhere; and the remains of any dead human
477.20 body after dissection or anatomical study, shall be decently buried, or entombed in a
477.21 public or private cemetery, alkaline hydrolyzed or cremated; within a reasonable time
477.22 after death. Where final disposition of a body will not be accomplished within 72 hours
477.23 following death or release of the body by a competent authority with jurisdiction over the
477.24 body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body
477.25 may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry
477.26 ice for a period that exceeds four calendar days, from the time of death or release of the
477.27 body from the coroner or medical examiner.

477.28 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or
477.29 cremated without a disposition permit. The disposition permit must be filed with the person
477.30 in charge of the place of final disposition. Where a dead human body will be transported out
477.31 of this state for final disposition, the body must be accompanied by a certificate of removal.

477.32 Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or
477.33 cremated remains and release to an appropriate party is considered final disposition and no
477.34 further permits or authorizations are required for transportation, interment, entombment, or
477.35 placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

478.1 Sec. 75. [149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE
478.2 HYDROLYSIS.

478.3 Subdivision 1. License required. A dead human body may only be hydrolyzed in
478.4 this state at an alkaline hydrolysis facility licensed by the commissioner of health.

478.5 Subd. 2. General requirements. Any building to be used as an alkaline hydrolysis
478.6 facility must comply with all applicable local and state building codes, zoning laws and
478.7 ordinances, wastewater management regulations, and environmental statutes, rules, and
478.8 standards. An alkaline hydrolysis facility must have, on site, a purpose built human
478.9 alkaline hydrolysis system approved by the commissioner of health, a system approved by
478.10 the commissioner of health for drying the hydrolyzed remains, a motorized mechanical
478.11 device approved by the commissioner of health for processing hydrolyzed remains and
478.12 must have in the building a holding facility approved by the commissioner of health for
478.13 the retention of dead human bodies awaiting alkaline hydrolysis. The holding facility
478.14 must be secure from access by anyone except the authorized personnel of the alkaline
478.15 hydrolysis facility, preserve the dignity of the remains, and protect the health and safety of
478.16 the alkaline hydrolysis facility personnel.

478.17 Subd. 3. Lighting and ventilation. The room where the alkaline hydrolysis vessel
478.18 is located and the room where the chemical storage takes place shall be properly lit and
478.19 ventilated with an exhaust fan that provides at least 12 air changes per hour.

478.20 Subd. 4. Plumbing connections. All plumbing fixtures, water supply lines,
478.21 plumbing vents, and waste drains shall be properly vented and connected pursuant to the
478.22 Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a
478.23 functional sink with hot and cold running water.

478.24 Subd. 5. Flooring, walls, ceiling, doors, and windows. The room where the
478.25 alkaline hydrolysis vessel is located and the room where the chemical storage takes place
478.26 shall have nonporous flooring, so that a sanitary condition is provided. The walls and
478.27 ceiling of the room where the alkaline hydrolysis vessel is located and the room where
478.28 the chemical storage takes place shall run from floor to ceiling and be covered with tile,
478.29 or by plaster or sheetrock painted with washable paint or other appropriate material so
478.30 that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be
478.31 constructed to prevent odors from entering any other part of the building. All windows
478.32 or other openings to the outside must be screened and all windows must be treated in a
478.33 manner that prevents viewing into the room where the alkaline hydrolysis vessel is located
478.34 and the room where the chemical storage takes place. A viewing window for authorized
478.35 family members or their designees is not a violation of this subdivision.

479.1 Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a
479.2 functional emergency eye wash and quick drench shower.

479.3 Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is
479.4 located and the room where the chemical storage takes place must be private and have no
479.5 general passageway through it. The room shall, at all times, be secure from the entrance of
479.6 unauthorized persons. Authorized persons are:

479.7 (1) licensed morticians;

479.8 (2) registered interns or students as described in section 149A.91, subdivision 6;

479.9 (3) public officials or representatives in the discharge of their official duties;

479.10 (4) trained alkaline hydrolysis facility operators; and

479.11 (5) the person(s) with the right to control the dead human body as defined in section
479.12 149A.80, subdivision 2, and their designees.

479.13 (b) Each door allowing ingress or egress shall carry a sign that indicates that the
479.14 room is private and access is limited. All authorized persons who are present in or enter
479.15 the room where the alkaline hydrolysis vessel is located while a body is being prepared for
479.16 final disposition must be attired according to all applicable state and federal regulations
479.17 regarding the control of infectious disease and occupational and workplace health and
479.18 safety.

479.19 Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline
479.20 hydrolysis vessel is located and the room where the chemical storage takes place and all
479.21 fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies
479.22 stored or used in the room must be maintained in a clean and sanitary condition at all times.

479.23 Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline
479.24 hydrolysis vessel for its operation, all state and local regulations for that boiler must be
479.25 followed.

479.26 Subd. 10. **Occupational and workplace safety.** All applicable provisions of state
479.27 and federal regulations regarding exposure to workplace hazards and accidents shall be
479.28 followed in order to protect the health and safety of all authorized persons at the alkaline
479.29 hydrolysis facility.

479.30 Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ
479.31 a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body.
479.32 It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for
479.33 all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for
479.34 compliance with this chapter and other applicable state and federal regulations regarding
479.35 occupational and workplace health and safety.

480.1 Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility
480.2 shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part
480.3 without receiving written authorization to do so from the person or persons who have the
480.4 legal right to control disposition as described in section 149A.80 or the person's legal
480.5 designee. The written authorization must include:

480.6 (1) the name of the deceased and the date of death of the deceased;

480.7 (2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;

480.8 (3) the name, address, telephone number, relationship to the deceased, and signature
480.9 of the person or persons with legal right to control final disposition or a legal designee;

480.10 (4) directions for the disposition of any nonhydrolyzed materials or items recovered
480.11 from the alkaline hydrolysis vessel;

480.12 (5) acknowledgment that the hydrolyzed remains will be dried and mechanically
480.13 reduced to a granulated appearance and placed in an appropriate container and
480.14 authorization to place any hydrolyzed remains that a selected urn or container will not
480.15 accommodate into a temporary container;

480.16 (6) acknowledgment that, even with the exercise of reasonable care, it is not possible
480.17 to recover all particles of the hydrolyzed remains and that some particles may inadvertently
480.18 become commingled with particles of other hydrolyzed remains that remain in the alkaline
480.19 hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;

480.20 (7) directions for the ultimate disposition of the hydrolyzed remains; and

480.21 (8) a statement that includes, but is not limited to, the following information:

480.22 "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an
480.23 alkaline solution is used to chemically break down the human tissue and the hydrolyzable
480.24 alkaline hydrolysis container. After the process is complete, the liquid effluent solution
480.25 contains the chemical by-products of the alkaline hydrolysis process except for the
480.26 deceased's bone fragments. The solution is cooled and released according to local
480.27 environmental regulations. A water rinse is applied to the hydrolyzed remains which are
480.28 then dried and processed to facilitate inurnment or scattering."

480.29 Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in
480.30 good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an
480.31 authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from
480.32 civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis
480.33 facility.

480.34 Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be
480.35 accepted for final disposition by alkaline hydrolysis unless:

480.36 (1) encased in an appropriate alkaline hydrolysis container;

481.1 (2) accompanied by a disposition permit issued pursuant to section 149A.93,
481.2 subdivision 3, including a photocopy of the completed death record or a signed release
481.3 authorizing alkaline hydrolysis of the body received from the coroner or medical
481.4 examiner; and

481.5 (3) accompanied by an alkaline hydrolysis authorization that complies with
481.6 subdivision 12.

481.7 (b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline
481.8 hydrolysis container where there is:

481.9 (1) evidence of leakage of fluids from the alkaline hydrolysis container;

481.10 (2) a known dispute concerning hydrolysis of the body delivered;

481.11 (3) a reasonable basis for questioning any of the representations made on the written
481.12 authorization to hydrolyze; or

481.13 (4) any other lawful reason.

481.14 Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed
481.15 within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of
481.16 the body.

481.17 Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.**

481.18 All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for
481.19 dead human bodies shall use universal precautions and otherwise exercise all reasonable
481.20 precautions to minimize the risk of transmitting any communicable disease from the body.

481.21 No dead human body shall be removed from the container in which it is delivered.

481.22 Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall
481.23 develop, implement, and maintain an identification procedure whereby dead human
481.24 bodies can be identified from the time the alkaline hydrolysis facility accepts delivery
481.25 of the remains until the hydrolyzed remains are released to an authorized party. After
481.26 hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the
481.27 hydrolyzed remains container before the hydrolyzed remains are released from the alkaline
481.28 hydrolysis facility. Each identification disk, tab, or label shall have a number that shall
481.29 be recorded on all paperwork regarding the decedent. This procedure shall be designed
481.30 to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains
481.31 are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the
481.32 inability to individually identify the hydrolyzed remains is a violation of this subdivision.

481.33 Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline
481.34 hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains
481.35 in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for
481.36 infectious disease control.

482.1 Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of
482.2 dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is
482.3 written authorization from the person with the legal right to control the disposition,
482.4 only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline
482.5 hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting
482.6 alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline
482.7 hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

482.8 Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains**
482.9 **prohibited.** Except with the express written permission of the person with the legal right
482.10 to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one
482.11 dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce
482.12 a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have
482.13 been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze
482.14 a dead human body and other human remains at the same time and in the same alkaline
482.15 hydrolysis vessel. This section does not apply where commingling of human remains
482.16 during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental
482.17 and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is
482.18 not a violation of this subdivision.

482.19 Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis**
482.20 **vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be
482.21 made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed
482.22 remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be
482.23 made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed
482.24 human remains and dispose of these materials in a lawful manner, by the alkaline
482.25 hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate
482.26 container to be transported to the processing area.

482.27 Subd. 22. **Drying device or mechanical processor procedures; commingling of**
482.28 **hydrolyzed remains prohibited.** Except with the express written permission of the
482.29 person with the legal right to control the final disposition or otherwise provided by
482.30 law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed
482.31 human remains of more than one body at a time in the same drying device or mechanical
482.32 processor, or introduce the hydrolyzed human remains of a second body into a drying
482.33 device or mechanical processor until processing of any preceding hydrolyzed human
482.34 remains has been terminated and reasonable efforts have been employed to remove all
482.35 fragments of the preceding hydrolyzed remains. The fact that there is incidental and

483.1 unavoidable residue in the drying device, the mechanical processor, or any container used
483.2 in a prior alkaline hydrolysis process, is not a violation of this provision.

483.3 Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The
483.4 hydrolyzed human remains shall be dried and then reduced by a motorized mechanical
483.5 device to a granulated appearance appropriate for final disposition and placed in an
483.6 alkaline hydrolysis remains container along with the appropriate identifying disk, tab,
483.7 or permanent label. Processing must take place within the licensed alkaline hydrolysis
483.8 facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they
483.9 can be identified, may be removed prior to processing the hydrolyzed remains, only by
483.10 staff licensed or registered by the commissioner of health; however, any dental gold and
483.11 silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains
483.12 container unless otherwise directed by the person or persons having the right to control the
483.13 final disposition. Every person who removes or possesses dental gold or silver, jewelry,
483.14 or mementos from any hydrolyzed remains without specific written permission of the
483.15 person or persons having the right to control those remains is guilty of a misdemeanor.
483.16 The fact that residue and any unavoidable dental gold or dental silver, or other precious
483.17 metals remain in the alkaline hydrolysis vessel or other equipment or any container used
483.18 in a prior hydrolysis is not a violation of this section.

483.19 Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.**
483.20 If a hydrolyzed remains container is of insufficient capacity to accommodate all
483.21 hydrolyzed remains of a given dead human body, subject to directives provided in the
483.22 written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess
483.23 hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the
483.24 second container, in a manner so as not to be easily detached through incidental contact, to
483.25 the primary alkaline hydrolysis remains container. The secondary container shall contain a
483.26 duplicate of the identification disk, tab, or permanent label that was placed in the primary
483.27 container and all paperwork regarding the given body shall include a notation that the
483.28 hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature
483.29 hydrolyzed remains containers are not subject to the requirements of this subdivision.

483.30 Subd. 25. **Disposition procedures; commingling of hydrolyzed remains**
483.31 **prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in
483.32 a location where the hydrolyzed remains are commingled with those of another person
483.33 without the express written permission of the person with the legal right to control
483.34 disposition or as otherwise provided by law. This subdivision does not apply to the
483.35 scattering or burial of hydrolyzed remains at sea or in a body of water from individual
483.36 containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to

484.1 the disposal in a dedicated cemetery of accumulated residue removed from an alkaline
484.2 hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members
484.3 of the same family in a common container designed for the hydrolyzed remains of more
484.4 than one body, or to the inurnment in a container or interment in a space that has been
484.5 previously designated, at the time of sale or purchase, as being intended for the inurnment
484.6 or interment of the hydrolyzed remains of more than one person.

484.7 **Subd. 26. Alkaline hydrolysis procedures; disposition of accumulated residue.**

484.8 Every alkaline hydrolysis facility shall provide for the removal and disposition in a
484.9 dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel,
484.10 drying device, mechanical processor, container, or other equipment used in alkaline
484.11 hydrolysis. Disposition of accumulated residue shall be according to the regulations of the
484.12 dedicated cemetery and any applicable local ordinances.

484.13 **Subd. 27. Alkaline hydrolysis procedures; release of hydrolyzed remains.**

484.14 Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be
484.15 released according to the instructions given on the written authorization to hydrolyze. If
484.16 the hydrolyzed remains are to be shipped, they must be securely packaged and transported
484.17 by a method which has an internal tracing system available and which provides for a
484.18 receipt signed by the person accepting delivery. Where there is a dispute over release
484.19 or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit
484.20 the hydrolyzed remains with a court of competent jurisdiction pending resolution of the
484.21 dispute or retain the hydrolyzed remains until the person with the legal right to control
484.22 disposition presents satisfactory indication that the dispute is resolved.

484.23 **Subd. 28. Unclaimed hydrolyzed remains.** If, after 30 calendar days following

484.24 the inurnment, the hydrolyzed remains are not claimed or disposed of according to the
484.25 written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment
484.26 may give written notice, by certified mail, to the person with the legal right to control
484.27 the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and
484.28 requesting further release directions. Should the hydrolyzed remains be unclaimed 120
484.29 calendar days following the mailing of the written notification, the alkaline hydrolysis
484.30 facility or funeral establishment may dispose of the hydrolyzed remains in any lawful
484.31 manner deemed appropriate.

484.32 **Subd. 29. Required records.** Every alkaline hydrolysis facility shall create and

484.33 maintain on its premises or other business location in Minnesota an accurate record of
484.34 every hydrolyzation provided. The record shall include all of the following information
484.35 for each hydrolyzation:

- 485.1 (1) the name of the person or funeral establishment delivering the body for alkaline
485.2 hydrolysis;
- 485.3 (2) the name of the deceased and the identification number assigned to the body;
485.4 (3) the date of acceptance of delivery;
- 485.5 (4) the names of the alkaline hydrolysis vessel, drying device, and mechanical
485.6 processor operator;
- 485.7 (5) the time and date that the body was placed in and removed from the alkaline
485.8 hydrolysis vessel;
- 485.9 (6) the time and date that processing and inurnment of the hydrolyzed remains
485.10 was completed;
- 485.11 (7) the time, date, and manner of release of the hydrolyzed remains;
- 485.12 (8) the name and address of the person who signed the authorization to hydrolyze;
485.13 (9) all supporting documentation, including any transit or disposition permits, a
485.14 photocopy of the death record, and the authorization to hydrolyze; and
- 485.15 (10) the type of alkaline hydrolysis container.

485.16 Subd. 30. **Retention of records.** Records required under subdivision 29 shall be
485.17 maintained for a period of three calendar years after the release of the hydrolyzed remains.
485.18 Following this period and subject to any other laws requiring retention of records, the
485.19 alkaline hydrolysis facility may then place the records in storage or reduce them to
485.20 microfilm, microfiche, laser disc, or any other method that can produce an accurate
485.21 reproduction of the original record, for retention for a period of ten calendar years from
485.22 the date of release of the hydrolyzed remains. At the end of this period and subject to any
485.23 other laws requiring retention of records, the alkaline hydrolysis facility may destroy
485.24 the records by shredding, incineration, or any other manner that protects the privacy of
485.25 the individuals identified.

485.26 Sec. 76. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:

485.27 Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95,
485.28 subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an
485.29 appropriate party is considered final disposition and no further permits or authorizations
485.30 are required for disinterment, transportation, or placement of the hydrolyzed or cremated
485.31 remains.

485.32 Sec. 77. Laws 2011, First Special Session chapter 9, article 2, section 27, is amended to
485.33 read:

485.34 Sec. 27. **MINNESOTA TASK FORCE ON PREMATURITY.**

486.1 Subdivision 1. **Establishment.** The Minnesota Task Force on Prematurity is
486.2 established to evaluate and make recommendations on methods for reducing prematurity
486.3 and improving premature infant health care in the state.

486.4 Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of at
486.5 least the following members, who serve at the pleasure of their appointing authority:

486.6 (1) 15 representatives of the Minnesota Prematurity Coalition including, but not
486.7 limited to, health care providers who treat pregnant women or neonates, organizations
486.8 focused on preterm births, early childhood education and development professionals, and
486.9 families affected by prematurity;

486.10 (2) one representative appointed by the commissioner of human services;

486.11 (3) two representatives appointed by the commissioner of health;

486.12 (4) one representative appointed by the commissioner of education;

486.13 (5) two members of the house of representatives, one appointed by the speaker of
486.14 the house and one appointed by the minority leader; and

486.15 (6) two members of the senate, appointed according to the rules of the senate.

486.16 (b) Members of the task force serve without compensation or payment of expenses.

486.17 (c) The commissioner of health must convene the first meeting of the Minnesota
486.18 Task Force on Prematurity by July 31, 2011. The task force must continue to meet at
486.19 least quarterly. Staffing and technical assistance shall be provided by the Minnesota
486.20 Perinatal Coalition.

486.21 Subd. 3. **Duties.** The task force must report the current state of prematurity in
486.22 Minnesota and develop recommendations on strategies for reducing prematurity and
486.23 improving premature infant health care in the state by ~~considering the following:~~

486.24 (1) promoting adherence to standards of care for premature infants born less than 37
486.25 weeks gestational age, including recommendations to improve utilization of appropriate
486.26 hospital discharge and follow-up care procedures;

486.27 (2) coordination of information among appropriate professional and advocacy
486.28 organizations on measures to improve health care for infants born prematurely;

486.29 (3) identification and centralization of available resources to improve access and
486.30 awareness for caregivers of premature infants; and

486.31 ~~(4) development and dissemination of evidence-based practices through networking~~
486.32 ~~and educational opportunities;~~

486.33 ~~(5) a review of relevant evidence-based research regarding the causes and effects of~~
486.34 ~~premature births in Minnesota;~~

486.35 ~~(6) a review of relevant evidence-based research regarding premature infant health~~
486.36 ~~care, including methods for improving quality of and access to care for premature infants;~~

487.1 ~~(7) (4)~~ a review of the potential improvements in health status related to the use of
487.2 health care homes to provide and coordinate pregnancy-related services; ~~and~~.

487.3 ~~(8) identification of gaps in public reporting measures and possible effects of these~~
487.4 ~~measures on prematurity rates.~~

487.5 Subd. 4. **Report; expiration.** (a) By ~~November 30, 2011~~ January 15, 2015, the
487.6 task force must submit a final report to the chairs and ranking minority members of
487.7 the legislative policy committees on health and human services on the current state of
487.8 prematurity in Minnesota to the chairs of the legislative policy committees on health and
487.9 human services, including any recommendations to reduce premature births and improve
487.10 premature infant health in the state.

487.11 ~~(b) By January 15, 2013, the task force must report its final recommendations,~~
487.12 ~~including any draft legislation necessary for implementation, to the chairs of the legislative~~
487.13 ~~policy committees on health and human services.~~

487.14 ~~(e) (b)~~ This task force expires on January 31, ~~2013~~ 2015, or upon submission of the
487.15 final report required in paragraph ~~(b)~~ (a), whichever is earlier.

487.16 Sec. 78. **FUNERAL ESTABLISHMENTS; BRANCH LOCATIONS.**

487.17 The commissioner of health shall review the statutory requirements for preparation
487.18 and embalming rooms and develop legislation with input from stakeholders that provides
487.19 appropriate health and safety protection for funeral home locations where deceased bodies
487.20 are present but are branch locations associated through a majority ownership of a licensed
487.21 funeral establishment that meets the requirements of Minnesota Statutes, sections 149A.50
487.22 and 149A.92, subdivisions 2 to 10. The review shall include consideration of distance
487.23 between the main location and branch and other health and safety issues.

487.24 Sec. 79. **STAFFING PLAN DISCLOSURE ACT.**

487.25 Subdivision 1. Definitions. (a) For the purposes of this section, the following terms
487.26 have the meanings given.

487.27 (b) "Core staffing plan" means the projected number of full-time equivalent
487.28 nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit.

487.29 (c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses,
487.30 and other health care workers, which may include but is not limited to nursing assistants,
487.31 nursing aides, patient care technicians, and patient care assistants, who perform
487.32 nonmanagerial direct patient care functions for more than 50 percent of their scheduled
487.33 hours on a given patient care unit.

488.1 (d) "Inpatient care unit" means a designated inpatient area for assigning patients and
488.2 staff for which a distinct staffing plan exists and that operates 24 hours per day, seven days
488.3 per week in a hospital setting. Inpatient care unit does not include any hospital-based
488.4 clinic, long-term care facility, or outpatient hospital department.

488.5 (e) "Staffing hours per patient day" means the number of full-time equivalent
488.6 nonmanagerial care staff who will ordinarily be assigned to provide direct patient care
488.7 divided by the expected average number of patients upon which such assignments are based.

488.8 (f) "Patient acuity tool" means a system for measuring an individual patient's need
488.9 for nursing care. This includes utilizing a professional registered nursing assessment of
488.10 patient condition to assess staffing need.

488.11 Subd. 2. **Hospital staffing report.** (a) The chief nursing executive or nursing
488.12 designee of every reporting hospital in Minnesota under section 144.50 will develop a
488.13 core staffing plan for each patient care unit.

488.14 (b) Core staffing plans shall specify the full-time equivalent for each patient care
488.15 unit for each 24-hour period.

488.16 (c) Prior to submitting the core staffing plan, as required in subdivision 3,
488.17 hospitals shall consult with representatives of the hospital medical staff, managerial and
488.18 nonmanagerial care staff, and other relevant hospital personnel about the core staffing plan
488.19 and the expected average number of patients upon which the staffing plan is based.

488.20 Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit
488.21 the core staffing plans to the Minnesota Hospital Association by January 1, 2014. The
488.22 Minnesota Hospital Association shall include each reporting hospital's core staffing plan on
488.23 the Minnesota Hospital Association's Minnesota Hospital Quality Report Web site by April
488.24 1, 2014. Any substantial changes to the core staffing plan shall be updated within 30 days.

488.25 (b) The Minnesota Hospital Association shall include on its Web site for each
488.26 reporting hospital on a quarterly basis the actual direct patient care hours per patient and
488.27 per unit. Hospitals must submit the direct patient care report to the Minnesota Hospital
488.28 Association by July 1, 2014, and quarterly thereafter.

488.29 Sec. 80. **STUDY; NURSE STAFFING LEVELS AND PATIENT OUTCOMES.**

488.30 The Department of Health shall convene a work group to study the correlation
488.31 between nurse staffing levels and patient outcomes. This report shall be presented to the
488.32 chairs and ranking minority members of the health and human services committees in the
488.33 house of representatives and the senate by January 15, 2015.

488.34 Sec. 81. **TRAUMA CENTERS.**

489.1 The commissioner of health, through the Office of Rural Health and Primary Care,
489.2 and in consultation with the commissioner of human services, shall study the 24-hour
489.3 costs of maintaining a level of readiness in hospitals designated as trauma centers under
489.4 Minnesota Statutes, section 144.605, and shall present recommendations to the legislature,
489.5 by December 15, 2013, on a state public programs level of readiness payment modifier
489.6 for hospitals designated as trauma centers.

489.7 **Sec. 82. HEALTH EQUITY REPORT.**

489.8 By February 1, 2014, the commissioner of health, in consultation with local public
489.9 health, health care, and community partners, must submit a report to the chairs and ranking
489.10 minority members of the committees with jurisdiction over health policy and finance, on a
489.11 plan for advancing health equity in Minnesota. The report must include the following:

489.12 (1) assessment of health disparities that exist in the state and how these disparities
489.13 relate to health equity;

489.14 (2) identification of policies, processes, and systems that contribute to health
489.15 inequity in the state;

489.16 (3) recommendations for changes to policies, processes and systems within the
489.17 Department of Health that would increase the department's leadership in addressing health
489.18 inequities;

489.19 (4) identification of best practices for local public health, health care, and community
489.20 partners to provide culturally responsive services and advance health equity; and

489.21 (5) recommendations for strategies for the use of data to document and monitor
489.22 existing health inequities and to evaluate effectiveness of policies, processes, systems,
489.23 and environmental changes that will advance health equity.

489.24 **Sec. 83. ELIMINATING HEALTH DISPARITIES GRANTS; ORGANIZATIONS**
489.25 **WITH LIMITED FISCAL CAPACITY.**

489.26 For grants awarded from the general fund under Minnesota Statutes, section 145.928,
489.27 during the fiscal years ending June 30, 2013, and June 30, 2014, the commissioner
489.28 of health may provide working capital advanced to grantees determined during the
489.29 application process to have limited financial capacity, in accordance with Office of Grant
489.30 Management Policies.

489.31 **Sec. 84. ASSESSMENT OF QUALITY METRICS FOR MEASURING THE**
489.32 **SCREENING, DIAGNOSIS, AND TREATMENT OF YOUNG CHILDREN WITH**
489.33 **AUTISM SPECTRUM DISORDER.**

491.1	<u>(c) General Assistance Grants</u>	<u>3,230,000</u>
491.2	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>(1,008,000)</u>
491.3	<u>(e) Group Residential Housing Grants</u>	<u>(5,423,000)</u>
491.4	<u>(f) MinnesotaCare Grants</u>	<u>(7,179,000)</u>
491.5	<u>This appropriation is from the health care</u>	
491.6	<u>access fund.</u>	
491.7	<u>(g) Medical Assistance Grants</u>	<u>(159,733,000)</u>
491.8	<u>(h) Alternative Care Grants</u>	<u>-0-</u>
491.9	<u>(i) CD Entitlement Grants</u>	<u>2,364,000</u>
491.10	<u>Subd. 3. Technical Activities</u>	<u>417,000</u>
491.11	<u>This appropriation is from the TANF fund.</u>	

491.12 Sec. 2. **EFFECTIVE DATE.**

491.13 Section 1 is effective the day following final enactment.

491.14 **ARTICLE 14**

491.15 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

491.16 Section 1. **SUMMARY OF APPROPRIATIONS.**

491.17 The amounts shown in this section summarize direct appropriations, by fund, made
 491.18 in this article.

491.19	<u>2014</u>	<u>2015</u>	<u>Total</u>
491.20 <u>General</u>	\$ <u>5,643,757,000</u>	\$ <u>5,877,152,000</u>	\$ <u>11,520,909,000</u>
491.21 <u>State Government Special</u>			
491.22 <u>Revenue</u>	<u>69,619,000</u>	<u>74,135,000</u>	<u>143,754,000</u>
491.23 <u>Health Care Access</u>	<u>664,087,000</u>	<u>432,345,000</u>	<u>1,096,433,000</u>
491.24 <u>Federal TANF</u>	<u>269,628,000</u>	<u>266,526,000</u>	<u>536,154,000</u>
491.25 <u>Lottery Prize Fund</u>	<u>1,667,000</u>	<u>1,668,000</u>	<u>3,335,000</u>
491.26 <u>Total</u>	\$ <u>6,648,757,000</u>	\$ <u>6,651,827,000</u>	\$ <u>13,300,584,000</u>

491.27 Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

491.28 The sums shown in the columns marked "Appropriations" are appropriated to the
 491.29 agencies and for the purposes specified in this article. The appropriations are from the
 491.30 general fund, or another named fund, and are available for the fiscal years indicated
 491.31 for each purpose. The figures "2014" and "2015" used in this article mean that the

493.1 **Nonfederal Share Transfers.** The
493.2 nonfederal share of activities for which
493.3 federal administrative reimbursement is
493.4 appropriated to the commissioner may be
493.5 transferred to the special revenue fund.

493.6 **ARRA Supplemental Nutrition Assistance**
493.7 **Benefit Increases.** The funds provided for
493.8 food support benefit increases under the
493.9 Supplemental Nutrition Assistance Program
493.10 provisions of the American Recovery and
493.11 Reinvestment Act (ARRA) of 2009 must be
493.12 used for benefit increases beginning July 1,
493.13 2009.

493.14 **Supplemental Nutrition Assistance**
493.15 **Program Employment and Training.**
493.16 (1) Notwithstanding Minnesota Statutes,
493.17 sections 256D.051, subdivisions 1a, 6b,
493.18 and 6c, and 256J.626, federal Supplemental
493.19 Nutrition Assistance employment and
493.20 training funds received as reimbursement of
493.21 MFIP consolidated fund grant expenditures
493.22 for diversionary work program participants
493.23 and child care assistance program
493.24 expenditures must be deposited in the general
493.25 fund. The amount of funds must be limited to
493.26 \$4,900,000 per year in fiscal years 2014 and
493.27 2015, and to \$4,400,000 per year in fiscal
493.28 years 2016 and 2017, contingent on approval
493.29 by the federal Food and Nutrition Service.

493.30 (2) Consistent with the receipt of the federal
493.31 funds, the commissioner may adjust the
493.32 level of working family credit expenditures
493.33 claimed as TANF maintenance of effort.
493.34 Notwithstanding any contrary provision in
493.35 this article, this rider expires June 30, 2017.

494.1 **TANF Maintenance of Effort.** (a) In order
494.2 to meet the basic maintenance of effort
494.3 (MOE) requirements of the TANF block grant
494.4 specified under Code of Federal Regulations,
494.5 title 45, section 263.1, the commissioner may
494.6 only report nonfederal money expended for
494.7 allowable activities listed in the following
494.8 clauses as TANF/MOE expenditures:

494.9 (1) MFIP cash, diversionary work program,
494.10 and food assistance benefits under Minnesota
494.11 Statutes, chapter 256J;

494.12 (2) the child care assistance programs
494.13 under Minnesota Statutes, sections 119B.03
494.14 and 119B.05, and county child care
494.15 administrative costs under Minnesota
494.16 Statutes, section 119B.15;

494.17 (3) state and county MFIP administrative
494.18 costs under Minnesota Statutes, chapters
494.19 256J and 256K;

494.20 (4) state, county, and tribal MFIP
494.21 employment services under Minnesota
494.22 Statutes, chapters 256J and 256K;

494.23 (5) expenditures made on behalf of legal
494.24 noncitizen MFIP recipients who qualify for
494.25 the MinnesotaCare program under Minnesota
494.26 Statutes, chapter 256L;

494.27 (6) qualifying working family credit
494.28 expenditures under Minnesota Statutes,
494.29 section 290.0671;

494.30 (7) qualifying Minnesota education credit
494.31 expenditures under Minnesota Statutes,
494.32 section 290.0674; and

494.33 (8) qualifying Head Start expenditures under
494.34 Minnesota Statutes, section 119A.50.

495.1 (b) The commissioner shall ensure that
495.2 sufficient qualified nonfederal expenditures
495.3 are made each year to meet the state's
495.4 TANF/MOE requirements. For the activities
495.5 listed in paragraph (a), clauses (2) to
495.6 (8), the commissioner may only report
495.7 expenditures that are excluded from the
495.8 definition of assistance under Code of
495.9 Federal Regulations, title 45, section 260.31.

495.10 (c) For fiscal years beginning with state fiscal
495.11 year 2003, the commissioner shall ensure
495.12 that the maintenance of effort used by the
495.13 commissioner of management and budget
495.14 for the February and November forecasts
495.15 required under Minnesota Statutes, section
495.16 16A.103, contains expenditures under
495.17 paragraph (a), clause (1), equal to at least 16
495.18 percent of the total required under Code of
495.19 Federal Regulations, title 45, section 263.1.

495.20 (d) The requirement in Minnesota Statutes,
495.21 section 256.011, subdivision 3, that federal
495.22 grants or aids secured or obtained under that
495.23 subdivision be used to reduce any direct
495.24 appropriations provided by law, do not apply
495.25 if the grants or aids are federal TANF funds.

495.26 (e) For the federal fiscal years beginning on
495.27 or after October 1, 2007, the commissioner
495.28 may not claim an amount of TANF/MOE in
495.29 excess of the 75 percent standard in Code
495.30 of Federal Regulations, title 45, section
495.31 263.1(a)(2), except:

495.32 (1) to the extent necessary to meet the 80
495.33 percent standard under Code of Federal
495.34 Regulations, title 45, section 263.1(a)(1),
495.35 if it is determined by the commissioner

496.1 that the state will not meet the TANF work
496.2 participation target rate for the current year;
496.3 (2) to provide any additional amounts
496.4 under Code of Federal Regulations, title 45,
496.5 section 264.5, that relate to replacement of
496.6 TANF funds due to the operation of TANF
496.7 penalties; and
496.8 (3) to provide any additional amounts that
496.9 may contribute to avoiding or reducing
496.10 TANF work participation penalties through
496.11 the operation of the excess MOE provisions
496.12 of Code of Federal Regulations, title 45,
496.13 section 261.43(a)(2).

496.14 For the purposes of clauses (1) to (3),
496.15 the commissioner may supplement the
496.16 MOE claim with working family credit
496.17 expenditures or other qualified expenditures
496.18 to the extent such expenditures are otherwise
496.19 available after considering the expenditures
496.20 allowed in this subdivision and subdivisions
496.21 2 and 3.

496.22 (f) Notwithstanding any contrary provision
496.23 in this article, paragraphs (a) to (e) expire
496.24 June 30, 2017.

496.25 **Working Family Credit Expenditures**
496.26 **as TANF/MOE.** The commissioner may
496.27 claim as TANF maintenance of effort up to
496.28 \$6,707,000 per year of working family credit
496.29 expenditures in each fiscal year.

496.30 **Subd. 2. Working Family Credit to be Claimed**
496.31 **for TANF/MOE**

496.32 The commissioner may count the following
496.33 amounts of working family credit
496.34 expenditures as TANF/MOE:
496.35 (1) fiscal year 2014, \$43,576,000; and

497.1 (2) fiscal year 2015, \$43,548,000.

497.2 **Subd. 3. TANF Transfer to Federal Child Care**
 497.3 **and Development Fund**

497.4 (a) The following TANF fund amounts
 497.5 are appropriated to the commissioner for
 497.6 purposes of MFIP/transition year child care
 497.7 assistance under Minnesota Statutes, section
 497.8 119B.05:

497.9 (1) fiscal year 2014; \$14,020,000; and

497.10 (2) fiscal year 2015, \$14,020,000.

497.11 (b) The commissioner shall authorize the
 497.12 transfer of sufficient TANF funds to the
 497.13 federal child care and development fund to
 497.14 meet this appropriation and shall ensure that
 497.15 all transferred funds are expended according
 497.16 to federal child care and development fund
 497.17 regulations.

497.18 **Subd. 4. Central Office**

497.19 The amounts that may be spent from this
 497.20 appropriation for each purpose are as follows:

497.21 **(a) Operations**

	<u>Appropriations by Fund</u>	
497.23 <u>General</u>	<u>88,410,000</u>	<u>89,985,000</u>
497.24 <u>State Government</u>		
497.25 <u>Special Revenue</u>	<u>3,974,000</u>	<u>6,207,000</u>
497.26 <u>Health Care Access</u>	<u>13,252,000</u>	<u>13,154,000</u>
497.27 <u>Federal TANF</u>	<u>117,000</u>	<u>100,000</u>

497.28 **Return on Taxpayer Investment**

497.29 **Implementation Study. \$100,000 is**
 497.30 appropriated in fiscal year 2014 from the
 497.31 general fund to the commissioner of human
 497.32 services for transfer to the commissioner
 497.33 of management and budget to develop
 497.34 recommendations for implementing a return
 497.35 on taxpayer investment (ROTI) methodology

498.1 and practice related to human services and
498.2 corrections programs administered and
498.3 funded by state and county government.
498.4 The scope of the study shall include
498.5 assessments of ROTI initiatives in other
498.6 states, design implications for Minnesota,
498.7 and identification of one or more Minnesota
498.8 institutions of higher education capable of
498.9 providing rigorous and consistent nonpartisan
498.10 institutional support for ROTI. The scope of
498.11 the study shall also include recommendations
498.12 on methods to evaluate the value of prepaid
498.13 medical assistance services (PMAP)
498.14 versus other ways of delivering public
498.15 health care programs. The commissioner
498.16 shall consult with representatives of other
498.17 state agencies, counties, legislative staff,
498.18 Minnesota institutions of higher education,
498.19 and other stakeholders in developing
498.20 recommendations. The commissioner shall
498.21 report findings and recommendations to the
498.22 governor and legislature by November 30,
498.23 2013.

498.24 **DHS Receipt Center Accounting.** The
498.25 commissioner is authorized to transfer
498.26 appropriations to, and account for DHS
498.27 receipt center operations in, the special
498.28 revenue fund.

498.29 **Administrative Recovery; Set-Aside.** The
498.30 commissioner may invoice local entities
498.31 through the SWIFT accounting system as an
498.32 alternative means to recover the actual cost
498.33 of administering the following provisions:
498.34 (1) Minnesota Statutes, section 125A.744,
498.35 subdivision 3;

499.1 (2) Minnesota Statutes, section 245.495,
499.2 paragraph (b);

499.3 (3) Minnesota Statutes, section 256B.0625,
499.4 subdivision 20, paragraph (k);

499.5 (4) Minnesota Statutes, section 256B.0924,
499.6 subdivision 6, paragraph (g);

499.7 (5) Minnesota Statutes, section 256B.0945,
499.8 subdivision 4, paragraph (d); and

499.9 (6) Minnesota Statutes, section 256F.10,
499.10 subdivision 6, paragraph (b).

499.11 **Systems Modernization.** The following
499.12 amounts are appropriated for transfer to
499.13 the state systems account authorized in
499.14 Minnesota Statutes, section 256.014:

499.15 (1) \$1,825,000 in fiscal year 2014 and
499.16 \$2,502,000 in fiscal year 2015 is for the
499.17 state share of Medicaid-allocated costs of
499.18 the health insurance exchange information
499.19 technology and operational structure. The
499.20 funding base is \$3,222,000 in fiscal year 2016
499.21 and \$3,037,000 in fiscal year 2017 but shall
499.22 not be included in the base thereafter; and

499.23 (2) Any unexpended balance from
499.24 the contingent system modernization
499.25 appropriation in article 15 must be
499.26 transferred from the Department of Human
499.27 Services state systems account to the Office
499.28 of Enterprise Technology when the Office
499.29 of Enterprise Technology has negotiated a
499.30 federally approved internal service fund rates
499.31 and billing process with sufficient internal
499.32 accounting controls to properly maximize
499.33 federal reimbursement to Minnesota for

500.1 human services system modernization
 500.2 projects, but not later than June 30, 2015.

500.3 **Base Adjustment.** The general fund base
 500.4 is increased by \$6,099,000 in fiscal year
 500.5 2016 and \$1,185,000 in fiscal year 2017.

500.6 The health access fund base is decreased by
 500.7 \$551,000 in fiscal years 2016 and 2017.

500.8 **(b) Children and Families**

500.9	<u>Appropriations by Fund</u>		
500.10	<u>General</u>	<u>7,626,000</u>	<u>7,634,000</u>
500.11	<u>Federal TANF</u>	<u>2,282,000</u>	<u>2,282,000</u>

500.12 **Financial Institution Data Match and**

500.13 **Payment of Fees.** The commissioner is
 500.14 authorized to allocate up to \$310,000 each
 500.15 year in fiscal years 2014 and 2015 from the
 500.16 PRISM special revenue account to make
 500.17 payments to financial institutions in exchange
 500.18 for performing data matches between account
 500.19 information held by financial institutions
 500.20 and the public authority's database of child
 500.21 support obligors as authorized by Minnesota
 500.22 Statutes, section 13B.06, subdivision 7.

500.23 **Base Adjustment.** The general fund base is
 500.24 decreased by \$300,000 in fiscal years 2016
 500.25 and 2017, and the federal TANF fund base is
 500.26 increased by \$300,000 in fiscal years 2016
 500.27 and 2017.

500.28 **(c) Health Care**

500.29	<u>Appropriations by Fund</u>		
500.30	<u>General</u>	<u>13,924,000</u>	<u>13,795,000</u>
500.31	<u>Health Care Access</u>	<u>26,599,000</u>	<u>30,306,000</u>

500.32 **Base Adjustment.** The health care access
 500.33 fund base is increased by \$8,177,000 in fiscal
 500.34 year 2016 and by \$6,712,000 in fiscal year
 500.35 2017.

501.1 **Medical assistance costs for inmates.** The
 501.2 commissioner of corrections, for fiscal years
 501.3 2014 through 2017, shall transfer to the
 501.4 commissioner of human services an amount
 501.5 equal to the state share of medical assistance
 501.6 costs related to implementation of Minnesota
 501.7 Statutes, section 256B.055, subdivision 14,
 501.8 paragraph (c).

501.9 **(d) Continuing Care**

501.10	<u>Appropriations by Fund</u>		
501.11	<u>General</u>	<u>18,734,000</u>	<u>19,272,000</u>
501.12	<u>State Government</u>		
501.13	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

501.14 **Base Adjustment.** The general fund base is
 501.15 increased by \$3,324,000 in fiscal year 2016
 501.16 and by \$3,324,000 in fiscal year 2017.

501.17 **(e) Chemical and Mental Health**

501.18	<u>Appropriations by Fund</u>		
501.19	<u>General</u>	<u>4,480,000</u>	<u>4,300,000</u>
501.20	<u>Lottery Prize Fund</u>	<u>159,000</u>	<u>160,000</u>

501.21 **Subd. 5. Forecasted Programs**

501.22 The amounts that may be spent from this
 501.23 appropriation for each purpose are as follows:

501.24 **(a) MFIP/DWP**

501.25	<u>Appropriations by Fund</u>		
501.26	<u>General</u>	<u>72,583,000</u>	<u>74,634,000</u>
501.27	<u>Federal TANF</u>	<u>83,104,000</u>	<u>80,510,000</u>

501.28	<u>(b) MFIP Child Care Assistance</u>	<u>59,662,000</u>	<u>59,393,000</u>
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501.29 Notwithstanding Minnesota Statutes, section
 501.30 256J.021, TANF funds may be used to pay for
 501.31 any additional costs related to repeal of the
 501.32 MFIP family cap for individuals identified
 501.33 under Minnesota Statutes, section 256J.021.

501.34	<u>(c) General Assistance</u>	<u>54,787,000</u>	<u>56,068,000</u>
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502.1 **General Assistance Standard.** The
 502.2 commissioner shall set the monthly standard
 502.3 of assistance for general assistance units
 502.4 consisting of an adult recipient who is
 502.5 childless and unmarried or living apart
 502.6 from parents or a legal guardian at \$203.
 502.7 The commissioner may reduce this amount
 502.8 according to Laws 1997, chapter 85, article
 502.9 3, section 54.

502.10 **Emergency General Assistance.** The
 502.11 amount appropriated for emergency general
 502.12 assistance funds is limited to no more
 502.13 than \$6,729,812 in fiscal year 2014 and
 502.14 \$6,729,812 in fiscal year 2015. Funds
 502.15 to counties shall be allocated by the
 502.16 commissioner using the allocation method in
 502.17 Minnesota Statutes, section 256D.06.

502.18	<u>(d) MN Supplemental Assistance</u>	<u>38,646,000</u>	<u>39,821,000</u>
502.19	<u>(e) Group Residential Housing</u>	<u>140,447,000</u>	<u>149,984,000</u>

502.20	<u>(f) MinnesotaCare</u>		
502.21	<u>Health Care Access</u>	<u>296,282,000</u>	<u>226,619,000</u>

502.22	<u>(g) Medical Assistance</u>		
502.23	<u>Appropriations by Fund</u>		
502.24	<u>General</u>	<u>4,371,808,000</u>	<u>4,595,789,000</u>
502.25	<u>Health Care Access</u>	<u>292,697,000</u>	<u>123,386,000</u>

502.26 The Departments of Human Services and
 502.27 Management and Budget shall identify
 502.28 general fund medical assistance populations
 502.29 costing \$240,426,000 for fiscal year 2016
 502.30 and \$218,557,000 for fiscal year 2017 and
 502.31 transfer those costs to the HCAF. The base for
 502.32 these costs shall be counted in the health care
 502.33 access fund for fiscal years 2016 and 2017.

503.1 **Newborn Screening.** \$121,000 in fiscal
 503.2 year 2014 and \$141,000 in fiscal year 2015
 503.3 are appropriated from the general fund, and
 503.4 \$10,000 in fiscal year 2014 and \$13,000 in
 503.5 fiscal year 2015 are appropriated from the
 503.6 health care access fund to the commissioner
 503.7 of human services for the hospital
 503.8 reimbursement increase in Minnesota
 503.9 Statutes, section 256.969, subdivision 29.
 503.10 The base for this appropriation in fiscal year
 503.11 2016 is \$14,000.

503.12 **Transfer.** \$704,000 in fiscal year 2014 and
 503.13 \$2,090,000 in fiscal year 2015 is transferred
 503.14 from the health care access fund to the
 503.15 general fund to provide increases in dental
 503.16 payment rates under Minnesota Statutes,
 503.17 section 256B.76, subdivision 2, paragraph (j).

503.18 <u>(h) Alternative Care</u>	<u>47,197,000</u>	<u>45,084,000</u>
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503.19 **Alternative Care Transfer.** Any money
 503.20 allocated to the alternative care program that
 503.21 is not spent for the purposes indicated does
 503.22 not cancel but shall be transferred to the
 503.23 medical assistance account.

503.24 <u>(i) CD Treatment Fund</u>	<u>81,440,000</u>	<u>74,875,000</u>
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503.25 **Balance Transfer.** The commissioner must
 503.26 transfer \$18,188,000 from the consolidated
 503.27 chemical dependency treatment fund to the
 503.28 general fund by September 30, 2013.

503.29 **Subd. 6. Grant Programs**

503.30 The amounts that may be spent from this
 503.31 appropriation for each purpose are as follows:

503.32 **(a) Support Services Grants**

504.1	<u>Appropriations by Fund</u>		
504.2	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
504.3	<u>Federal TANF</u>	<u>91,832,000</u>	<u>90,952,000</u>

504.4 **MFIP Housing Assistance Grants.** MFIP
 504.5 housing assistance grants under Minnesota
 504.6 Statutes, section 256J.35, paragraph (d),
 504.7 must be paid out of support services grants
 504.8 under this paragraph.

504.9 **Base Adjustment.** The general fund base is
 504.10 decreased by \$4,618,000 in fiscal years 2016
 504.11 and 2017. The TANF fund base is increased
 504.12 by \$1,700,000 in fiscal years 2016 and 2017.

504.13	<u>(b) Basic Sliding Fee Child Care Assistance</u>		
504.14	<u>Grants</u>	<u>38,356,000</u>	<u>38,681,000</u>

504.15 **Base Adjustment.** The general fund base is
 504.16 increased by \$1,278,000 in fiscal year 2016
 504.17 and by \$1,349,000 in fiscal year 2017.

504.18	<u>(c) Child Care Development Grants</u>	<u>1,487,000</u>	<u>1,487,000</u>
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504.19	<u>(d) Child Support Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
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504.20 **Federal Child Support Demonstration**
 504.21 **Grants.** Federal administrative
 504.22 reimbursement resulting from the federal
 504.23 child support grant expenditures authorized
 504.24 under United States Code, title 42, section
 504.25 1315, is appropriated to the commissioner
 504.26 for this activity.

504.27 **(e) Children's Services Grants**

504.28	<u>Appropriations by Fund</u>		
504.29	<u>General</u>	<u>47,438,000</u>	<u>47,801,000</u>
504.30	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

504.31 **Adoption Assistance and Relative Custody**
 504.32 **Assistance.** The commissioner may transfer
 504.33 unencumbered appropriation balances for
 504.34 adoption assistance and relative custody

505.1 assistance between fiscal years and between
 505.2 programs.

505.3 **Privatized Adoption Grants.** Federal
 505.4 reimbursement for privatized adoption grant
 505.5 and foster care recruitment grant expenditures
 505.6 is appropriated to the commissioner for
 505.7 adoption grants and foster care and adoption
 505.8 administrative purposes.

505.9 **Adoption Assistance Incentive Grants.**
 505.10 Federal funds available during fiscal years
 505.11 2014 and 2015 for adoption incentive grants
 505.12 are appropriated to the commissioner for
 505.13 these purposes.

505.14 **Base Adjustment.** The general fund base is
 505.15 increased by \$5,139,000 in fiscal year 2016
 505.16 and by \$9,155,000 in fiscal year 2017.

505.17 <u>(f) Child and Community Service Grants</u>	<u>53,301,000</u>	<u>53,301,000</u>
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505.18 <u>(g) Child and Economic Support Grants</u>	<u>16,597,000</u>	<u>16,598,000</u>
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505.19 **Minnesota Food Assistance Program.**
 505.20 Unexpended funds for the Minnesota food
 505.21 assistance program for fiscal year 2014 do
 505.22 not cancel but are available for this purpose
 505.23 in fiscal year 2015.

505.24 **Family Assets for Independence.** \$250,000
 505.25 each year is for the Family Assets for
 505.26 Independence Minnesota program. This
 505.27 appropriation is available in either year of the
 505.28 biennium and may be transferred between
 505.29 fiscal years. This appropriation is added to
 505.30 the base.

505.31 **Food Shelf Programs.** \$25,000 each year
 505.32 from the general fund is for food shelf
 505.33 programs under Minnesota Statutes, section
 505.34 256E.34. This appropriation is onetime.

506.1 Notwithstanding Minnesota Statutes, section
 506.2 256E.34, subdivision 4, no portion of this
 506.3 appropriation may be used by Hunger
 506.4 Solutions for its administrative expenses,
 506.5 including but not limited to rent and salaries.

506.6 **(h) Health Care Grants**

506.7	<u>Appropriations by Fund</u>		
506.8	<u>General</u>	<u>90,000</u>	<u>90,000</u>
506.9	<u>Health Care Access</u>	<u>2,228,000</u>	<u>1,413,000</u>

506.10 **Premium Subsidy.** \$..... is appropriated
 506.11 from the general fund in fiscal years 2014
 506.12 and 2015 to the commissioner of human
 506.13 services for the purpose of providing a
 506.14 premium subsidy to families purchasing
 506.15 supplemental autism coverage for young
 506.16 children on the private market if a family has
 506.17 an income below 400 percent of the federal
 506.18 poverty level. The commissioner may utilize
 506.19 the existing eligibility and enrollment system
 506.20 described in Minnesota Statutes, section
 506.21 252.27, to determine a family's eligibility
 506.22 for subsidies under this section. This
 506.23 appropriation is available until expended and
 506.24 does not become part of the base.

506.25 **Base Adjustment.** The health care access
 506.26 fund is decreased by \$1,223,000 in fiscal
 506.27 years 2016 and 2017.

506.28 **(i) Aging and Adult Services Grants** 18,556,000 19,422,000

506.29 **Community Service Development Grants**
 506.30 **and Community Services Grants.** Of
 506.31 this appropriation, \$1,025,000 each year is
 506.32 for community service development grants
 506.33 and \$1,165,000 each year is for community
 506.34 services grants.

506.35 **(j) Deaf and Hard-of-Hearing Grants** 1,767,000 1,767,000

507.1 **(k) Disabilities Grants** 17,984,000 17,861,000

507.2 \$180,000 each year from the general fund is
 507.3 for a grant to the Minnesota Organization
 507.4 on Fetal Alcohol Syndrome (MOFAS) to
 507.5 support nonprofit Fetal Alcohol Spectrum
 507.6 Disorders (FASD) outreach prevention
 507.7 programs in Olmsted County. This is a
 507.8 onetime appropriation.

507.9 **Base Adjustment.** The general fund base
 507.10 is increased by \$502,000 in fiscal year 2016
 507.11 and by \$676,000 in fiscal year 2017.

507.12 **(l) Adult Mental Health Grants**

507.13	<u>Appropriations by Fund</u>		
507.14	<u>General</u>	<u>71,257,000</u>	<u>69,588,000</u>
507.15	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
507.16	<u>Lottery Prize</u>	<u>1,508,000</u>	<u>1,508,000</u>

507.17 **Funding Usage.** Up to 75 percent of a fiscal
 507.18 year's appropriations for adult mental health
 507.19 grants may be used to fund allocations in that
 507.20 portion of the fiscal year ending December
 507.21 31.

507.22 **Base Adjustment.** The general fund base is
 507.23 decreased by \$4,461,000 in fiscal years 2016
 507.24 and 2017.

507.25 **Mental Health Pilot Project.** \$230,000
 507.26 each year is for a grant to the Zumbro
 507.27 Valley Mental Health Center. The grant
 507.28 shall be used to implement a pilot project
 507.29 to test an integrated behavioral health care
 507.30 coordination model. The grant recipient must
 507.31 report measurable outcomes and savings
 507.32 to the commissioner of human services
 507.33 by January 15, 2016. This is a onetime
 507.34 appropriation.

508.1 **High-risk adults.** \$100,000 in fiscal year
 508.2 2014 and \$100,000 in fiscal year 2015 are
 508.3 appropriated from the general fund to the
 508.4 commissioner of human services for a grant
 508.5 to the nonprofit organization selected to
 508.6 administer the demonstration project for
 508.7 high-risk adults under Laws 2007, chapter
 508.8 54, article 1, section 19, in order to complete
 508.9 the project. This is a onetime appropriation.

508.10 <u>(m) Child Mental Health Grants</u>	<u>17,599,000</u>	<u>19,988,000</u>
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508.11 **Funding Usage.** Up to 75 percent of a fiscal
 508.12 year's appropriation for child mental health
 508.13 grants may be used to fund allocations in that
 508.14 portion of the fiscal year ending December
 508.15 31.

508.16 <u>(n) CD Treatment Support Grants</u>	<u>1,516,000</u>	<u>1,516,000</u>
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508.17 **Base Adjustment.** The general fund base is
 508.18 decreased by \$300,000 in fiscal years 2016
 508.19 and 2017.

508.20 <u>Subd. 7. State-Operated Services</u>	<u>186,744,000</u>	<u>188,183,000</u>
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508.21 **Transfer Authority Related to**
 508.22 **State-Operated Services.** Money
 508.23 appropriated for state-operated services
 508.24 may be transferred between fiscal years
 508.25 of the biennium with the approval of the
 508.26 commissioner of management and budget.
 508.27 The amounts that may be spent from the
 508.28 appropriation for each purpose are as follows:

508.29 <u>(a) SOS Mental Health</u>	<u>116,598,000</u>	<u>117,467,000</u>
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508.30 **Dedicated Receipts Available.** Of the
 508.31 revenue received under Minnesota Statutes,
 508.32 section 246.18, subdivision 8, paragraph
 508.33 (a), \$1,000,000 each year is available for
 508.34 the purposes of paragraph (b), clause (1),

509.1 of that subdivision, \$1,000,000 each year
 509.2 is available to transfer to the adult mental
 509.3 health budget activity for the purposes of
 509.4 paragraph (b), clause (2), of that subdivision,
 509.5 and up to \$2,713,000 each year is available
 509.6 for the purposes of paragraph (b), clause (3),
 509.7 of that subdivision.

509.8 **(b) SOS MN Security Hospital** 70,146,000 70,715,000

509.9 **Subd. 8. Sex Offender Program** 77,341,000 80,895,000

509.10 **Transfer Authority Related to Minnesota**
 509.11 **Sex Offender Program.** Money
 509.12 appropriated for the Minnesota sex offender
 509.13 program may be transferred between fiscal
 509.14 years of the biennium with the approval of the
 509.15 commissioner of management and budget.

509.16 **Subd. 9. Technical Activities** 80,440,000 80,829,000

509.17 This appropriation is from the federal TANF
 509.18 fund.

509.19 **Base Adjustment.** The federal TANF fund
 509.20 base is decreased by \$22,000 in fiscal year
 509.21 2016 and by \$49,000 in fiscal year 2017.

509.22 **Subd. 10. Transfer.**

509.23 The commissioner of management and
 509.24 budget must transfer \$65,000,000 in fiscal
 509.25 year 2014 from the general fund to the health
 509.26 care access fund. This is a onetime transfer.

509.27 **Sec. 4. COMMISSIONER OF HEALTH**

509.28 **Subdivision 1. Total Appropriation** **\$ 172,440,000 \$ 173,946,000**

509.29	<u>Appropriations by Fund</u>	
509.30	<u>2014</u>	<u>2015</u>
509.31	<u>General</u>	<u>80,151,000 75,001,000</u>
509.32	<u>State Government</u>	
509.33	<u>Special Revenue</u>	<u>48,296,000 50,515,000</u>

510.1	<u>Health Care Access</u>	<u>32,280,000</u>	<u>36,717,000</u>
510.2	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

510.3 The amounts that may be spent for each
 510.4 purpose are specified in the following
 510.5 subdivisions.

510.6 **Subd. 2. Health Improvement**

510.7	<u>Appropriations by Fund</u>		
510.8	<u>General</u>	<u>53,475,000</u>	<u>48,260,000</u>
510.9	<u>State Government</u>		
510.10	<u>Special Revenue</u>	<u>1,040,000</u>	<u>1,047,000</u>
510.11	<u>Health Care Access</u>	<u>21,725,000</u>	<u>26,731,000</u>
510.12	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

510.13 Notwithstanding the cancellation requirement
 510.14 in Minnesota Statutes, section 256J.02,
 510.15 subdivision 6, TANF funds awarded under
 510.16 Minnesota Statutes, section 145.928, during
 510.17 fiscal year 2013 to grantees determined
 510.18 during the application process to have limited
 510.19 financial capacity, are available until June
 510.20 30, 2014.

510.21 **Statewide Health Improvement Program.**

510.22 (a) \$20,000,000 in fiscal year 2014 and
 510.23 \$25,000,000 in fiscal year 2015 is from the
 510.24 Health Care Access fund for the Statewide
 510.25 Health Improvement Program (SHIP) for
 510.26 grants to all local community health boards
 510.27 and tribal governments. Funds appropriated
 510.28 under this paragraph are available until
 510.29 expended. Public health agencies in their
 510.30 third cycle of SHIP funding shall incorporate
 510.31 activities targeted to addressing populations
 510.32 with health disparities or persons with
 510.33 disabilities.

510.34 (b) Of the appropriated amount, \$500,000
 510.35 in fiscal year 2015 shall be distributed as

511.1 two-year pilot grants focused on improving
511.2 health and reducing health care costs in
511.3 populations over age 60. Grants shall be
511.4 awarded by February 1, 2014, to five county
511.5 public health agencies, multicounty public
511.6 health agency partnerships, or county/city
511.7 public health agency partnerships to initiate
511.8 evidence-based strategies for improving
511.9 the physical activity levels of citizens over
511.10 age 60 with a goal of improving health and
511.11 reducing health care costs. Partnerships with
511.12 community education, health providers, or
511.13 other local institutions shall be encouraged
511.14 to establish ongoing outreach and sustainable
511.15 programming.

511.16 (c) Pilot project funds shall be distributed
511.17 based on a \$30,000 base with a per senior
511.18 add-on based on the population to be served
511.19 and shall include urban, suburban, regional
511.20 center, and rural counties. Each grant shall
511.21 serve an area with a minimum population
511.22 base of persons over age 60 and shall target
511.23 those seniors most at risk of high health costs
511.24 due to a sedentary lifestyle, chronic disease,
511.25 or other risk factors. Up to 8 percent of the
511.26 above appropriation is available for creating
511.27 a library of evidence-based programs that
511.28 improve health and reduce health care costs,
511.29 outcome-based reporting, and administration.

511.30 The planning for the pilots shall engage
511.31 local public health officials, other health
511.32 promotion organizations and Board of Aging
511.33 staff, and explore the potential future use of
511.34 Title III Older American Act funds and other
511.35 nonstate funding.

512.1 (d) No more than 16 percent of the SHIP
512.2 budget may be used for administration,
512.3 technical assistance, and state-level
512.4 evaluation costs.

512.5 **Statewide Cancer Surveillance System.**
512.6 Of the general fund appropriation, \$350,000
512.7 in fiscal year 2014 and \$350,000 in fiscal
512.8 year 2015 are appropriated to develop and
512.9 implement a new cancer reporting system
512.10 under Minnesota Statutes, sections 144.671
512.11 to 144.69. Any information technology
512.12 development or support costs necessary
512.13 for the cancer surveillance system must
512.14 be incorporated into the agency's service
512.15 level agreement and paid to the Office of
512.16 Enterprise Technology.

512.17 **Eliminating Reproductive Health**
512.18 **Disparities.** To the extent funds are
512.19 available for fiscal years 2014 and 2015
512.20 for grants provided pursuant to Minnesota
512.21 Statutes, section 145.928, the commissioner
512.22 may provide a grant to a Somali-based
512.23 organization located in Minnesota to
512.24 develop a reproductive health strategic
512.25 plan to eliminate reproductive health
512.26 disparities for Somali women. The plan shall
512.27 develop initiatives to provide educational
512.28 and information resources to health care
512.29 providers, community organizations, and
512.30 Somali women to ensure effective interaction
512.31 with Somali culture and western medicine
512.32 and the delivery of appropriate health care
512.33 services, and the achievement of better health
512.34 outcomes for Somali women. The plan must
512.35 engage health care providers, the Somali
512.36 community, and Somali health-centered

513.1 organizations. The commissioner shall
513.2 submit a report to the chairs and ranking
513.3 minority members of the senate and house
513.4 committees with jurisdiction over health
513.5 policy on the strategic plan developed under
513.6 this grant for eliminating reproductive health
513.7 disparities for Somali women. The report
513.8 must be submitted by February 15, 2014.

513.9 **TANF Appropriations.** (1) \$1,156,000 of
513.10 the TANF funds is appropriated each year of
513.11 the biennium to the commissioner for family
513.12 planning grants under Minnesota Statutes,
513.13 section 145.925.

513.14 (2) \$3,579,000 of the TANF funds is
513.15 appropriated each year of the biennium to
513.16 the commissioner for home visiting and
513.17 nutritional services listed under Minnesota
513.18 Statutes, section 145.882, subdivision 7,
513.19 clauses (6) and (7). Funds must be distributed
513.20 to community health boards according to
513.21 Minnesota Statutes, section 145A.131,
513.22 subdivision 1.

513.23 (3) \$2,000,000 of the TANF funds is
513.24 appropriated each year of the biennium to
513.25 the commissioner for decreasing racial and
513.26 ethnic disparities in infant mortality rates
513.27 under Minnesota Statutes, section 145.928,
513.28 subdivision 7.

513.29 (4) \$4,978,000 of the TANF funds is
513.30 appropriated each year of the biennium to the
513.31 commissioner for the family home visiting
513.32 grant program according to Minnesota
513.33 Statutes, section 145A.17. \$4,000,000 of the
513.34 funding must be distributed to community
513.35 health boards according to Minnesota

514.1 Statutes, section 145A.131, subdivision 1.
 514.2 \$978,000 of the funding must be distributed
 514.3 to tribal governments based on Minnesota
 514.4 Statutes, section 145A.14, subdivision 2a.
 514.5 (5) The commissioner may use up to 6.23
 514.6 percent of the funds appropriated each fiscal
 514.7 year to conduct the ongoing evaluations
 514.8 required under Minnesota Statutes, section
 514.9 145A.17, subdivision 7, and training and
 514.10 technical assistance as required under
 514.11 Minnesota Statutes, section 145A.17,
 514.12 subdivisions 4 and 5.
 514.13 **TANF Carryforward.** Any unexpended
 514.14 balance of the TANF appropriation in the
 514.15 first year of the biennium does not cancel but
 514.16 is available for the second year.

514.17 **Subd. 3. Policy Quality and Compliance**

514.18		<u>Appropriations by Fund</u>	
514.19	<u>General</u>	<u>9,400,000</u>	<u>9,409,000</u>
514.20	<u>State Government</u>		
514.21	<u>Special Revenue</u>	<u>14,481,000</u>	<u>16,548,000</u>
514.22	<u>Health Care Access</u>	<u>10,555,000</u>	<u>9,986,000</u>

514.23 **Base Level Adjustment.** The state
 514.24 government special revenue fund base shall
 514.25 be reduced by \$2,000 in fiscal year 2017. The
 514.26 health care access base shall be increased by
 514.27 \$600,000 in fiscal year 2015.

514.28 **Subd. 4. Health Protection**

514.29		<u>Appropriations by Fund</u>	
514.30	<u>General</u>	<u>9,503,000</u>	<u>9,558,000</u>
514.31	<u>State Government</u>		
514.32	<u>Special Revenue</u>	<u>32,775,000</u>	<u>32,920,000</u>

514.33 **Infectious Disease Laboratory.** Of the
 514.34 general fund appropriation, \$200,000 in
 514.35 fiscal year 2014 and \$200,000 in fiscal year
 514.36 2015 are appropriated to the commissioner

515.1 to monitor infectious disease trends and
515.2 investigate infectious disease outbreaks.

515.3 **Surveillance for Elevated Blood Lead**
515.4 **Levels.** Of the general fund appropriation,
515.5 \$100,000 in fiscal year 2014 and \$100,000
515.6 in fiscal year 2015 are appropriated to the
515.7 commissioner for the blood lead surveillance
515.8 system under Minnesota Statutes, section
515.9 144.9502.

515.10 **Newborn Screening.** (a) \$365,000 in fiscal
515.11 year 2014 and \$349,000 in fiscal year 2015
515.12 are appropriated for the purpose of providing
515.13 support services to families as required
515.14 under Minnesota Statutes, section 144.966,
515.15 subdivision 3a.

515.16 (b) \$164,000 in fiscal year 2014 and
515.17 \$156,000 in fiscal year 2015 are appropriated
515.18 for home-based education in American Sign
515.19 Language for families with children who
515.20 are deaf or have hearing loss, as required
515.21 under Minnesota Statutes, section 144.966,
515.22 subdivision 3a.

515.23 **Sexual Violence Prevention.** Within
515.24 available appropriations, by January 15,
515.25 2015, the commissioner must report to the
515.26 legislature on its activities to prevent sexual
515.27 violence, including activities to promote
515.28 coordination of existing state programs and
515.29 services to achieve maximum impact on
515.30 addressing the root causes of sexual violence.

515.31 **Safe Harbor for Sexually Exploited**
515.32 **Youth.** (a) \$1,000,000 in fiscal year 2014
515.33 and \$1,000,000 in fiscal year 2015 are
515.34 for supportive service grants for the safe
515.35 harbor for sexually exploited youth program,

516.1 under Minnesota Statutes, section 145.4716,
 516.2 including advocacy services, civil legal
 516.3 services, health care services, mental and
 516.4 chemical health services, education and
 516.5 employment services, aftercare and relapse
 516.6 prevention, and family reunification services.
 516.7 This appropriation shall be added to the base.

516.8 (b) \$381,000 in fiscal year 2014 and
 516.9 \$381,000 in fiscal year 2015 are for
 516.10 grants to six regional navigators under
 516.11 Minnesota Statutes, section 145.4717. This
 516.12 appropriation shall be added to the base.

516.13 (c) \$82,500 in fiscal year 2014 and \$82,500
 516.14 in fiscal year 2015 are for the director of
 516.15 child sex trafficking prevention position.
 516.16 This appropriation shall be added to the base.

516.17 (d) \$72,900 in fiscal year 2015 is for
 516.18 program evaluation required under
 516.19 Minnesota Statutes, section 145.4718. This
 516.20 appropriation shall be added to the base.

516.21 **Base Level Adjustment.** The state
 516.22 government special revenue base is increased
 516.23 by \$6,000 in fiscal year 2016 and by \$27,000
 516.24 in fiscal year 2017.

516.25 **Subd. 5. Administrative Support Services** 7,773,000 7,774,000

516.26 **Regional Support for Local Public Health**
 516.27 **Departments.** \$350,000 in fiscal year
 516.28 2014 and \$350,000 in fiscal year 2015
 516.29 are appropriated to the commissioner for
 516.30 regional staff who provide specialized
 516.31 expertise to local public health departments.

516.32 **Sec. 5. HEALTH-RELATED BOARDS**

516.33 **Subdivision 1. Total Appropriation** **\$ 17,224,000 \$ 17,288,000**

517.1	<u>This appropriation is from the state</u>		
517.2	<u>government special revenue fund. The</u>		
517.3	<u>amounts that may be spent for each purpose</u>		
517.4	<u>are specified in the following subdivisions.</u>		
517.5	<u>Subd. 2. Board of Chiropractic Examiners</u>	<u>473,000</u>	<u>477,000</u>
517.6	<u>Subd. 3. Board of Dentistry</u>	<u>1,835,000</u>	<u>1,850,000</u>
517.7	<u>Health Professional Services Program. Of</u>		
517.8	<u>this appropriation, \$704,000 in fiscal year</u>		
517.9	<u>2014 and \$704,000 in fiscal year 2015 from</u>		
517.10	<u>the state government special revenue fund are</u>		
517.11	<u>for the health professional services program.</u>		
517.12	<u>Subd. 4. Board of Dietetic and Nutrition</u>		
517.13	<u>Practice</u>	<u>112,000</u>	<u>112,000</u>
517.14	<u>Subd. 5. Board of Marriage and Family</u>		
517.15	<u>Therapy</u>	<u>169,000</u>	<u>170,000</u>
517.16	<u>Subd. 6. Board of Medical Practice</u>	<u>3,883,000</u>	<u>3,900,000</u>
517.17	<u>Subd. 7. Board of Nursing</u>	<u>3,664,000</u>	<u>3,692,000</u>
517.18	<u>Subd. 8. Board of Nursing Home</u>		
517.19	<u>Administrators</u>	<u>1,630,000</u>	<u>1,586,000</u>
517.20	<u>Administrative Services Unit - Operating</u>		
517.21	<u>Costs.</u> <u>Of this appropriation, \$676,000</u>		
517.22	<u>in fiscal year 2014 and \$626,000 in</u>		
517.23	<u>fiscal year 2015 are for operating costs</u>		
517.24	<u>of the administrative services unit. The</u>		
517.25	<u>administrative services unit may receive</u>		
517.26	<u>and expend reimbursements for services</u>		
517.27	<u>performed by other agencies.</u>		
517.28	<u>Administrative Services Unit - Volunteer</u>		
517.29	<u>Health Care Provider Program.</u> <u>Of this</u>		
517.30	<u>appropriation, \$150,000 in fiscal year 2014</u>		
517.31	<u>and \$150,000 in fiscal year 2015 are to pay</u>		
517.32	<u>for medical professional liability coverage</u>		
517.33	<u>required under Minnesota Statutes, section</u>		
517.34	<u>214.40.</u>		

518.1 **Administrative Services Unit - Contested**
 518.2 **Cases and Other Legal Proceedings.** Of
 518.3 this appropriation, \$200,000 in fiscal year
 518.4 2014 and \$200,000 in fiscal year 2015 are
 518.5 for costs of contested case hearings and other
 518.6 unanticipated costs of legal proceedings
 518.7 involving health-related boards funded
 518.8 under this section. Upon certification of a
 518.9 health-related board to the administrative
 518.10 services unit that the costs will be incurred
 518.11 and that there is insufficient money available
 518.12 to pay for the costs out of money currently
 518.13 available to that board, the administrative
 518.14 services unit is authorized to transfer money
 518.15 from this appropriation to the board for
 518.16 payment of those costs with the approval
 518.17 of the commissioner of management and
 518.18 budget. This appropriation does not cancel.
 518.19 Any unencumbered and unspent balances
 518.20 remain available for these expenditures in
 518.21 subsequent fiscal years.

518.22 **Criminal Background Checks.** \$390,000
 518.23 each year from the state government special
 518.24 revenue fund is for the Administrative
 518.25 Support Services Unit for the implementation
 518.26 of a criminal background check program.

518.27	<u>Subd. 9. Board of Optometry</u>	<u>108,000</u>	<u>108,000</u>
518.28	<u>Subd. 10. Board of Pharmacy</u>	<u>2,362,000</u>	<u>2,380,000</u>

518.29 **Prescription Electronic Reporting.** Of
 518.30 this appropriation, \$356,000 in fiscal year
 518.31 2014 and \$356,000 in fiscal year 2015 from
 518.32 the state government special revenue fund
 518.33 are to the board to operate the prescription
 518.34 electronic reporting system in Minnesota
 518.35 Statutes, section 152.126.

519.1	<u>Subd. 11. Board of Physical Therapy</u>	<u>348,000</u>	<u>351,000</u>
519.2	<u>Subd. 12. Board of Podiatry</u>	<u>76,000</u>	<u>77,000</u>
519.3	<u>Subd. 13. Board of Psychology</u>	<u>853,000</u>	<u>861,000</u>
519.4	<u>Subd. 14. Board of Social Work</u>	<u>1,061,000</u>	<u>1,069,000</u>
519.5	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>232,000</u>	<u>234,000</u>
519.6	<u>Subd. 16. Board of Behavioral Health and</u>		
519.7	<u>Therapy</u>	<u>418,000</u>	<u>421,000</u>
519.8	<u>Sec. 6. EMERGENCY MEDICAL SERVICES</u>		
519.9	<u>REGULATORY BOARD</u>	<u>\$ 2,749,000</u>	<u>\$ 2,756,000</u>

519.10 **Regional Grants.** \$585,000 in fiscal year
 519.11 2014 and \$585,000 in fiscal year 2015 are
 519.12 for regional emergency medical services
 519.13 programs, to be distributed equally to the
 519.14 eight emergency medical service regions.

519.15 **Cooper/Sams Volunteer Ambulance**
 519.16 **Program.** \$700,000 in fiscal year 2014 and
 519.17 \$700,000 in fiscal year 2015 are for the
 519.18 Cooper/Sams volunteer ambulance program
 519.19 under Minnesota Statutes, section 144E.40.

519.20 (a) Of this amount, \$611,000 in fiscal year
 519.21 2014 and \$611,000 in fiscal year 2015
 519.22 are for the ambulance service personnel
 519.23 longevity award and incentive program under
 519.24 Minnesota Statutes, section 144E.40.

519.25 (b) Of this amount, \$89,000 in fiscal year
 519.26 2014 and \$89,000 in fiscal year 2015 are
 519.27 for the operations of the ambulance service
 519.28 personnel longevity award and incentive
 519.29 program under Minnesota Statutes, section
 519.30 144E.40.

519.31 **Ambulance Training Grant.** \$361,000 in
 519.32 fiscal year 2014 and \$361,000 in fiscal year
 519.33 2015 are for training grants.

521.1 Subdivision 1. **Grants.** The commissioner of human services, with the approval of
521.2 the commissioner of management and budget, may transfer unencumbered appropriation
521.3 balances for the biennium ending June 30, 2015, within fiscal years among the MFIP,
521.4 general assistance, general assistance medical care under Minnesota Statutes 2009
521.5 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP
521.6 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental
521.7 aid, group residential housing programs, the entitlement portion of the chemical
521.8 dependency consolidated treatment fund, and between fiscal years of the biennium. The
521.9 commissioner shall inform the chairs and ranking minority members of the senate Health
521.10 and Human Services Finance Division and the house of representatives Health and Human
521.11 Services Finance Committee quarterly about transfers made under this provision.

521.12 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
521.13 money may be transferred within the Departments of Human Services and Health as the
521.14 commissioners consider necessary, with the advance approval of the commissioner of
521.15 management and budget. The commissioner shall inform the chairs and ranking minority
521.16 members of the senate Health and Human Services Finance Division and the house of
521.17 representatives Health and Human Services Finance Committee quarterly about transfers
521.18 made under this provision.

521.19 Sec. 14. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

521.20 The commissioners of health and human services shall not use indirect cost
521.21 allocations to pay for the operational costs of any program for which they are responsible.

521.22 Sec. 15. **EXPIRATION OF UNCODIFIED LANGUAGE.**

521.23 All uncodified language contained in this article expires on June 30, 2015, unless a
521.24 different expiration date is explicit.

521.25 Sec. 16. **EFFECTIVE DATE.**

521.26 This article is effective July 1, 2013, unless a different effective date is specified.

521.27 **ARTICLE 15**

521.28 **HUMAN SERVICES CONTINGENT APPROPRIATIONS**

521.29 Section 1. **HUMAN SERVICES APPROPRIATIONS.**

521.30 The sums shown in the columns marked "Appropriations" are added to or, if shown
521.31 in parentheses, subtracted from the appropriations in article 14 to the agencies and for the
521.32 purposes specified in this article. The appropriations are from the general fund or other

522.1 named fund and are available for the fiscal years indicated for each purpose. The figures
 522.2 "2014" and "2015" used in this article mean that the addition to or subtraction from the
 522.3 appropriation listed under them is available for the fiscal year ending June 30, 2014, or
 522.4 June 30, 2015, respectively. Supplemental appropriations and reductions to appropriations
 522.5 for the fiscal year ending June 30, 2014, are effective the day following final enactment
 522.6 unless a different effective date is explicit.

522.7		<u>APPROPRIATIONS</u>	
522.8		<u>Available for the Year</u>	
522.9		<u>Ending June 30</u>	
522.10		<u>2014</u>	<u>2015</u>

522.11 **Sec. 2. COMMISSIONER OF HUMAN**
 522.12 **SERVICES**

522.13	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>1,906,000</u>	<u>\$</u>	<u>2,047,000</u>
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522.14	<u>Appropriations by Fund</u>				
522.15		<u>2014</u>		<u>2015</u>	
522.16	<u>General</u>	<u>1,906,000</u>		<u>2,047,000</u>	

522.17 **Reform 2020 Contingency.** The
 522.18 appropriation from the general fund may
 522.19 be adjusted as provided in article 2, section
 522.20 49, in order to implement Reform 2020 and
 522.21 systems modernization.

522.22 **Subd. 2. Central Office Operations**

522.23	<u>(a) Operations</u>	<u>3,384,000</u>	<u>14,506,000</u>
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522.24 **Systems Modernization Transfer.** If
 522.25 contingent funding is fully or partially
 522.26 disbursed as provided in article 2, section 49,
 522.27 and transferred to the state systems account,
 522.28 the unexpended balance of that appropriation
 522.29 must be transferred to the Office of Enterprise
 522.30 Technology in accordance with clause (2)
 522.31 of the systems modernization provision in
 522.32 article 14. Contingent funding under this
 522.33 provision must not exceed \$16,992,000 for
 522.34 the biennium.

522.35	<u>(b) Children and Families</u>	<u>109,000</u>	<u>206,000</u>
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523.1	<u>(c) Health Care</u>	<u>100,000</u>	<u>100,000</u>
523.2	<u>(d) Continuing Care</u>	<u>5,236,000</u>	<u>5,541,000</u>
523.3	<u>Subd. 3. Forecasted Programs</u>		
523.4	<u>(a) Group Residential Housing</u>	<u>(1,166,000)</u>	<u>(8,602,000)</u>
523.5	<u>(b) Medical Assistance</u>	<u>(3,770,000)</u>	<u>(10,086,000)</u>
523.6	<u>(c) Alternative Care</u>	<u>(6,981,000)</u>	<u>(4,394,000)</u>
523.7	<u>Subd. 4. Grant Programs</u>		
523.8	<u>(a) Child and Community Services Grants</u>	<u>3,000,000</u>	<u>3,000,000</u>
523.9	<u>(b) Aging and Adult Services Grants</u>	<u>1,430,000</u>	<u>1,237,000</u>
523.10	<u>(c) Disability Grants</u>	<u>564,000</u>	<u>539,000</u>

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Article locations in H1233-2

ARTICLE 1	AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH CARE FOR MORE MINNESOTANS	Page.Ln 3.1
ARTICLE 2	REFORM 2020; REDESIGNING HOME AND COMMUNITY-BASED SERVICES	Page.Ln 42.28
ARTICLE 3	HOME AND COMMUNITY-BASED SERVICES DISABILITY RATE SETTING	Page.Ln 110.15
ARTICLE 4	STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES	Page.Ln 126.10
ARTICLE 5	DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY	Page.Ln 146.1
ARTICLE 6	HEALTH CARE	Page.Ln 156.12
ARTICLE 7	CONTINUING CARE	Page.Ln 181.23
ARTICLE 8	WAIVER PROVIDER STANDARDS	Page.Ln 222.18
ARTICLE 9	WAIVER PROVIDER STANDARDS TECHNICAL CHANGES	Page.Ln 319.17
ARTICLE 10	MISCELLANEOUS	Page.Ln 337.7
ARTICLE 11	HOME CARE PROVIDERS	Page.Ln 370.5
ARTICLE 12	HEALTH DEPARTMENT	Page.Ln 435.15
ARTICLE 13	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 490.18
ARTICLE 14	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 491.14
ARTICLE 15	HUMAN SERVICES CONTINGENT APPROPRIATIONS	Page.Ln 521.27

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:

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(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

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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

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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.

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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:

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(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;

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(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.

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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 waived services for four or fewer adults are exempt from compliance with Minnesota Rules, parts 9543.0040, subpart 2, item C; 9555.5505; 9555.5515, items B and G; 9555.5605; 9555.5705; 9555.6125, subparts 3, item C, subitem (2), and 4 to 6; 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265; and as provided under section 245B.06, subdivision 2, the license holder is exempt from the program abuse prevention plans and individual abuse prevention plans otherwise required under sections 245A.65, subdivision 2, and 626.557, subdivision 14. The commissioner may approve alternative methods of providing overnight supervision using the process and criteria for granting a variance in section 245A.04, subdivision 9. This chapter does not apply to foster care homes that do not provide residential habilitation services funded under the home and community-based waiver programs defined in section 256B.092.

(d) Residential service sites controlled by license holders licensed under this chapter for home and community-based waived services for four or fewer children are exempt from compliance with Minnesota Rules, parts 2960.3060, subpart 3, items B and C; 2960.3070; 2960.3100, subpart 1, items C, F, and I; and 2960.3210.

(e) The commissioner may exempt license holders from applicable standards of this chapter when the license holder meets the standards under section 245A.09, subdivision 7. License holders that are accredited by an independent accreditation body shall continue to be licensed under this chapter.

(f) License holders governed by sections 245B.02 to 245B.07 must also meet the licensure requirements in chapter 245A.

(g) Nothing in this chapter prohibits license holders from concurrently serving consumers with and without developmental disabilities provided this chapter's standards are met as well as other relevant standards.

(h) The documentation that sections 245B.02 to 245B.07 require of the license holder meets the individual program plan required in section 256B.092 or successor provisions.

Subd. 3. **Continuity of care.** (a) When a consumer changes service to the same type of service provided under a different license held by the same license holder and the policies and

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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).

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(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;

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- (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

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(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

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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:

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(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

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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.

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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 licenser, when services are also licensed as an adult foster home. Adult foster home means a licensed residence operated by an operator who, for financial gain or otherwise, provides 24-hour foster care to no more than four functionally impaired residents.

Subd. 3. **Retention of consumer's records.** The license holder must retain the records required for consumers for at least three years following termination of services.

Subd. 4. **Staff qualifications.** (a) The license holder must ensure that staff is competent through training, experience, and education to meet the consumer's needs and additional requirements as written in the individual service plan. Staff qualifications must be documented. Staff under 18 years of age may not perform overnight duties or administer medication.

(b) Delivery and evaluation of services provided by the license holder to a consumer must be coordinated by a designated person. The designated person or coordinator must minimally have a four-year degree in a field related to service provision, and one year work experience with consumers with developmental disabilities, a two-year degree in a field related to service provision, and two years of work experience with consumers with developmental disabilities, or a diploma in community-based developmental disability services from an accredited postsecondary institution and two years of work experience with consumers with developmental disabilities. The coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities designated in the individual service plan;

(2) instruction and assistance to staff implementing the individual service plan areas;

(3) evaluation of the effectiveness of service delivery, methodologies, and progress on consumer outcomes based on the condition set for objective change; and

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(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

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(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;

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(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

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(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).

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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;

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(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.

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.

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(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

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(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;

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(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;

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(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;

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(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

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(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.

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Subd. 14. **Essential community supports grants.** (a) The purpose of the essential community supports grant program is to provide targeted services to persons 65 years and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Within the limits of the appropriation and not to exceed \$400 per person per month, funding must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) would otherwise be financially eligible for the alternative care program under section 256B.0913, subdivision 4;

(4) has received a community assessment under section 256B.0911, subdivision 3a or 3b, and does not require the level of care provided in a nursing facility;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, subdivision 3a or 3b, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) caregiver support;

(ii) homemaker;

(iii) chore; or

(iv) a personal emergency response device or system.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination as part of their community support plan.

(d) A person who has been determined to be eligible for an essential community support grant must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for an essential community support grant.

(e) The commissioner shall allocate grants to counties and tribes under contract with the department based upon the historic use of the medical assistance elderly waiver and alternative care grant programs and other criteria as determined by the commissioner.

256B.096 QUALITY MANAGEMENT, ASSURANCE, AND IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY SERVICES.

Subdivision 1. **Scope.** In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a statewide quality assurance and improvement system for Minnesotans receiving disability services shall be developed. The disability services included are the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, and for persons with disabilities under section 256B.49.

Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system, including representatives of disability service recipients, disability service providers, disability advocacy groups, county human service agencies, and state agency staff from the Departments of Human Services and Health, and the ombudsman for mental health and developmental disabilities on the development of a statewide quality assurance and improvement system.

Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation with the stakeholder advisory group, shall develop an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services. The survey shall be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services quality management requirements and framework. The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs. The survey shall be field tested during 2008. The biennial report established in subdivision 5 shall include recommendations on statewide and regional reports of the survey results that, if published, would be useful to regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 4. **Improvements for incident reporting, investigation, analysis, and follow-up.** In consultation with the stakeholder advisory group, the commissioner shall identify the information, data sources, and technology needed to improve the system of incident reporting, including:

(1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and

(2) investigation, analysis, and follow-up for disability services.

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The commissioner must ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated service-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

256B.14 RELATIVE'S RESPONSIBILITY.

Subd. 3a. **Spousal contribution.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "commissioner" means the commissioner of human services;

(2) "community spouse" means the spouse, who lives in the community, of an individual receiving long-term care services in a long-term care facility or home care services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913. A community spouse does not include a spouse living in the community who receives a monthly income allowance under section 256B.058, subdivision 2, or who receives home and community-based services under section 256B.0915, 256B.092, or 256B.49, or the alternative care program under section 256B.0913;

(3) "cost of care" means the actual fee-for-service costs or capitated payments for the long-term care spouse;

(4) "department" means the Department of Human Services;

(5) "disabled child" means a blind or permanently and totally disabled son or daughter of any age based on the Social Security Administration disability standards;

(6) "income" means earned and unearned income, attributable to the community spouse, used to calculate the adjusted gross income on the prior year's income tax return. Evidence of income includes, but is not limited to, W-2 and 1099 forms; and

(7) "long-term care spouse" means the spouse who is receiving long-term care services in a long-term care facility or home and community based services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913.

(b) The community spouse of a long-term care spouse who receives medical assistance or alternative care services has an obligation to contribute to the cost of care. The community spouse must pay a monthly fee on a sliding fee scale based on the community spouse's income. If a minor or disabled child resides with and receives care from the community spouse, then no fee shall be assessed.

(c) For a community spouse with an income equal to or greater than 250 percent of the federal poverty guidelines for a family of two and less than 545 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be determined using a sliding fee scale established by the commissioner that begins at 7.5 percent of the community spouse's income and increases to 15 percent for those with an income of up to 545 percent of the federal poverty guidelines for a family of two.

(d) For a community spouse with an income equal to or greater than 545 percent of the federal poverty guidelines for a family of two and less than 750 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be determined using a sliding fee scale established by the commissioner that begins at 15 percent of the community spouse's income and increases to 25 percent for those with an income of up to 750 percent of the federal poverty guidelines for a family of two.

(e) For a community spouse with an income equal to or greater than 750 percent of the federal poverty guidelines for a family of two and less than 975 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be determined using a sliding fee scale established by the commissioner that begins at 25 percent of the community spouse's income and increases to 33 percent for those with an income of up to 975 percent of the federal poverty guidelines for a family of two.

(f) For a community spouse with an income equal to or greater than 975 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be 33 percent of the community spouse's income.

(g) The spousal contribution shall be explained in writing at the time eligibility for medical assistance or alternative care is being determined. In addition to explaining the formula used to determine the fee, the county or tribal agency shall provide written information describing how to request a variance for undue hardship, how a contribution may be reviewed or redetermined, the right to appeal a contribution determination, and that the consequences for not complying with a request to provide information shall be an assessment against the community spouse for the full cost of care for the long-term care spouse.

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(h) The contribution shall be assessed for each month the long-term care spouse has a community spouse and is eligible for medical assistance payment of long-term care services or alternative care.

(i) The spousal contribution shall be reviewed at least once every 12 months and when there is a loss or gain in income in excess of ten percent. Thirty days prior to a review or redetermination, written notice must be provided to the community spouse and must contain the amount the spouse is required to contribute, notice of the right to redetermination and appeal, and the telephone number of the division at the agency that is responsible for redetermination and review. If, after review, the contribution amount is to be adjusted, the county or tribal agency shall mail a written notice to the community spouse 30 days in advance of the effective date of the change in the amount of the contribution.

(1) The spouse shall notify the county or tribal agency within 30 days of a gain or loss in income in excess of ten percent and provide the agency supporting documentation to verify the need for redetermination of the fee.

(2) When a spouse requests a review or redetermination of the contribution amount, a request for information shall be sent to the spouse within ten calendar days after the county or tribal agency receives the request for review.

(3) No action shall be taken on a review or redetermination until the required information is received by the county or tribal agency.

(4) The review of the spousal contribution shall be completed within ten days after the county or tribal agency receives completed information that verifies a loss or gain in income in excess of ten percent.

(5) An increase in the contribution amount is effective in the month in which the increase in income occurs.

(6) A decrease in the contribution amount is effective in the month the spouse verifies the reduction in income, retroactive to no longer than six months.

(j) In no case shall the spousal contribution exceed the amount of medical assistance expended or the cost of alternative care services for the care of the long-term care spouse. Annually, upon redetermination, or at termination of eligibility, the total amount of medical assistance paid or costs of alternative care for the care of the long-term care spouse and the total amount of the spousal contribution shall be compared. If the total amount of the spousal contribution exceeds the total amount of medical assistance expended or cost of alternative care, then the agency shall reimburse the community spouse the excess amount if the long-term care spouse is no longer receiving services, or apply the excess amount to the spousal contribution due until the excess amount is exhausted.

(k) A community spouse may request a variance by submitting a written request and supporting documentation that payment of the calculated contribution would cause an undue hardship. An undue hardship is defined as the inability to pay the calculated contribution due to medical expenses incurred by the community spouse. Documentation must include proof of medical expenses incurred by the community spouse since the last annual redetermination of the contribution amount that are not reimbursable by any public or private source, and are a type, regardless of amount, that would be allowable as a federal tax deduction under the Internal Revenue Code.

(1) A spouse who requests a variance from a notice of an increase in the amount of spousal contribution shall continue to make monthly payments at the lower amount pending determination of the variance request. A spouse who requests a variance from the initial determination shall not be required to make a payment pending determination of the variance request. Payments made pending outcome of the variance request that result in overpayment must be returned to the spouse, if the long-term care spouse is no longer receiving services, or applied to the spousal contribution in the current year. If the variance is denied, the spouse shall pay the additional amount due from the effective date of the increase or the total amount due from the effective date of the original notice of determination of the spousal contribution.

(2) A spouse who is granted a variance shall sign a written agreement in which the spouse agrees to report to the county or tribal agency any changes in circumstances that gave rise to the undue hardship variance.

(3) When the county or tribal agency receives a request for a variance, written notice of a grant or denial of the variance shall be mailed to the spouse within 30 calendar days after the county or tribal agency receives the financial information required in this clause. The granting of a variance will necessitate a written agreement between the spouse and the county or tribal agency with regard to the specific terms of the variance. The variance will not become effective until the written agreement is signed by the spouse. If the county or tribal agency denies in whole or

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in part the request for a variance, the denial notice shall set forth in writing the reasons for the denial that address the specific hardship and right to appeal.

(4) If a variance is granted, the term of the variance shall not exceed 12 months unless otherwise determined by the county or tribal agency.

(5) Undue hardship does not include action taken by a spouse which divested or diverted income in order to avoid being assessed a spousal contribution.

(l) A spouse aggrieved by an action under this subdivision has the right to appeal under subdivision 4. If the spouse appeals on or before the effective date of an increase in the spousal fee, the spouse shall continue to make payments to the county or tribal agency in the lower amount while the appeal is pending. A spouse appealing an initial determination of a spousal contribution shall not be required to make monthly payments pending an appeal decision. Payments made that result in an overpayment shall be reimbursed to the spouse if the long-term care spouse is no longer receiving services, or applied to the spousal contribution remaining in the current year. If the county or tribal agency's determination is affirmed, the community spouse shall pay within 90 calendar days of the order the total amount due from the effective date of the original notice of determination of the spousal contribution. The commissioner's order is binding on the spouse and the agency and shall be implemented subject to section 256.045, subdivision 7. No additional notice is required to enforce the commissioner's order.

(m) If the county or tribal agency finds that notice of the payment obligation was given to the community spouse and the spouse was determined to be able to pay, but that the spouse failed or refused to pay, a cause of action exists against the community spouse for that portion of medical assistance payment of long-term care services or alternative care services granted after notice was given to the community spouse. The action may be brought by the county or tribal agency in the county where assistance was granted for the assistance together with the costs of disbursements incurred due to the action. In addition to granting the county or tribal agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a community spouse found able to repay the county or tribal agency. The order shall be effective only for the period of time during which a contribution shall be assessed.

(n) Counties and tribes are entitled to one-half of the nonfederal share of contributions made under this section for long-term care spouses on medical assistance that are directly attributed to county or tribal efforts. Counties and tribes are entitled to 25 percent of the contributions made under this section for long-term care spouses on alternative care directly attributed to county or tribal efforts.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR DISABLED.

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, and structured day service under 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;

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- (ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;
- (iii) a minimum of five hours of related training annually; and
- (iv) when applicable:
 - (A) safe medication administration;
 - (B) proper handling of consumer funds; and
 - (C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.
- (e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:
 - (1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;
 - (2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and
 - (3) safe medication management and administration.The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.
- (f) The commissioner shall seek federal waiver approval for Medicaid reimbursement of family adult day services under all disability waivers. After the waiver is granted, the commissioner shall include family adult day services in the common services menu that is currently under development.

256B.4913 PAYMENT METHODOLOGY DEVELOPMENT.

- Subdivision 1. **Research period and rates.** (a) For the purposes of this section, "research rate" means a proposed payment rate for the provision of home and community-based waived services to meet federal requirements and assess the implications of changing resources on the provision of services and "research period" means the time period during which the research rate is being assessed by the commissioner.
- (b) The commissioner shall determine and publish initial frameworks and values to generate research rates for individuals receiving home and community-based services.
 - (c) The initial values issued by the commissioner shall ensure projected spending for home and community-based services for each service area is equivalent to projected spending under current law in the most recent expenditure forecast.
 - (d) The initial values issued shall be based on the most updated information and cost data available on supervision, employee-related costs, client programming and supports, programming planning supports, transportation, administrative overhead, and utilization costs. These service areas are:
 - (1) residential services, defined as corporate foster care, family foster care, residential care, supported living services, customized living, and 24-hour customized living;
 - (2) day program services, defined as adult day care, day training and habilitation, prevocational services, structured day services, and transportation;
 - (3) unit-based services with programming, defined as in-home family support, independent living services, supported living services, supported employment, behavior programming, and housing access coordination; and
 - (4) unit-based services without programming, defined as respite, personal support, and night supervision.
 - (e) The commissioner shall make available the underlying assessment information, without any identifying information, and the statistical modeling used to generate the initial research rate and calculate budget neutrality.
- Subd. 2. **Framework values.** (a) The commissioner shall propose legislation with the specific payment methodology frameworks, process for calculation, and specific values to populate the frameworks by February 15, 2013.

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(b) The commissioner shall provide underlying data and information used to formulate the final frameworks and values to the existing stakeholder workgroup by January 15, 2013.

(c) The commissioner shall provide recommendations for the final frameworks and values, and the basis for the recommendations, to the legislative committees with jurisdiction over health and human services finance by February 15, 2013.

(d) The commissioner shall review the following topics during the research period and propose, as necessary, recommendations to address the following research questions:

- (1) underlying differences in the cost to provide services throughout the state;
- (2) a data-driven process for determining labor costs and customizations for staffing classifications included in each rate framework based on the services performed;
- (3) the allocation of resources previously established under section 256B.501, subdivision 4b;
- (4) further definition and development of unit-based services;
- (5) the impact of splitting the allocation of resources for unit-based services for those with programming aspects and those without;
- (6) linking assessment criteria to future assessment processes for determination of customizations;
- (7) recognition of cost differences in the use of monitoring technology where it is appropriate to substitute for supervision;
- (8) implications for day services of reimbursement based on a unit rate and a daily rate;
- (9) a definition of shared and individual staffing for unit-based services;
- (10) the underlying costs of providing transportation associated with day services; and
- (11) an exception process for individuals with exceptional needs that cannot be met under the initial research rate, and an alternative payment structure for those individuals.

(e) The commissioner shall develop a comprehensive plan based on information gathered during the research period that uses statistically reliable and valid assessment data to refine payment methodologies.

(f) The commissioner shall make recommendations and provide underlying data and information used to formulate these research recommendations to the existing stakeholder workgroup by January 15, 2013.

Subd. 3. **Data collection.** (a) The commissioner shall conduct any necessary research and gather additional data for the further development and refinement of payment methodology components. These include but are not limited to:

- (1) levels of service utilization and patterns of use;
- (2) staffing patterns for each service;
- (3) profiles of individual service needs; and
- (4) cost factors involved in providing transportation services.

(b) The commissioner shall provide this information to the existing stakeholder workgroup by January 15, 2013.

Subd. 4. **Rate stabilization adjustment.** Beginning January 1, 2014, the commissioner shall adjust individual rates determined by the new payment methodology so that the new rate varies no more than one percent per year from the rate effective on December 31 of the prior calendar year. This adjustment is made annually and is effective for three calendar years from the date of implementation. This subdivision expires January 1, 2017.

256B.5012 ICF/MR PAYMENT SYSTEM IMPLEMENTATION.

Subd. 13. **ICF/DD rate decrease effective July 1, 2013.** Notwithstanding subdivision 12, and if the commissioner has not received federal approval before July 1, 2013, of the Long-Term Care Realignment Waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, for each facility reimbursed under this section for services provided from July 1, 2013, through December 31, 2013, the commissioner shall decrease operating payments up to 1.67 percent of the operating payment rates in effect on June 30, 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in Laws 2012, chapter 247, article 6, section 2, subdivision 4, paragraph (f). For each facility, the commissioner shall apply the rate reduction based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate,

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in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.

Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth;

(5) the child is the mother's first child subsequent to a pregnancy that did not result in a live birth; or

(6) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.

256K.45 RUNAWAY AND HOMELESS YOUTH ACT.

Subd. 2. **Homeless and runaway youth report.** The commissioner shall develop a report for homeless youth, youth at risk of homelessness, and runaways. The report shall include coordination of services as defined under subdivisions 3 to 5.

256L.01 DEFINITIONS.

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

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(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility.

256L.031 HEALTHY MINNESOTA CONTRIBUTION PROGRAM.

Subdivision 1. **Defined contributions to enrollees.** (a) Beginning July 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income equal to or greater than 200 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration, continue to apply to enrollees obtaining coverage under this section.

Subd. 2. **Use of defined contribution; health plan requirements.** (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3, or as provided in section 256L.031, subdivision 6.

(b) An enrollee must select a health plan within four calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) Coverage purchased under this section must:

(1) include mental health and chemical dependency treatment services; and

(2) comply with the coverage limitations specified in section 256L.03, subdivision 1, paragraph (b).

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

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(2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage may not reenroll until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning July 1, 2012, MinnesotaCare enrollees eligible for coverage through a health plan offered by the Minnesota Comprehensive Health Association may enroll in MCHA in accordance with section 62E.14. Any difference between the revenue and actual covered losses to MCHA related to the implementation of this section are appropriated annually to the commissioner of human services from the health care access fund and shall be paid to MCHA.

Subd. 7. **Federal approval.** The commissioner shall seek federal financial participation for the adult enrollees eligible under this section.

256L.04 ELIGIBLE PERSONS.

Subd. 1b. **Children with family income greater than 275 percent of federal poverty guidelines.** Children with family income greater than 275 percent of federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

Subd. 9. **General assistance medical care.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month. Eligibility for MinnesotaCare cannot be replaced by eligibility for general assistance medical care, and eligibility for general assistance medical care cannot be replaced by eligibility for MinnesotaCare.

Subd. 10a. **Sponsor's income and resources deemed available; documentation.** (a) When determining eligibility for any federal or state benefits under sections 256L.01 to 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of support as defined under United States Code, title 8, section 1183a, shall be deemed to include their sponsors' income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules. To be eligible for the program, noncitizens must provide documentation of their immigration status.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, sponsor deeming does not apply to pregnant women and children who are qualified noncitizens, as described in section 256B.06, subdivision 4, paragraph (b).

256L.05 APPLICATION PROCEDURES.

Subd. 3b. **Reapplication.** Beginning January 1, 1999, families and individuals must reapply after a lapse in coverage of one calendar month or more and must meet all eligibility criteria.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

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.

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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.11 PROVIDER PAYMENT.

Subd. 5. **Enrollees younger than 18.** Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

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.

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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

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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.

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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.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

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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.

485.14 VITAL STATISTICS, RECORDS RECEIVED FOR PRESERVATION.

The court administrators of the district court may, at their option as county registrars of vital statistics, receive for preservation records or certificates of live birth, death or stillbirth from town clerks, statutory city clerks, city agents of a board of health as authorized under section 145A.04 of cities which do not maintain local registration of vital statistics under section 144.214, or other local officers, who may have lawful custody and possession thereof in their respective counties. The court administrators taking possession of such records and certificates shall with regard to them be subject to all applicable provisions of sections 144.211 to 144.227.

609.093 JUVENILE PROSTITUTES; DIVERSION OR CHILD PROTECTION PROCEEDINGS.

Subdivision 1. **First-time prostitution offense; applicability; procedure.** (a) This section applies to a 16 or 17 year old child alleged to have engaged in prostitution as defined in section 609.321, subdivision 9, who:

(1) has not been previously adjudicated delinquent for engaging in prostitution as defined in section 609.321, subdivision 9;

(2) has not previously participated in or completed a diversion program for engaging in prostitution as defined in section 609.321, subdivision 9;

(3) has not previously been placed on probation without an adjudication or received a continuance under section 260B.198, subdivision 7, for engaging in prostitution as defined in section 609.321, subdivision 9;

(4) has not previously been found to be a child in need of protection or services for engaging in prostitution as defined in section 609.321, subdivision 9, or because the child is a sexually exploited youth as defined in section 260C.007, subdivision 31, clause (1); and

(5) agrees to successfully complete a diversion program under section 388.24 or fully comply with a disposition order under sections 260C.201, 260C.202, and 260C.204.

(b) The prosecutor shall refer a child described in paragraph (a) to a diversion program under section 388.24 or file a petition under section 260C.141 alleging the child to be in need of protection or services.

Subd. 2. **Failure to comply.** If a child fails to successfully complete diversion or fails to fully comply with a disposition order under sections 260C.201, 260C.202, and 260C.204, the child may be referred back to the court for further proceedings under chapter 260B.

Subd. 3. **Dismissal of charge.** The court shall dismiss the charge against the child if any of the following apply:

(1) the prosecutor referred the child to a diversion program and the prosecutor notifies the court that the child successfully completed the program;

(2) the prosecutor filed a petition under section 260C.141 and the court does not find that the child is in need of protection or services; or

(3) the prosecutor filed a petition under section 260C.141, the court entered an order under sections 260C.201, 260C.202, and 260C.204, and the child fully complied with the order.

Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012, chapter 247, article 4, section 42; as amended by Laws 2012, chapter 298, section 3

Sec. 42. Laws 2011, First Special Session chapter 9, article 7, section 54, is amended to read:

Sec. 54. CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.

(a) Notwithstanding any other rate reduction in this article, if the commissioner of human services has not received federal approval before July 1, 2013, of the long-term care realignment waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, the commissioner shall decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.67 percent effective July 1, 2013, for services rendered from July 1, 2013, through December 31, 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in article 6, section 2, subdivision 4, paragraph (f). County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease, and must be retroactive from the effective date of the rate decrease.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waived services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waived services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waived services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60; and

(10) alternative care services under Minnesota Statutes, section 256B.0913.

(c) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers. To implement the rate reductions in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect up to a 1.67 percent reduction for the specified services for the period of July 1, 2013, through December 31, 2013.

The above payment rate reduction, allocation rates, and rate limits shall expire for services rendered on December 31, 2013.

4668.0002 APPLICABILITY, AUTHORITY, AND SCOPE.

This chapter implements the licensing of home care providers under Minnesota Statutes, sections 144A.43 to 144A.47, under the authority of Minnesota Statutes, sections 144A.45, subdivision 1, and 144A.4605. Unless otherwise provided, all licensed home care providers must meet the requirements of this chapter. Provisions that apply only to specified classes of licensees are identified by those provisions. The commissioner may delegate any authority or responsibility to an agent of the department. This chapter must be read together with Minnesota Statutes, sections 144A.43 to 144A.47.

4668.0003 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 4668.0002 to 4668.0870, the terms in subparts 2 to 45 have the meanings given them.

Subp. 2. **Ambulatory.** "Ambulatory" means the ability to move about and transfer between locations without the assistance of another person, either with or without the assistance of a walking device or wheel chair.

Subp. 2a. **Assistance with self-administration of medication.** "Assistance with self-administration of medication" means performing a task to enable a client to self-administer medication, including:

- A. bringing the medication to the client;
- B. opening a container containing medications set up by a nurse, physician, or pharmacist;
- C. emptying the contents from the container into the client's hand;
- D. providing liquids or nutrition to accompany medication that a client is self-administering; or
- E. reporting information to a nurse regarding concerns about a client's self-administration of medication.

Subp. 2b. **Class F home care provider.** "Class F home care provider" has the meaning given in Minnesota Statutes, section 144A.4605, subdivision 1.

Subp. 2c. **Assisted living home care service.** "Assisted living home care service" means a nursing service, delegated nursing service, other service performed by an unlicensed person, or central storage of medications provided solely for a resident of a housing with services establishment registered under Minnesota Statutes, chapter 144D.

Subp. 3. **Assisted living services.** "Assisted living services," as provided under a class E home care license, means individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. In this subpart, "individualized" means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illnesses, disabilities, or physical conditions.

Subp. 4. **Business.** "Business" means an individual or other legal entity that provides services to persons in their homes.

Subp. 5. **Client.** "Client" means a person to whom a home care provider provides home care services.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 7. **Contract.** "Contract" means a legally binding agreement, whether in writing or not.

Subp. 8. **Department.** "Department" means the Minnesota Department of Health.

Subp. 9. **Home care aide tasks.** "Home care aide tasks" means those services specified in part 4668.0110, subpart 1.

Subp. 10. **Home care provider or provider.** "Home care provider" or "provider" has the meaning given to home care provider by Minnesota Statutes, section 144A.43, subdivision 4.

Subp. 11. **Home care service.** "Home care service" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3.

Subp. 12. **Home health aide tasks.** "Home health aide tasks" means those tasks allowed in part 4668.0100, subpart 1.

Subp. 13. **Home management services.** "Home management services" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3, clause (8).

Subp. 14. **Home management tasks.** "Home management tasks" means all home management services that are not home health aide or home care aide tasks.

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Subp. 15. [Repealed, 28 SR 1639]

Subp. 16. **Hospital.** "Hospital" means a facility licensed as a hospital under chapter 4640 and Minnesota Statutes, sections 144.50 to 144.56.

Subp. 17. **Inpatient facility.** "Inpatient facility" means a hospital or nursing home.

Subp. 17a. **Legend drug.** "Legend drug" has the meaning given in Minnesota Statutes, section 151.01, subdivision 17.

Subp. 18. **Licensee.** "Licensee" means a home care provider that is licensed under parts 4668.0002 to 4668.0870 and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 19. **Licensed practical nurse.** "Licensed practical nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 8.

Subp. 20. **Managerial official.** "Managerial official" means a director, officer, trustee, or employee of a provider, however designated, who has the authority to establish or control business policy.

Subp. 21. **Medical social work or medical social services.** "Medical social work" or "medical social services" means social work related to the medical, health, or supportive care of clients.

Subp. 21a. **Medication administration.** "Medication administration" means performing a task to ensure a client takes a medication, and includes the following tasks, performed in the following order:

- A. checking the client's medication record;
- B. preparing the medication for administration;
- C. administering the medication to the client;
- D. documenting after administration, or the reason for not administering the medication as ordered; and
- E. reporting information to a nurse regarding concerns about the medication or the client's refusal to take the medication.

Subp. 21b. **Medication reminder.** "Medication reminder" means providing a verbal or visual reminder to a client to take medication.

Subp. 22. **Nurse.** "Nurse" means a registered nurse or licensed practical nurse.

Subp. 23. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, sections 144A.01 to 144A.16.

Subp. 24. **Nutritional services.** "Nutritional services" means the services provided by a dietitian, including evaluation of a client's nutritional status and recommendation for changes in nutritional care; planning, organizing, and coordinating nutritional parts of other health services; adapting a medically ordered diet to the needs and understanding of the client; and translating the recommendations for nutritional care into appropriate food selection and food preparation guidelines.

Subp. 25. **Occupational therapist.** "Occupational therapist" means a person who performs occupational therapy.

Subp. 26. **Occupational therapy.** "Occupational therapy" means services designed to assist a client, who has functional disabilities related to developmental, restorative, or health needs, to adapt the client's environment and skills to aid in the performance of daily living tasks.

Subp. 26a. **Oral hygiene.** "Oral hygiene" means care of teeth, gums, and oral prosthetic devices.

Subp. 26b. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription," and as a result, may be sold without a prescription.

Subp. 27. **Owner.** "Owner" means a:

- A. proprietor;
- B. general partner;
- C. limited partner who has five percent or more of equity interest in a limited partnership;
- D. person who owns or controls voting stock in a corporation in an amount equal to or greater than five percent of the shares issued and outstanding; or
- E. corporation that owns an equity interest in a licensee or applicant for a license.

Subp. 28. **Paraprofessional.** "Paraprofessional" means a person who performs home health aide, home care aide, or home management tasks.

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Subp. 28a. **Pharmacist.** "Pharmacist" means a person currently licensed under Minnesota Statutes, chapter 151.

Subp. 29. **Physical therapist.** "Physical therapist" has the meaning given by Minnesota Statutes, section 148.65, subdivision 2.

Subp. 30. **Physical therapy.** "Physical therapy" has the meaning given by Minnesota Statutes, section 148.65, subdivision 1.

Subp. 31. **Physician.** "Physician" means a person licensed under Minnesota Statutes, chapter 147.

Subp. 32. **Prescriber.** "Prescriber" means a person who is authorized by law to prescribe legend drugs.

Subp. 33. **Registered nurse.** "Registered nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 20.

Subp. 34. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine.

Subp. 35. **Residential center.** "Residential center" means a building or complex of contiguous or adjacent buildings in which clients rent or own distinct living units.

Subp. 36. **Respiratory therapist.** "Respiratory therapist" means a person who performs respiratory therapy.

Subp. 37. **Respiratory therapy.** "Respiratory therapy" means therapeutic services provided under medical orders for the assessment, treatment, management, diagnostic evaluation, and care of clients with deficiencies, abnormalities, and diseases of the cardiopulmonary system.

Subp. 38. **Responsible person.** "Responsible person" means a person who, because of the client's incapacity, makes decisions about the client's care on behalf of the client. A responsible person may be a guardian, conservator, attorney-in-fact, family member, or other agent of the client. Nothing in this chapter expands or diminishes the rights of persons to act on behalf of clients under other law.

Subp. 39. **Social work.** "Social work" has the meaning of "social work practice" as defined by Minnesota Statutes, section 148B.18, subdivision 11.

Subp. 40. **Speech therapy.** "Speech therapy" means diagnostic, screening, preventive, or corrective services for clients with speech, hearing, and language disorders.

Subp. 41. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. Surveys include investigations of complaints.

Subp. 42. **Surveyor.** "Surveyor" means a representative of the department authorized by the commissioner to conduct surveys of licensees.

Subp. 43. **Therapist.** "Therapist" means a respiratory therapist, physical therapist, occupational therapist, speech therapist, or provider of nutritional services.

Subp. 44. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or the United States, and includes any instrumentality of a unit of government.

Subp. 44a. **Unlicensed person.** "Unlicensed person" means a person who is employed by the licensee and who is not a nurse. Unlicensed person does not include nonemployee family members, nonemployee significant others, and nonemployee responsible persons.

Subp. 45. **Verbal.** "Verbal" means oral and not in writing.

4668.0005 PROFESSIONAL LICENSES.

Nothing in this chapter limits or expands the rights of health care professionals to provide services within the scope of their licenses or registrations, as provided by Minnesota law.

4668.0008 SERVICES INCLUDED IN AND EXCLUDED FROM LICENSURE.

Subpart 1. **Purpose.** This part implements Minnesota Statutes, section 144A.43, and establishes a process for determining what businesses are subject to licensure under this chapter. This part must be read together with Minnesota Statutes, section 144A.43. A business that is not required to be licensed under this chapter may obtain a license for the purpose of excluding individual contractors under subpart 6 or for other lawful purposes.

Subp. 2. **Determination of direct services.** As defined in Minnesota Statutes, section 144A.43, subdivision 4, a home care provider is a business that provides at least one home care

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service directly. A service that is provided directly means a service provided to a client by the provider or employees of the provider, and not by contract with an independent contractor. The administration of a contract for home care services is not in itself a direct service. Factors that shall be considered in determining whether a business provides home care services directly include whether the business:

- A. has the right to control and does control the types of services provided;
- B. has the right to control and does control when and how the services are provided;
- C. establishes the charges;
- D. collects fees from the clients or receives payment from third party payers on the clients' behalf;
- E. pays compensation on an hourly, weekly, or similar time basis;
- F. treats the individuals as employees for purposes of payroll taxes and workers' compensation insurance; and
- G. holds itself out as a provider of services or acts in a manner that leads clients or potential clients reasonably to believe that it is a provider of services.

None of the factors listed in items A to G is solely determinative.

Subp. 3. **Contract services.** If a licensee contracts for a home care service with a business that is not subject to licensure under this chapter, it must require, in the contract, that the business comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Coordination of providers of home care services.** The coordination of home care services is not itself a home care service. Coordination of home care services means one or more of the following:

- A. Determination whether a client needs home care services, what services are needed, and whether existing services need to continue or be modified.
- B. Referral of clients to home care providers.
- C. Administration of payments for home care services.

Subp. 5. **Determination of regularly engaged.** As used in Minnesota Statutes, section 144A.43, subdivision 4, "regularly engaged" means providing, or offering to provide, home care services as a regular part of a provider's business. The following factors shall be considered by the commissioner in determining whether a person is regularly engaged in providing home care services:

- A. whether the person markets services specifically to individuals whose illnesses, disabilities, or physical conditions create needs for the services;
- B. whether the services are designed and intended specifically to assist the individuals;
- C. whether the individuals constitute a substantial part of the person's clientele; and
- D. whether the home care services are other than occasional or incidental to the provision of services that are not home care services.

None of the factors listed in items A to D is solely determinative.

Subp. 6. **Exclusion for a paraprofessional not regularly engaged in delivering home care services.** For purposes of subpart 5, an individual who performs home care aide tasks or home management tasks for no more than 14 hours each calendar week to no more than one client, is not regularly engaged in the delivery of home care services, and is not subject to licensure under this chapter.

Subp. 7. **Exclusion of individual contractors.** An individual who is not an employee of a licensed provider need not be licensed under this chapter, if the person:

- A. only provides services as an independent contractor with one or more licensed providers;
- B. provides no services under direct agreements with clients; and
- C. is contractually bound to perform services in compliance with the contracting providers' policies and service agreements.

Individuals excluded from licensure under this subpart must comply with the same requirements of this chapter as employees of the contracting licensee.

Subp. 8. **Governmental providers.** Except as otherwise provided in this chapter or in law, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

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Subp. 9. **Exclusion of certain instructional and incidental services.** A business is not subject to Minnesota Statutes, sections 144A.43 to 144A.47, and is not required to be licensed under this chapter if the business only provides services that are primarily instructional and not medical services or health-related support services.

Subp. 10. **Temporary staffing agencies.** A business that provides staff to home care providers, such as temporary employment agencies, is not required to be licensed under this chapter if the business:

- A. only provides staff under contract to licensed or exempt providers;
- B. provides no services under direct agreements with clients; and
- C. is contractually bound to perform services under the contracting providers' direction and supervision.

Subp. 11. **Status of temporary staff.** For purposes of this chapter, staff of businesses excluded from licensure under subpart 10 shall be treated as if they are employees of the contracting licensee.

Subp. 12. **Medical equipment provider.** A provider of medical supplies and equipment is subject to this chapter only if:

- A. the provider provides a home care service;
- B. the provider makes more than one visit to a client's residence to provide the home care service; and
- C. the supplies or equipment are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber.

In this subpart, home care service does not include maintenance of supplies or equipment or instruction in their use.

4668.0012 LICENSURE.

Subpart 1. **License issued.** If a provider complies with the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall issue to the provider a certificate of licensure that will contain:

- A. the provider's name and address;
- B. the class of license as provided in subpart 3;
- C. the beginning and expiration dates; and
- D. a unique license number.

Subp. 2. **Multiple units.** Multiple units of a provider must share the same management that supervises and administers services provided by all units. Multiple units of a provider must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services with the main office because of distinct organizational structures.

Subp. 3. **Classes of licenses.** In issuing a license under this part, the commissioner shall assign a license classification according to items A and B. A provider performing only home management tasks must be registered according to Minnesota Statutes, section 144A.461, and need not obtain a home care license.

A. A provider must apply for one of the classes of the home care license listed in subitems (1) to (5).

(1) Class A, or professional home care agency license. Under this license, a provider may provide all home care services in a place of residence, including a residential center, at least one of which is nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, medical social services, home health aide tasks, or the provision of medical supplies and equipment when accompanied by the provision of a home care service.

(2) Class B, or paraprofessional agency license. Under this license, a provider may perform home care aide tasks and home management tasks, as provided by parts 4668.0110 and 4668.0120.

(3) Class C, or individual paraprofessional license. Under this license, a provider may perform home health aide, home care aide, and home management tasks.

(4) Class E, or assisted living programs license. Under this license, a provider may only provide assisted living services to residents of a residential center.

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(5) Class F home care provider license. Under this license, a provider may provide assisted living home care services solely for residents of one or more registered housing with services establishments, as provided by Minnesota Statutes, section 144A.4605.

B. If a provider meets the requirements of more than one license class, the commissioner shall issue to the provider a separate license for each applicable class of home care licensure.

Subp. 4. Applicability of rules to classes.

A. A class A licensee must comply with parts 4668.0002 to 4668.0180, and 4668.0218 to 4668.0240, except that one certified for Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with the requirements listed in part 4668.0180, subpart 10.

B. A class B licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0190, and 4668.0218 to 4668.0240.

C. A class C licensee must comply with parts 4668.0002 to 4668.0035, 4668.0050 to 4668.0065, 4668.0075 to 4668.0170, 4668.0200, and 4668.0218 to 4668.0240.

D. A class E licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0215, and 4668.0218 to 4668.0240.

E. A class F home care provider licensee must comply with parts 4668.0002 to 4668.0050, 4668.0065, 4668.0070, 4668.0170, 4668.0218 to 4668.0240, and 4668.0800 to 4668.0870.

Subp. 5. New license. A license shall be issued to an applicant that is not currently licensed if the applicant completes the application, pays the fee in full, and complies with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. A license is effective for one year after the date the license is issued.

Subp. 6. License application. To apply for a license under this chapter, an applicant must follow the procedures in items A and B.

A. An applicant for a license under this chapter must provide the following information on forms provided by the commissioner:

(1) the applicant's name and address, including the name of the county in which the applicant resides or has its principal place of business;

(2) address and telephone number of the principal administrative office;

(3) address and telephone number of each branch office, if any;

(4) names and addresses of all owners and managerial officials;

(5) documentation of compliance with the background study requirements of Minnesota Statutes, section 144A.46, subdivision 5, for all persons involved in the management, operation, or control of a provider;

(6) evidence of workers' compensation coverage, as required by Minnesota Statutes, sections 176.181 and 176.182;

(7) in the case of class C applicants, proof that the applicant is not contagious with tuberculosis, as required by part 4668.0065, subparts 1 and 2;

(8) in the case of class C applicants, proof that the applicant has met any applicable training and supervision requirements for paraprofessionals, as provided by parts 4668.0100 and 4668.0110; and

(9) a list of those home care services listed in Minnesota Statutes, section 144A.43, subdivision 3, or 144A.4605, that will be made available to clients.

B. An application on behalf of a corporation, association, or unit of government must be signed by an officer or managing agent.

Subp. 7. Agent. Each application for a home care provider license or for renewal of a home care provider license shall designate one or more owners, managerial officials, or employees, as an agent:

A. who is authorized to transact business with the commissioner of health on all matters provided for in this chapter and Minnesota Statutes, sections 144A.43 to 144A.47; and

B. upon whom all notices and orders shall be served, and who is authorized to accept service of notices and orders on behalf of the licensee, in proceedings under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

The designation of one or more persons under this subpart shall not affect the legal responsibility of any other owner or managerial official under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

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Subp. 8. **Notification of changes in information.** The licensee shall notify the commissioner in writing within ten working days after any change in the information required to be provided by subparts 6 and 7, except for the information required by subpart 6, item A, subitem (4), which will be required at the time of license renewal, and except for services reported under subpart 6, item A, subitem (9), that are discontinued for less than 90 days.

Subp. 9. **Application processing.** The commissioner shall process an application in the manner provided by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (b). No application shall be processed without payment of the license fee in full, in the amount provided by subpart 18.

Subp. 10. **Prelicensing survey.** Before granting a license, the commissioner may investigate the applicant for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 11. **Denial of license.** A license shall be denied if:

A. the applicant; an owner of the applicant, individually or as an owner of another home care provider; or another home care provider of which an owner of the applicant also was or is an owner; has ever been issued a correction order for failing to assist its clients, in violation of part 4668.0050, subpart 2, upon the licensee's decision to cease doing business as a home care provider;

B. the applicant is not in compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

C. the applicant is disqualified under Minnesota Statutes, sections 144.057 and 245A.04;

D. the applicant or an owner or managerial official has been unsuccessful in having a disqualification under Minnesota Statutes, section 144.057 or 245A.04, set aside; or

E. the commissioner determines that an owner or managerial official, as an owner or managerial official of another licensee, was substantially responsible for the other licensee's failure to substantially comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 12. **Change of classification.** A licensee may change to a different class of license under subpart 3, by submitting a new application under subpart 6 and meeting all applicable requirements of this chapter. An application under this subpart shall be accompanied by the fee provided by subpart 18.

Subp. 13. **License renewals.** Except as provided in subpart 14 or 15, a license will be renewed for a period of one year if the licensee satisfies items A to C. The licensee must:

A. submit an application for renewal on forms provided by the commissioner at least 30 days before expiration of the license;

B. submit the renewal fee, in the amount provided by subpart 18; and

C. comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 14. **Conditional license.** If a licensee is not in full compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, at the time of expiration of its license, and the violations do not warrant denial of renewal of the license, the commissioner shall issue a license for a limited period conditioned on the licensee achieving full compliance within the term of the license or the term of any correction orders.

Subp. 15. **Suspension, revocation, or denial of renewal of license.** The commissioner may deny renewal of a license, or may suspend, revoke, or make conditional a license, if the licensee, or an owner or managerial official of the licensee:

A. is in violation, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47;

B. permits, aids, or abets the commission of any illegal act in the provision of home care;

C. performs any act detrimental to the welfare of a client;

D. obtained the license by fraud or misrepresentation;

E. knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

F. denies representatives of the commissioner access to any part of the provider, its books, records, or files, or employees;

G. interferes with or impedes a representative of the commissioner in contacting the provider's clients;

H. interferes with or impedes a representative of the commissioner in the enforcement of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

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I. destroys or makes unavailable any records or other evidence relating to the licensee's compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

J. refuses to initiate a background study under Minnesota Statutes, section 144.057 or 245A.04; or

K. has failed to timely pay any fines assessed under part 4668.0230 or 4668.0800, subpart 6.

Subp. 16. **Transfers prohibited; changes in ownership.** A license issued under this part may not be transferred to another party. Before changing ownership, a prospective provider must apply for a new license under this part. A change of ownership means a transfer of operational control to a different business entity, and includes:

A. transfer of the business to a different or new corporation;

B. in the case of a partnership, the dissolution or termination of the partnership under Minnesota Statutes, chapter 323A, with the business continuing by a successor partnership or other entity;

C. relinquishment of control of the provider by the licensee to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

D. transfer of the business by a sole proprietor to another party or entity; or

E. in the case of a privately held corporation, the change in ownership or control of 50 percent or more of the outstanding voting stock.

Subp. 17. **Display of license.** The original license must be displayed in the provider's principal business office and copies must be displayed in all other offices. The licensee must provide a copy of the license to any person who requests it.

Subp. 18. **Fees.** Each application for a license must include payment in full of the fee according to the schedule in chapter 4669.

4668.0016 WAIVERS AND VARIANCES.

Subpart 1. **Definitions.** For purposes of this part:

A. "waiver" means an exemption from compliance with a requirement of this chapter; and

B. "variance" means a specified alternative to a requirement of this chapter.

Subp. 2. **Criteria for waiver or variance.** Upon application of a licensee, the commissioner shall waive or vary any provision of this chapter, except for those provisions relating to criminal disqualification, part 4668.0020, and to the home care bill of rights, part 4668.0030, if the commissioner finds that:

A. the waiver or variance is necessary because of the unavailability of services or resources in the provider's geographic area; or

B. enforcement of a requirement would result in unreasonable hardship on the licensee; and

C. the waiver or variance will not adversely affect the health, safety, or welfare of any client.

Subp. 3. **Experimental variance.** A variance may be granted to allow a provider to offer home care services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the clients, and is likely to improve the services provided.

Subp. 4. **Conditions.** The commissioner may impose conditions on the granting of a waiver or variance that the commissioner considers necessary.

Subp. 5. **Duration and renewal.** The commissioner may limit the duration of any waiver or variance, and may renew a limited waiver or variance.

Subp. 6. **Applications.** An application for waiver or variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following:

A. the rule from which the waiver or variance is requested;

B. the time period for which the waiver or variance is requested;

C. if the request is for a variance, the specific alternative action that the licensee proposes;

D. the reasons for the request; and

E. justification that subpart 2 or 3 will be satisfied.

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The commissioner may require additional information from the licensee before acting on the request.

Subp. 7. **Grants and denials.** The commissioner shall grant or deny each request for waiver or variance in writing. Notice of a denial shall contain the reasons for the denial. The terms of a requested variance may be modified upon agreement between the commissioner and a licensee.

Subp. 8. **Violation of variances.** A failure to comply with the terms of a variance shall be deemed to be a violation of this chapter.

Subp. 9. **Revocation or denial of renewal.** The commissioner shall revoke or deny renewal of a waiver or variance if:

- A. it is determined that the waiver or variance is adversely affecting the health, safety, or welfare of the licensee's clients;
- B. the licensee has failed to comply with the terms of the variance;
- C. the licensee notifies the commissioner in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or
- D. the revocation or denial is required by a change in law.

Subp. 10. **Hearings.** A denial of a waiver or variance may be contested by requesting a hearing as provided by part 4668.0017. The licensee bears the burden of proving that the denial of a waiver or variance was in error.

4668.0017 HEARINGS.

Subpart 1. **Hearing rights.** An applicant for a license or a licensee that has been assessed a fine under part 4668.0230 or 4668.0800, subpart 6, that has had a waiver or variance denied or revoked under part 4668.0016, or that has a right to a hearing under Minnesota Statutes, section 144A.46, subdivision 3, may request a hearing to contest that action or decision according to the rights and procedures provided by Minnesota Statutes, chapter 14, and this part.

Subp. 2. **Request for hearing.** A request for a hearing shall be in writing and shall:

- A. be mailed or delivered to the commissioner or the commissioner's designee;
- B. contain a brief and plain statement describing every matter or issue contested; and
- C. contain a brief and plain statement of any new matter that the licensee believes constitutes a defense or mitigating factor.

Subp. 3. **Informal conference.** At any time, the licensee and the commissioner may hold an informal conference to exchange information, clarify issues, or resolve any or all issues.

4668.0019 ADVERTISING.

Licensees shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this part, advertising includes any means of communicating to potential clients the availability, nature, or terms of home care services.

4668.0030 HOME CARE BILL OF RIGHTS.

Subpart 1. **Scope and enforcement against those exempt from licensure.** All home care providers, including those exempt from licensure under Minnesota Statutes, section 144A.46, subdivision 2, must comply with this part and the home care bill of rights, as provided by Minnesota Statutes, section 144A.44. The commissioner shall enforce this part and the home care bill of rights against providers exempt from licensure in the same manner as against licensees.

Subp. 2. **Notification of client.** The provider shall give a written copy of the home care bill of rights, as required by Minnesota Statutes, section 144A.44, to each client or each client's responsible person.

Subp. 3. **Time of notice.** The provider shall deliver the bill of rights at the time that the provider and the client or the client's responsible person agree to a service agreement, or before services are initiated, whichever is earlier.

Subp. 4. **Content of notice.** In addition to the text of the bill of rights in Minnesota Statutes, section 144A.44, subdivision 1, the written notice to the client must include the following:

- A. a statement, printed prominently in capital letters, that is substantially the same as the following:

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING
YOU HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF

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HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR OLDER MINNESOTANS.

B. the telephone number, mailing address, and street address, of the Office of Health Facility Complaints;

C. the telephone number and address of the office of the ombudsman for older Minnesotans; and

D. the licensee's name, address, telephone number, and name or title of the person to whom problems or complaints may be directed.

The information required by items B and C shall be provided by the commissioner to licensees upon issuance of licenses and whenever changes are made.

Subp. 5. **Acknowledgment of receipt.** The provider shall obtain written acknowledgment of the client's receipt of the bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's responsible person.

Subp. 6. **Documentation.** The licensee shall retain in the client's record documentation of compliance with this part.

Subp. 7. **Prohibition against waivers.** The licensee may not request nor obtain from clients any waiver of any of the rights enumerated in Minnesota Statutes, section 144A.44, subdivision 1. Any waiver obtained in violation of this subpart is void.

4668.0035 HANDLING OF CLIENTS' FINANCES AND PROPERTY.

Subpart 1. **Powers-of-attorney.** A licensee may not accept powers-of-attorney from clients for any purpose, and may not accept appointments as guardians or conservators of clients, unless the licensee maintains a clear organizational separation between the home care service and the program that accepts guardianship or conservatorship appointments. This subpart does not apply to licensees that are Minnesota counties or other units of government.

Subp. 2. **Handling clients' finances.** A licensee may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A licensee must provide a client with receipts for all transactions and purchases paid with the clients' funds. When receipts are not available, the transaction or purchase must be documented. A licensee must maintain records of all such transactions.

Subp. 3. **Security of clients' property.** A licensee may not borrow a client's property, nor in any way convert a client's property to the licensee's possession, except in payment of a fee at the fair market value of the property.

Subp. 4. **Gifts and donations.** Nothing in this part precludes a licensee or its staff from accepting bona fide gifts of minimal value, or precludes the acceptance of donations or bequests made to a licensee that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

4668.0040 COMPLAINT PROCEDURE.

Subpart 1. **Complaint procedure.** A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

Subp. 2. **Informing clients.** The system required by subpart 1 must provide written notice to each client that includes:

- A. the client's right to complain to the licensee about the services received;
- B. the name or title of the person or persons to contact with complaints;
- C. the method of submitting a complaint to the licensee;
- D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and

E. a statement that the provider will in no way retaliate because of a complaint.

Subp. 3. **Prohibition against retaliation.** A licensee must not take any action that negatively affects a client in retaliation for a complaint made by the client.

Subp. 4. **Scope.** This part applies to all licensees except class C licensees.

4668.0050 ACCEPTANCE, RETENTION, DISCONTINUATION OF SERVICES, AND DISCHARGE OF CLIENTS.

Subpart 1. **Acceptance of clients.** No licensee may accept a person as a client unless the licensee has staff, sufficient in qualifications and numbers, to adequately provide the services

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agreed to in the service agreement, under part 4668.0140 for class A, B, and C licensees, or the service plan, under part 4668.0815, for class F home care provider licensees.

Subp. 2. **Assistance upon discontinuance of services.** If the licensee discontinues a home care service to a client for any reason and the client continues to need the home care service, the licensee shall provide to the client a list of home care providers that provide similar services in the client's geographic area.

This subpart does not apply to a licensee that discontinues a service to a client because of the client's failure to pay for the service.

4668.0060 ADMINISTRATION.

Subpart 1. **Services by contract.** The licensee may contract for services to be provided to its clients. Personnel providing services under contract must meet the same requirements required by this chapter of personnel employed by the licensee.

Subp. 2. **Responsibility of licensee for contractors.** A violation of this chapter by a contractor of the licensee will be considered to be a violation by the licensee.

Subp. 3. **Fulfillment of services.** The licensee shall provide all services required by the client's service agreement, required by part 4668.0140.

Subp. 4. **Scheduled appointments for nonessential services.** If a licensee, contractor, or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee shall:

- A. follow the procedure, if any, established in the service agreement;
- B. provide a replacement person; or
- C. notify the client that the appointment will not be kept, and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 5. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time, and the licensee, contractor, or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee shall make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 6. **Availability of contact person.** Every class A or class B licensee that provides home health aide or home care aide tasks, must have a contact person available for consultation whenever a paraprofessional is performing home health aide or home care aide tasks for a client. The contact person must be available to the paraprofessional in person, by telephone, or by other means.

4668.0065 INFECTION CONTROL.

Subpart 1. **Tuberculosis screening.** No person who is contagious with tuberculosis may provide services that require direct contact with clients. All individual licensees and employees and contractors of licensees must document the following before providing services that require direct contact with clients:

- A. the person must provide documentation of having received a negative reaction to a Mantoux test administered within the 12 months before working in a position involving direct client contact, and no later than every 24 months after the most recent Mantoux test; or
- B. if the person has had a positive reaction to a Mantoux test upon employment or within the two years before working in a position involving direct client contact, or has a positive reaction to a Mantoux test in repeat testing during the course of employment, the person must provide:
 - (1) documentation of a negative chest x-ray administered within the three months before working in a position involving direct client contact; or
 - (2) documentation of a negative chest x-ray administered each 12 months, for two years after the positive reaction to a Mantoux test or documentation of completing or currently taking a course of tuberculosis preventative therapy; or
- C. if the person has had a positive reaction to a Mantoux test more than two years before working in a position involving direct client contact, the person must provide documentation of a negative chest x-ray taken within the previous 12 months or documentation of completing or currently taking a course of tuberculosis preventative therapy.

In this subpart, "Mantoux test" means a Mantoux tuberculin skin test.

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Subp. 2. **Exposure to tuberculosis.** In addition to the requirements of subpart 1, a person who has been exposed to active tuberculosis must document a negative result of a Mantoux test or chest x-ray administered no earlier than ten weeks and no later than 14 weeks after the exposure.

Subp. 3. **Infection control in-service training.** For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

- A. hand washing techniques;
- B. the need for and use of protective gloves, gowns, and masks;
- C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;
- D. disinfecting reusable equipment; and
- E. disinfecting environmental surfaces.

4668.0070 PERSONNEL RECORDS.

Subpart 1. **Scope.** This part applies to all licensees except class C licensees.

Subp. 2. **Personnel records.** The licensee must maintain a record of each employee, of each individual contractor excluded under part 4668.0008, subpart 7, and of other individual contractors. The record must include the following information:

- A. evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this chapter, statute, or other rules;
- B. records of training required by this chapter; and
- C. evidence of licensure under this chapter, if required.

Subp. 3. **Job descriptions.** The licensee shall maintain current job descriptions, including qualifications, responsibilities, and identification of supervisors, if any, for each job classification.

Subp. 4. **Retention of personnel records.** Each personnel record must be retained for at least three years after an employee or contractor ceases to be employed by the licensee.

4668.0075 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** Every individual applicant for a license, and every person who provides direct care, supervision of direct care, or management of services for a licensee, shall complete an orientation to home care requirements before providing home care services to clients. This orientation may be incorporated into the training required of paraprofessionals under part 4668.0130. This orientation need only be completed once.

Subp. 2. **Content.** The orientation required by subpart 1 must contain the following topics:

- A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- B. handling of emergencies and use of emergency services;
- C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- D. home care bill of rights;
- E. handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints; and
- F. services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by the licensee or may be obtained from other sources. The commissioner shall provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** Each licensee shall retain evidence that each person required under subpart 1, has completed the orientation training required by this part.

Subp. 5. **Transferability.** Licensees may accept from another provider written verification that a person has completed the orientation.

4668.0080 QUALIFICATIONS OF PROFESSIONAL PERSONNEL.

Subpart 1. **Occupational therapy.** A person who provides occupational therapy as a licensee or as an employee or contractor of a licensee must:

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A. have earned a baccalaureate degree from an occupational therapy program accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association;

B. be registered as an occupational therapist by the American Occupational Therapy Certification Board; or

C. meet the standards established for registration by the American Occupational Therapy Certification Board, in effect on June 1, 1990.

Subp. 2. **Speech therapy.** A person who provides speech therapy as a licensee or as an employee or contractor of a licensee must be registered with the department as a speech- language pathologist, under parts 4750.0010 to 4750.0700.

Subp. 3. **Respiratory therapy.** A person who provides respiratory therapy as a licensee or as an employee or contractor of a licensee must have completed a respiratory care program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation and the Joint Review Committee for Respiratory Therapy Education or by an accrediting agency approved by the commissioner.

Subp. 4. **Dietitians.** A person who provides nutritional services as a licensee or as an employee or contractor of a licensee, must have a baccalaureate degree in nutrition or a comparable program, including at least six months of supervised experience, or be registered by the Commission on Dietetic Registration of the American Dietetic Association.

Subp. 5. **Physical therapy.** A person who provides physical therapy as an employee or contractor of a licensee must be registered as a physical therapist with the Board of Medical Practice under Minnesota Statutes, sections 148.65 to 148.78.

4668.0100 HOME HEALTH AIDE TASKS.

Subpart 1. **Home health aide tasks.** For a class A or C licensee, a registered nurse may delegate medical or nursing services as tasks or a therapist may assign therapy services as tasks only to a person who satisfies the requirements of subpart 5. These delegated or assigned tasks, as set forth in this part, include home care aide tasks as set forth in part 4668.0110. Class A licensees providing home care aide tasks must satisfy the training and supervision requirements of this part, and not part 4668.0110. These tasks include:

- A. administration of medications, as provided by subpart 2;
- B. performing routine delegated medical or nursing or assigned therapy procedures, as provided by subpart 4, except items C to H;
- C. assisting with body positioning or transfers of clients who are not ambulatory;
- D. feeding of clients who, because of their condition, are at risk of choking;
- E. assistance with bowel and bladder control, devices, and training programs;
- F. assistance with therapeutic or passive range of motion exercises;
- G. providing skin care, including full or partial bathing and foot soaks; and
- H. during episodes of serious disease or acute illness, providing services performed for a client or to assist a client to maintain the hygiene of the client's body and immediate environment, to satisfy nutritional needs, and to assist with the client's mobility, including movement, change of location, and positioning, and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Administration of medications.** A person who satisfies the requirements of subpart 5 may administer medications, whether oral, suppository, eye drops, ear drops, inhalant, topical, or administered through a gastrostomy tube, if:

- A. the medications are regularly scheduled;
- B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:
 - (1) within 24 hours after its administration; or
 - (2) within a time period that is specified by a registered nurse prior to the administration;
- C. prior to the administration, the person is instructed by a registered nurse in the procedures to administer the medications to each client;
- D. a registered nurse specifies, in writing, and documents in the clients' records, the procedures to administer the medications; and

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E. prior to the administration, the person demonstrates to a registered nurse the person's ability to competently follow the procedure.

For purposes of this subpart, "pro re nata medication," commonly called p.r.n. medication, means a medication that is ordered to be administered to or taken by a client as necessary.

Subp. 3. **Limitations on administering medications.** A person who administers medications under subpart 2 may not inject medications into veins, muscle, or skin.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of subpart 5 may perform delegated medical or nursing and assigned therapy procedures, if:

A. prior to performing the procedures, the person is instructed by a registered nurse or therapist, respectively, in the proper methods to perform the procedures with respect to each client;

B. a registered nurse or therapist, respectively, specifies, in writing, specific instructions for performing the procedures for each client;

C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person's ability to competently follow the procedures; and

D. the procedures for each client are documented in the clients' records.

Subp. 5. **Qualifications for persons who perform home health aide tasks.** A person may only offer or perform home health aide tasks, or be employed to perform home health aide tasks, if the person has:

A. successfully completed the training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction substantially equivalent to that required by item A;

D. satisfied the requirements of Medicare for training or competency of home health aides, as provided by Code of Federal Regulations, title 42, section 484.36;

E. satisfied subitems (1) and (2):

(1) meets the requirements of title XVIII of the Social Security Act for nursing assistants in nursing facilities certified for participation in the Medicare program, or has successfully completed a nursing assistant training program approved by the state; and

(2) has had at least 20 hours of supervised practical training or experience performing home health aide tasks in a home setting under the supervision of a registered nurse, or completes the supervised practical training or experience within one month after beginning work performing home health aide tasks, except that a class C licensee must have completed this supervised training or experience before a license will be issued; or

F. before April 19, 1993, completed a training course of at least 60 hours for home health aides that had been approved by the department.

Subp. 6. **In-service training and demonstration of competence.** For each person who performs home health aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

C. If a person has not performed home health aide tasks for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence in the skills listed in part 4668.0130, subpart 3, item A, subitem (1).

Subp. 7. **Documentation.** Class A licensees shall verify that persons employed or contracted by the licensees to perform home health aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home health aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 8. **Initiation of home health aide tasks.** Prior to the initiation of home health aide tasks, a registered nurse or therapist shall orient each person who is to perform home health aide tasks to each client and to the tasks to be performed.

Subp. 9. **Periodic supervision of home health aide tasks.** After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under

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the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

- A. within 14 days after initiation of home health aide tasks; and
- B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4; or
- C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4.

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse at least every other visit, and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

4668.0110 HOME CARE AIDE TASKS.

Subpart 1. **Home care aide tasks.** For a class B or C licensee, only a person who satisfies the requirements of subpart 2 or part 4668.0100, subpart 5, may perform the following services for clients:

- A. preparing modified diets, such as diabetic or low sodium diets;
- B. reminding clients to take regularly scheduled medications or perform exercises;
- C. household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;
- D. household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease; and
- E. assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the client is ambulatory, and if the client has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Qualifications for persons who perform home care aide tasks.** No person may offer or perform home care aide tasks, or be employed to perform home care aide tasks, unless the person has:

- A. successfully completed training and passed the competency evaluation required by part 4668.0130, subpart 1;
- B. passed the competency evaluation required by part 4668.0130, subpart 3;
- C. successfully completed training in another jurisdiction comparable to that required by item A; or
- D. satisfied the requirements of part 4668.0100.

Subp. 3. **Documentation.** Class B licensees shall verify that the persons employed or contracted by the licensees to perform home care aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home care aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 4. **In-service training.** For each person who performs home care aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home care aide tasks must complete at least six hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

Subp. 5. [Repealed, L 2009 c 174 art 2 s 12]

Subp. 6. **Class E visits.** A class E licensee must visit the client and observe the provision of home care services every 60 days after initiation of home care aide tasks to verify that the work is being performed adequately and to identify problems.

4668.0120 HOME MANAGEMENT TASKS.

Subpart 1. **Home management tasks.** Any person may perform services that are not listed in part 4668.0100, subpart 1, or part 4668.0110, subpart 1, including housekeeping, meal preparation, and shopping.

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Subp. 2. **Training of persons who perform home management tasks.** Except for the orientation training required by Minnesota Statutes, section 144A.461, no training is required of persons who perform home management tasks.

4668.0130 TRAINING AND COMPETENCY EVALUATION FOR PERSONS WHO PERFORM HOME HEALTH AIDE AND HOME CARE AIDE TASKS.

Subpart 1. **Scope of training course and instructor.** The training required by part 4668.0100, subpart 5, and by part 4668.0110, subpart 2, must:

- A. include the topics and course requirements specified in subpart 2 and use a curriculum approved by the commissioner;
- B. be taught by a registered nurse with experience or training in home care, except that specific topics required by subpart 2 may be taught by another instructor in conjunction with the registered nurse; and
- C. include a competency evaluation required by subpart 3.

Subp. 2. **Curriculum.** The training required in part 4668.0100, subpart 5 for home health aide tasks must contain the topics described in items A to N, and must contain no less than 75 hours of classroom and laboratory instruction. The training required in part 4668.0110, subpart 2 for home care aide tasks, must contain the topics described in items A to G, and must contain no less than 24 hours of classroom and laboratory instruction. The required topics are:

- A. those topics required in the orientation training required by part 4668.0075;
- B. observation, reporting, and documentation of client status and of the care or services provided;
- C. basic infection control;
- D. maintenance of a clean, safe, and healthy environment;
- E. medication reminders;
- F. appropriate and safe techniques in personal hygiene and grooming, including bathing and skin care, the care of teeth, gums, and oral prosthetic devices, and assisting with toileting;
- G. adequate nutrition and fluid intake including basic meal preparation and special diets;
- H. communication skills;
- I. reading and recording temperature, pulse, and respiration;
- J. basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional;
- K. recognition of and handling emergencies;
- L. physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family;
- M. safe transfer techniques and ambulation; and
- N. range of motion and positioning.

Subp. 3. **Competency evaluation.** The competency evaluation tests must be approved by the commissioner.

- A. To qualify to perform home health aide tasks, the person must pass the following:
 - (1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E, F, I, M, and N; and
 - (2) a written, oral, or practical test of the topics listed in subpart 2, items A to D, G, H, and J to L.
- B. To qualify to perform home care aide tasks, the person must pass the competency evaluation for home health aide tasks, or the following:
 - (1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E and F; and
 - (2) a written, oral, or practical test of the topics in subpart 2, items A to D and G.

Subp. 4. **Evidence of qualifications.** A licensee that provides the training and the competency evaluation required by this part shall provide each person who completes the training or passes the competency evaluation with written certification of satisfying this part.

4668.0140 SERVICE AGREEMENTS.

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Subpart 1. **Service agreements.** No later than the second visit to a client, a licensee shall enter into a written service agreement with the client or the client's responsible person. Any modifications of the service agreement must be in writing and agreed to by the client or the client's responsible person.

Subp. 2. **Contents of service agreement.** The service agreement required by subpart 1 must include:

- A. a description of the services to be provided, and their frequency;
- B. identification of the persons or categories of persons who are to provide the services;
- C. the schedule or frequency of sessions of supervision or monitoring required, if any;
- D. fees for services;
- E. a plan for contingency action that includes:
 - (1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;
 - (2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;
 - (3) who to contact in case of an emergency or significant adverse change in the client's condition;
 - (4) the method for the licensee to contact a responsible person of the client, if any; and
 - (5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.

Class C licensees need not comply with items B and C and this item, subitems (2) and (5). Subitems (3) and (5) are not required for clients receiving only home management services.

4668.0150 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to medications and treatments that are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber to be administered by the licensee.

Subp. 2. **Medication and treatment orders.** Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Subp. 3. **Authorizations.** All orders for medications and treatments must be dated and signed by the prescriber, except as provided by subpart 5.

Subp. 4. **Content of orders.** All orders for medications must contain the name of the drug, dosage, and directions for use.

Subp. 5. **Verbal orders.** Upon receiving an order verbally from a prescriber, the nurse or therapist shall:

- A. record and sign the order; and
- B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 6. **Renewal of orders.** All orders must be renewed at least every three months.

4668.0160 CLIENT RECORDS.

Subpart 1. **Maintenance of client record.** The licensee shall maintain a record for each client.

Subp. 2. **Security.** The licensee shall establish written procedures to control use and removal of client records from the provider's offices and for security in client residences and to establish criteria for release of information. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 3. **Retention.** A client's record must be retained for at least five years following discharge. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider, other health care practitioner or provider, or is admitted to an inpatient facility, the licensee, upon request of the client, shall send a copy or summary of the client's record to the new provider or facility or to the client.

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Subp. 5. **Form of entries.** All entries in the client record must be:

- A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or
- B. recorded in an electronic media in a secure manner.

Subp. 6. **Content of client record.** The client record must contain:

- A. the following information about the client:
 - (1) name;
 - (2) address;
 - (3) telephone number;
 - (4) date of birth;
 - (5) dates of the beginning and end of services; and
 - (6) names, addresses, and telephone numbers of any responsible persons;
- B. a service agreement as required by part 4668.0140;
- C. medication and treatment orders, if any;
- D. notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact;
- E. names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;
- F. a summary following the termination of services, which includes the reason for the initiation and termination of services, and the client's condition at the termination of services.

Class C licensees need only include the information required by items A, B, and E. Class E licensees need only include the information required by items A, B, D, and E.

Subp. 7. **Confidentiality.** The licensee shall not disclose to any other person any personal, financial, medical, or other information about the client, except:

- A. as may be required by law;
- B. to staff, contractors of the licensee, another home care provider, other health care practitioner or provider, or inpatient facility who require information in order to provide services to the client, but only such information that is necessary to the provision of services;
- C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; and
- D. representatives of the commissioner authorized to survey or investigate home care providers.

4668.0170 REQUEST BY CLIENT FOR DISCONTINUATION OF LIFE SUSTAINING TREATMENT.

Subpart 1. **Action by person receiving request.** If a client, family member, or other caregiver of the client requests that an employee or other agent of the licensee discontinue a life sustaining treatment, the employee or other agent of the licensee receiving the request:

- A. shall take no action to discontinue the treatment; and
- B. shall promptly inform the person's supervisor or other representative of the licensee of the client's request.

Subp. 2. **Action by licensee.** Upon being informed of a request for termination of treatment, the licensee shall promptly:

- A. inform the client that the request will be made known to the physician who ordered the client's treatment; and
- B. inform the physician of the client's request.

Subp. 3. **Right to maintain treatment.** This part does not require the licensee to discontinue treatment, except as may be required by law or court order.

Subp. 4. **Rights of clients.** This part does not diminish the rights of clients to control their treatments or terminate their relationships with providers.

Subp. 5. **Health care declarations.** This part shall be construed in a manner consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by clients under that act.

4668.0180 CLASS A PROVIDER, PROFESSIONAL HOME CARE AGENCY.

Subpart 1. **Scope.** This part applies only to a professional home care agency with a class A license under part 4668.0012, subpart 3.

Subp. 2. **Required services.** The licensee shall provide at least one of the following home care services directly:

- A. professional nursing;
- B. physical therapy;
- C. speech therapy;
- D. respiratory therapy;
- E. occupational therapy;
- F. nutritional services;
- G. medical social services;
- H. home health aide tasks; or
- I. provision of medical supplies and equipment when accompanied by the provision of a home care service.

Subp. 3. **Scope of services.** The licensee may provide all home care services, except that the licensee may provide a hospice program only if licensed as a hospice program under part 4664.0010, as provided by Minnesota Statutes, section 144A.753, subdivision 1.

Subp. 4. **Medical social services.** If provided, medical social services must be provided in compliance with Minnesota Statutes, sections 148B.18 to 148B.28.

Subp. 5. **Nursing services.** If provided, nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 6. **Physical therapy.** If provided, physical therapy must be provided according to Minnesota Statutes, sections 148.65 to 148.78.

Subp. 7. **Other services.** Other services not addressed in this chapter may be provided.

Subp. 8. **Referrals.** If a licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee shall:

- A. inform the client of the possible need;
- B. determine the client's preferences with respect to obtaining the service; and
- C. if the client desires the service, inform the client about available providers or referral services.

Subp. 9. **Quality assurance.** The licensee shall establish and implement a quality assurance plan, described in writing, in which the licensee must:

- A. monitor and evaluate two or more selected components of its services at least once every 12 months; and
- B. document the collection and analysis of data and the action taken as a result.

Subp. 10. **Equivalent requirements for certified providers.** A class A licensee that is certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with this part, or with the following items, if the Medicare certification is based on compliance with the federal conditions of participation, and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services:

- A. part 4668.0040;
- B. part 4668.0050;
- C. part 4668.0060, subparts 1, 2, 3, and 6;
- D. part 4668.0070, subparts 2 and 3;
- E. part 4668.0080, subparts 1 and 2;
- F. part 4668.0100, subparts 1 and 4 to 9;
- G. part 4668.0110;
- H. part 4668.0130;
- I. part 4668.0140, subparts 1 and 2, items A to D;
- J. part 4668.0150;

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- K. part 4668.0160;
- L. part 4668.0180, subparts 1 to 9.

4668.0190 CLASS B PROVIDER, PARAPROFESSIONAL AGENCY.

A paraprofessional agency with a class B license under part 4668.0012, subpart 3, may perform home care aide tasks and home management tasks.

4668.0200 CLASS C PROVIDER, INDIVIDUAL PARAPROFESSIONALS.

Subpart 1. **Scope.** This part applies only to a paraprofessional with a class C license under part 4668.0012, subpart 3.

Subp. 2. **Services.** The licensee may perform:

- A. home health aide tasks;
- B. home care aide tasks; and
- C. home management tasks.

Subp. 3. **Training.** The licensee who performs home health aide tasks or home care aide tasks must meet the requirements of part 4668.0130 before a license will be issued.

Subp. 4. **Record of supervision.** The licensee who performs home health aide tasks must maintain a record of the supervision required by part 4668.0100, subpart 9.

Subp. 5. **Records.** The licensee must maintain a written record of the services provided at each visit to clients.

Subp. 6. **Notice of clientele.** Upon request of the commissioner, class C licensees shall provide the name, address, and telephone numbers of all or specified clients and the clients' responsible persons.

4668.0218 INFORMATION AND REFERRAL SERVICES.

The commissioner shall request from licensees information necessary to establish and maintain information and referral services required by Minnesota Statutes, section 144A.47, and licensees shall provide the requested information. This information may be required to be provided together with the licensing information required by part 4668.0012, or may be required to be provided separately.

4668.0220 SURVEYS AND INVESTIGATIONS.

Subpart 1. **Surveys.** Except as provided in subpart 3 or 10, the commissioner may survey each applicant or licensee before issuing a new license or renewing an existing license. An applicant for a license that is certified and surveyed by the Minnesota Department of Health for Medicare or medical assistance shall be surveyed at the time of its next certification survey. Applicants and licensees shall provide any and all information requested by the surveyor or investigator that is within the scope of licensure.

Subp. 2. **Coordination of surveys.** If feasible, the commissioner shall survey licensees to determine compliance with this chapter at the same time as surveys for certification for Medicare and medical assistance if Medicare certification is based on compliance with the federal conditions of participation and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services.

Subp. 3. **Biennial surveys.** A licensee that has been licensed for at least two consecutive years and that has been in substantial compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, and has had no serious violations in that period, may be surveyed every second license term rather than during each license term.

Subp. 4. **Complaint investigations.** Upon receiving information that a licensee may be violating or may have violated a requirement of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall investigate the complaint.

Subp. 5. **Scheduling surveys.** Surveys and investigations shall be conducted without advance notice to licensees. Surveyors may contact licensees on the day of a survey to arrange for someone to be available at the survey site. The contact does not constitute advance notice.

Subp. 6. **Contacting and visiting clients.** Surveyors may contact or visit a licensee's clients without notice to the licensee. Licensees shall provide a list of current and past clients and responsible persons with addresses and telephone numbers upon request of a surveyor. Before visiting a client, a surveyor shall obtain the client's or responsible person's permission by

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telephone, by mail, or in person. Surveyors shall inform all clients and responsible persons of their right to decline permission for a visit.

Subp. 7. **Information from clients.** The commissioner may solicit information from clients by telephone, mail, or other means.

Subp. 8. **Client information.** Upon the commissioner's request, licensees shall provide to the commissioner information identifying some or all of its clients and any other information about the licensee's services to the clients.

Subp. 9. **Sampling of clientele.** The commissioner may conduct a written survey of all or a sampling of home care clients to determine their satisfaction with the services provided.

Subp. 10. **Surveys of class C licensees.** The commissioner may survey class C licensees by telephoning, visiting, or writing to the licensees' clients. Office visits may be conducted, but are not required.

4668.0230 FINES FOR UNCORRECTED VIOLATIONS.

Subpart 1. **Authority.** The fines provided under this part are under the authority of Minnesota Statutes, sections 144.653, subdivision 6, and 144A.45, subdivision 2, clause (4).

Subp. 2. **Fines for license classes.** Class A and class B licensees shall be assessed fines at 100 percent of the amounts provided in subpart 3. Class C licensees shall be assessed fines at 25 percent of the amounts provided in subpart 3.

Subp. 3. **Schedule of fines for violations of statutory provisions.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective provision that was violated in Minnesota Statutes:

- A. section 144A.44, subdivision 1, clause (1), \$250;
- B. section 144A.44, subdivision 1, clause (2), \$250;
- C. section 144A.44, subdivision 1, clause (3), \$50;
- D. section 144A.44, subdivision 1, clause (4), \$350;
- E. section 144A.44, subdivision 1, clause (5), \$250;
- F. section 144A.44, subdivision 1, clause (6), \$250;
- G. section 144A.44, subdivision 1, clause (7), \$50;
- H. section 144A.44, subdivision 1, clause (8), \$250;
- I. section 144A.44, subdivision 1, clause (9), \$250;
- J. section 144A.44, subdivision 1, clause (10), \$250;
- K. section 144A.44, subdivision 1, clause (11), \$350;
- L. section 144A.44, subdivision 1, clause (12), \$250;
- M. section 144A.44, subdivision 1, clause (13), \$500;
- N. section 144A.44, subdivision 1, clause (14), \$250;
- O. section 144A.44, subdivision 1, clause (15), \$350;
- P. section 144A.44, subdivision 1, clause (16), \$250;
- Q. section 144A.44, subdivision 1, clause (17), \$500; and
- R. section 144A.44, subdivision 2, \$250.

Subp. 4. **Schedule of fines for violations of Vulnerable Adults Act.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 626.557, the following fines shall be assessed:

- A. subdivision 3, \$250;
- B. subdivision 3a, \$100;
- C. subdivision 4, \$250;
- D. subdivision 9, \$250; and
- E. subdivision 17, \$250.

Subp. 5. **Schedule of fines for violations of rules.** For each violation of a rule provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective rule that was violated:

- A. part 4668.0008, subpart 3, \$300;
- B. for providing false information required by part 4668.0012, subpart 6, \$500;

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- C. part 4668.0012, subpart 8, \$100;
- D. part 4668.0012, subpart 17, \$50;
- E. a variance, under part 4668.0016, subpart 8, the fine shall be the amount of the fine established for the rule that was varied;
- F. part 4668.0019, \$250;
- G. part 4668.0030, subpart 2, \$250;
- H. part 4668.0030, subpart 3, \$50;
- I. part 4668.0030, subpart 4, \$50;
- J. part 4668.0030, subpart 5, \$50;
- K. part 4668.0030, subpart 6, \$50;
- L. part 4668.0030, subpart 7, \$250;
- M. part 4668.0035, subpart 1, \$250;
- N. part 4668.0035, subpart 2, \$100;
- O. part 4668.0035, subpart 3, \$100;
- P. part 4668.0040, subpart 1, \$250;
- Q. part 4668.0040, subpart 2, \$50;
- R. part 4668.0040, subpart 3, \$250;
- S. part 4668.0050, subpart 1, \$350;
- T. part 4668.0050, subpart 2, \$100;
- U. part 4668.0060, subpart 1, \$50;
- V. part 4668.0060, subpart 3, \$350;
- W. part 4668.0060, subpart 4, \$350;
- X. part 4668.0060, subpart 5, \$500;
- Y. part 4668.0060, subpart 6, \$300;
- Z. part 4668.0065, subpart 1, \$500;
- AA. part 4668.0065, subpart 2, \$500;
- BB. part 4668.0065, subpart 3, \$300;
- CC. part 4668.0070, subpart 2, \$50;
- DD. part 4668.0070, subpart 3, \$50;
- EE. part 4668.0070, subpart 4, \$50;
- FF. part 4668.0075, subpart 1, \$300;
- GG. part 4668.0075, subpart 2, \$100;
- HH. part 4668.0075, subpart 4, \$50;
- II. part 4668.0080, subpart 1, \$300;
- JJ. part 4668.0080, subpart 2, \$300;
- KK. part 4668.0080, subpart 3, \$300;
- LL. part 4668.0080, subpart 4, \$300;
- MM. part 4668.0080, subpart 5, \$300;
- NN. part 4668.0100, subpart 1, \$350;
- OO. part 4668.0100, subpart 2, \$350;
- PP. part 4668.0100, subpart 3, \$500;
- QQ. part 4668.0100, subpart 4, \$350;
- RR. part 4668.0100, subpart 5, \$300;
- SS. part 4668.0100, subpart 6, \$300;
- TT. part 4668.0100, subpart 7, \$50;
- UU. part 4668.0100, subpart 8, \$350;
- VV. part 4668.0100, subpart 9, \$350;
- WW. part 4668.0110, subpart 1, \$350;
- XX. part 4668.0110, subpart 2, \$300;
- YY. part 4668.0110, subpart 3, \$50;
- ZZ. part 4668.0110, subpart 4, \$300;

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AAA. part 4668.0110, subpart 5, \$350;
BBB. part 4668.0110, subpart 6, \$350;
CCC. part 4668.0120, subpart 2, \$50;
DDD. part 4668.0130, subpart 1, \$300;
EEE. part 4668.0130, subpart 2, \$300;
FFF. part 4668.0130, subpart 3, \$300;
GGG. part 4668.0130, subpart 4, \$50;
HHH. part 4668.0140, subpart 1, \$250;
III. part 4668.0140, subpart 2, \$50;
JJJ. part 4668.0150, subpart 2, \$350;
KKK. part 4668.0150, subpart 3, \$350;
LLL. part 4668.0150, subpart 4, \$350;
MMM. part 4668.0150, subpart 5, \$350;
NNN. part 4668.0150, subpart 6, \$350;
OOO. part 4668.0160, subpart 1, \$100;
PPP. part 4668.0160, subpart 2, \$100;
QQQ. part 4668.0160, subpart 3, \$50;
RRR. part 4668.0160, subpart 4, \$100;
SSS. part 4668.0160, subpart 5, \$50;
TTT. part 4668.0160, subpart 6, \$100;
UUU. part 4668.0160, subpart 7, \$350;
VVV. part 4668.0170, subpart 1, \$500;
WWW. part 4668.0170, subpart 2, \$500;
XXX. part 4668.0180, subpart 3, \$500;
YYY. part 4668.0180, subpart 4, \$300;
ZZZ. part 4668.0180, subpart 5, \$300;
AAAA. part 4668.0180, subpart 6, \$300;
BBBB. part 4668.0180, subpart 8, \$200;
CCCC. part 4668.0180, subpart 9, \$100;
DDDD. part 4668.0190, \$500;
EEEE. part 4668.0200, subpart 2, \$500;
FFFF. part 4668.0200, subpart 4, \$100;
GGGG. part 4668.0200, subpart 5, \$50;
HHHH. part 4668.0200, subpart 6, \$500;
IIII. part 4668.0220, subpart 6, \$500; and
JJJJ. part 4668.0220, subpart 8, \$500.

4668.0240 FAILURE TO CORRECT DEFICIENCY AFTER FINE HAS BEEN IMPOSED.

If, upon subsequent reinspection after a fine has been imposed under part 4668.0230, the deficiency has still not been corrected, another fine shall be assessed. This fine shall be double the amount of the previous fine.

4668.0800 CLASS F HOME CARE PROVIDER.

Subpart 1. **Scope of license.** A class F home care provider licensee may provide nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications, solely for residents of one or more housing with services establishments registered under Minnesota Statutes, chapter 144D.

Subp. 2. **Required services.** A class F home care provider licensee must provide at least one of the following assisted living home care services directly:

- A. professional nursing services;
- B. delegated nursing services;
- C. non-nursing services performed by unlicensed personnel; or
- D. central storage of medications.

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Subp. 3. **Fulfillment of services.** A class F home care provider licensee must provide all services required by a client's service plan under part 4668.0815.

Subp. 4. **Referrals.** If a class F home care provider licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee must:

- A. inform the client of the possible need;
- B. determine the client's preferences with respect to obtaining the service; and
- C. if the client desires the service, inform the client about available providers or referral services.

Subp. 5. **Availability of contact person.** A class F home care provider licensee must have a contact person available for consultation whenever an unlicensed person employed by the licensee is performing assisted living home care services for a client. The contact person must be available to unlicensed personnel in person, by telephone, or by other means of direct communication.

Subp. 6. **Violations of rules.** For each violation of parts 4668.0800 to 4668.0870 subject to a fine under Minnesota Statutes, section 144.653, subdivisions 5 to 8, a fine shall be assessed according to the schedules established in parts 4668.0800 to 4668.0870.

Subp. 7. **Failure to correct deficiency.** If, upon subsequent reinspection after a fine has been imposed under subpart 6, the deficiency has still not been corrected, another fine must be assessed. This fine must be double the amount of the previous fine.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 3, \$350;
- B. subpart 4, \$200; and
- C. subpart 5, \$300.

4668.0805 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.

Subp. 2. **Content.** The orientation required under subpart 1 must contain the following topics:

- A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- B. handling emergencies and using emergency services;
- C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- D. the home care bill of rights, Minnesota Statutes, section 144A.44;
- E. handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and
- F. the services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by a class F home care provider licensee or may be obtained from other sources. The commissioner must provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** A class F home care provider licensee must retain evidence that each person has completed the orientation training required under this part.

Subp. 5. **Transferability.** A class F home care provider licensee may accept written verification from another provider that a person has completed the orientation required under this part.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 1, \$300;
- B. subpart 2, \$100; and
- C. subpart 4, \$50.

4668.0810 CLIENT RECORDS.

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Subpart 1. **Maintenance of client record.** A class F home care provider licensee must maintain a record for each client at the housing with services establishment where the services are provided. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 2. **Security.** A class F home care provider licensee must establish and implement written procedures for security of client records, including:

- A. the use of client records;
- B. the removal of client records from the establishment; and
- C. the criteria for release of client information.

Subp. 3. **Retention.** A class F home care provider licensee must retain a client's record for at least five years following the client's discharge or discontinuation of services. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider or other health care practitioner or provider or is admitted to an inpatient facility, a class F home care provider licensee, upon request of the client, must send a copy or summary of the client's record to the new provider or facility or to the client.

Subp. 5. **Form of entries.** Except as required by subpart 6, items F and G, documentation of a class F home care service must be created and signed by the staff person providing the service no later than the end of the work period. The documentation must be entered into the client record no later than two weeks after the end of the day service was provided. All entries in the client record must be:

- A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or
- B. recorded in an electronic media in a manner that ensures the confidentiality and security of the electronic information, according to current standards of practice in health information management, and that allows for a printed copy to be created.

Subp. 6. **Content of client record.** The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

- A. the following information about the client:
 - (1) name;
 - (2) address;
 - (3) telephone number;
 - (4) date of birth;
 - (5) dates of the beginning and end of services;
 - (6) names, addresses, and telephone numbers of any responsible persons;
 - (7) primary diagnosis and any other relevant current diagnoses;
 - (8) allergies, if any; and
 - (9) the client's advance directive, if any;
- B. an evaluation and service plan as required under part 4668.0815;
- C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;
- D. medication and treatment orders, if any;
- E. the client's current tuberculosis infection status, if known;
- F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;
- G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;
- H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;
- I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

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J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

Subp. 7. **Confidentiality.** A Class F home care provider licensee must not disclose to any other person any personal, financial, medical, or other information about the client, except:

A. as may be required by law;

B. to staff, another home care provider, a health care practitioner or provider, or an inpatient facility that requires information to provide services to the client, but only the information that is necessary to provide services;

C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; or

D. to representatives of the commissioner authorized to survey or investigate home care providers.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, \$100;

B. subpart 2, \$100;

C. subpart 3, \$50;

D. subpart 4, \$100;

E. subpart 5, \$50;

F. subpart 6, \$100; and

G. subpart 7, \$350.

4668.0815 EVALUATION AND SERVICE PLAN.

Subpart 1. **Evaluation; documentation.** No later than two weeks after the initiation of assisted living home care services to a client, a registered nurse must complete an individualized evaluation of the client's needs and must establish, with the client or the client's responsible person, a suitable and up-to-date service plan for providing assisted living home care services in accordance with accepted standards of practice for professional nursing. The service plan must be in writing and include a signature or other authentication by the class F home care provider licensee and by the client or the client's responsible person documenting agreement on the services to be provided.

Subp. 2. **Reevaluation.** A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

Subp. 3. **Modifications.** A modification of the service plan must be in writing and agreed to by the client or the client's responsible person before the modification is initiated. A modification must be authenticated by the client or the client's responsible person and must be entered into the client's record no later than two weeks after the modification is initiated.

Subp. 4. **Contents of service plan.** The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the class F home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

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(4) the method for the class F home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

Subp. 5. **Scheduled appointments for nonessential services.** If a class F home care provider licensee or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee must:

- A. follow the procedure established in the service plan;
- B. provide a replacement person; or
- C. notify the client that the appointment will not be kept and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 6. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time and the class F home care provider licensee or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee must make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 7. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 1, \$250;
- B. subpart 2, \$250;
- C. subpart 3, \$250;
- D. subpart 4, \$50;
- E. subpart 5, \$350; and
- F. subpart 6, \$500.

4668.0820 NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services.

Subp. 2. **Compliance with Minnesota Nurse Practice Act.** Nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285, and rules adopted thereunder.

4668.0825 DELEGATED NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services delegated to unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** Before initiating delegated nursing services for a client, a registered nurse must conduct a nursing assessment of the client's functional status and need for nursing services and must develop a service plan for providing the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for delegated nursing services must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Nursing services delegated to unlicensed personnel.** A registered nurse may delegate the nursing services specified in items A to I only to a person who satisfies the requirements of part 4668.0835 and possesses the knowledge and skills consistent with the complexity of the nursing task being delegated, only in accordance with Minnesota Statutes, sections 148.171 to 148.285. Nursing services that may be delegated are:

- A. performing assistance with self-administration of medication and medication administration according to part 4668.0855;
- B. performing routine delegated medical or nursing procedures, as provided under subpart 4;
- C. assisting with body positioning or transfer of a client;
- D. feeding a client who, because of the client's condition, is at risk of choking;
- E. assisting with bowel and bladder control, devices, and training programs;
- F. assisting with therapeutic or passive range of motion exercises;

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- G. providing skin care, including full or partial bathing and foot soaks;
- H. during episodes of serious disease or acute illness, providing the following services or assisting a client to:
 - (1) maintain the hygiene of the client's body and immediate environment;
 - (2) satisfy nutritional needs;
 - (3) assist with the client's mobility, including movement, change of location, and positioning;
 - (4) bathe;
 - (5) maintain oral hygiene;
 - (6) dress;
 - (7) care for hair;
 - (8) use the toilet;
 - (9) change bedding;
 - (10) perform basic housekeeping; and
 - (11) prepare meals; and
- I. providing central storage of medications, according to part 4668.0865.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

- A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
- B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;
- C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
- D. the procedures for each client are documented in the client's record; and
- E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 5. **Information to determine delegation.** The licensee must establish and implement policies to communicate up-to-date information to the registered nurse regarding the current available unlicensed personnel and their training and qualifications, so the registered nurse has sufficient information to determine the appropriateness of delegating tasks in individual situations.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$250;
- B. subpart 3, \$350;
- C. subpart 4, \$350; and
- D. subpart 5, \$350.

4668.0830 OTHER SERVICES PERFORMED BY UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides other services performed by unlicensed personnel.

Subp. 2. **Other services.** A person who satisfies the requirements of part 4668.0835 may perform services in the registered housing with services establishment including:

- A. preparing modified diets, including diabetic or low sodium diets;
- B. providing medication reminders;
- C. performing household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;
- D. performing household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease;
- E. assisting with dressing, oral hygiene, hair care, grooming, and bathing; and
- F. performing home management tasks.

Subp. 3. **Schedule of fines.** A fine of \$350 shall be assessed for a violation of subpart 2.

4668.0835 QUALIFICATIONS FOR UNLICENSED PERSONNEL WHO PERFORM ASSISTED LIVING HOME CARE SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Qualifications.** An unlicensed person may offer to perform, or be employed to perform nursing services delegated to unlicensed personnel as provided under part 4668.0825, other services performed by unlicensed personnel as provided under part 4668.0830, or central storage of medications as provided under part 4668.0865, only if the person has:

A. successfully completed the training and passed the competency evaluation according to part 4668.0840, subpart 2;

B. successfully completed the training under part 4668.0840, subpart 3, and passed a competency evaluation according to part 4668.0840, subpart 4; or

C. satisfied the requirements of part 4668.0100, subpart 5.

Subp. 3. **In-service training and demonstration of competency.** For each unlicensed person who performs assisted living home care services, a class F home care provider licensee must comply with items A to C.

A. For each 12 months of employment, a person who performs assisted living home care services must complete at least eight hours of in-service training in topics relevant to the provision of home care services, including training in infection control required under part 4668.0065, subpart 3, obtained from the licensee or another source.

B. If a person has not performed assisted living home care services for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence according to part 4668.0840, subpart 4, item C.

C. A licensee must retain documentation of satisfying this part and must provide documentation to a person who completes the in-service training.

Subp. 4. **Documentation.**

A. An unlicensed person who performs assisted living home care services must provide documentation to the employing licensee of satisfying this part.

B. A class F home care provider licensee must verify that unlicensed persons employed by the licensee to perform assisted living home care services have satisfied the requirements of this part, and must retain documentation in the personnel records.

Subp. 5. **Initiation of services by unlicensed personnel.** Before initiating delegated nursing services by unlicensed personnel, a registered nurse must orient each person who is to perform assisted living home care services to each client and to the assisted living home care services to be performed. Based on the professional judgment of the registered nurse and on the individual needs of the client, the orientation may occur onsite, verbally, or in writing.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, \$300;

B. subpart 3, \$300;

C. subpart 4, \$50; and

D. subpart 5, \$350.

4668.0840 TRAINING AND COMPETENCY EVALUATION FOR UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Scope of training course and instructor.** The training required under part 4668.0835, subpart 2, must:

A. include each assisted living home care service offered to clients that the unlicensed person will perform, taught by a registered nurse with experience or training in the subject being taught;

B. include the core training requirements specified in subpart 3;

C. include the competency evaluation required under subpart 4; and

D. use a curriculum that meets the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

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Subp. 3. Core training of unlicensed personnel.

A. An unlicensed person performing assisted living home care services must successfully complete training or demonstrate competency in the topics described in subitems (1) to (12). The required topics are:

- (1) an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- (2) recognizing and handling emergencies and using emergency services;
- (3) reporting maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- (4) the home care bill of rights, Minnesota Statutes, section 144A.44;
- (5) handling clients' complaints and reporting complaints to the Office of Health Facility Complaints;
- (6) the services of the ombudsman for older Minnesotans;
- (7) communication skills;
- (8) observing, reporting, and documenting client status and the care or services provided;
- (9) basic infection control;
- (10) maintaining a clean, safe, and healthy environment;
- (11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and
- (12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

B. The core training of unlicensed personnel must be taught by a registered nurse with experience or training in home care, except that item A, subitems (1) to (7), may be taught by another instructor under the direction of the registered nurse.

C. The core training curriculum must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. Competency evaluation.

A. The competency evaluation tests required under part 4668.0835, subpart 2, items A and B, must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

B. A registered nurse must complete and document each competency evaluation.

C. To qualify to perform assisted living home care services, a person must demonstrate competency by successfully completing:

- (1) a written, oral, or practical test of the topics in subpart 3; and
- (2) a written, oral, or practical test of all assisted living home care provider services that the person will perform.

Subp. 5. Evidence of qualifications. A class F home care provider licensee that provides the training and the competency evaluation required by this part must provide each person who successfully completes the training or passes the competency evaluation with written verification of satisfying this part.

Subp. 6. Schedule of fines. For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$300;
- B. subpart 3, \$300;
- C. subpart 4, \$300; and
- D. subpart 5, \$50.

4668.0845 PERIODIC SUPERVISION OF UNLICENSED PERSONNEL.

Subpart 1. Scope. This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. Services that require supervision by a registered nurse.

A. After the orientation required under part 4668.0835, subpart 5, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who perform assisted living home care services that require supervision by

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a registered nurse at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. Supervision or monitoring must be provided no less often than the following schedule:

(1) within 14 days after initiation of assisted living home care services that require supervision by a registered nurse; and

(2) at least every 62 days thereafter, or more frequently if indicated by a nursing assessment and the client's individualized service plan.

B. If the unlicensed person is monitored by a licensed practical nurse, the client must be supervised by a registered nurse at the housing with services establishment at least every other visit and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 3. **Services that do not require supervision by a registered nurse.** After the orientation required under part 4668.0835, subpart 5, unlicensed persons who perform services listed under part 4668.0830, subpart 2, or other assisted living home care services that do not require supervision by a registered nurse must be supervised at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. The service plan developed under part 4668.0815 must address the frequency of the supervision of each service and the appropriate person to perform the supervision.

Subp. 4. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, \$350; and

B. subpart 3, \$300.

4668.0855 MEDICATION ADMINISTRATION AND ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides medication administration or assistance with self-administration of medication by unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845, and must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Delegation by a registered nurse.** A registered nurse may delegate medication administration or assistance with self-administration of medication only to a person who satisfies the requirements of part 4668.0835, subpart 2, and possesses the knowledge and skills consistent with the complexity of medication administration or assistance with self-administration of medication, only in accordance with Minnesota Statutes, sections 148.171 to 148.285.

Subp. 4. **Training for assistance with self-administration of medication or medication administration.** Before the registered nurse delegates the task of assistance with self-administration of medication or the task of medication administration, a registered nurse must instruct the unlicensed person on the following:

A. the complete procedure for checking a client's medication record;

B. preparation of the medication for administration;

C. administration of the medication to the client;

D. assistance with self-administration of medication;

E. documentation, after assistance with self-administration of medication or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with self-administration of medication or medication administration as ordered, and the signature of the nurse or authorized person who assisted or administered and observed the same; and

F. the type of information regarding assistance with self-administration of medication and medication administration reportable to a nurse.

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Subp. 5. **Administration of medications.** A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

- A. the medications are regularly scheduled; and
- B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:
 - (1) within 24 hours after its administration; or
 - (2) within a time period that is specified by a registered nurse prior to the administration.

Subp. 6. **Limitations on administering medications.** A person who administers medications under subpart 3 may not draw up injectables. Medication administered by injection under subpart 5 is limited to insulin.

Subp. 7. **Performance of routine procedures.** A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration if:

- A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
- B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;
- C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
- D. the procedures for each client are documented in the client's records; and
- E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 8. **Documentation.** A class F home care provider licensee must retain documentation in the personnel records of the unlicensed personnel who have satisfied the training requirements of this part.

Subp. 9. **Medication records.** The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$350;
- B. subpart 3, \$350;
- C. subpart 4, \$300;
- D. subpart 5, \$350;
- E. subpart 6, \$500;
- F. subpart 7, \$350;
- G. subpart 8, \$50; and
- H. subpart 9, \$300.

4668.0860 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee when an authorized prescriber orders a medication or treatment to be administered by the licensee.

Subp. 2. **Prescriber's order required.** There must be a written prescriber's order for a drug for which a class F home care provider licensee provides assistance with self-administration of medication or medication administration, including an over-the-counter drug.

Subp. 3. **Medication and treatment orders.** A medication or treatment must be administered by a nurse qualified to implement the order or by an unlicensed person under the direction of a nurse and the supervision of a registered nurse, according to part 4668.0845.

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Subp. 4. **Authorizations.** An order for medication or treatment must be dated and signed by the prescriber, except as provided by subparts 6 and 7, and must be current and consistent with the nursing assessment required under part 4668.0855, subpart 2.

Subp. 5. **Content of medication orders.** An order for medication must contain the name of the drug, dosage indication, and directions for use.

Subp. 6. **Verbal orders.** Upon receiving an order verbally from a prescriber, a nurse must:

- A. record and sign the order; and
- B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 7. **Electronically transmitted orders.**

A. An order received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.291 to 144.298 and 144A.44.

B. An order received by telephone, facsimile machine, or other electronic means must be communicated to the supervising registered nurse within one hour of receipt.

C. An order received by electronic means, not including facsimile machine, must be immediately recorded or placed in the client's record by a nurse and must be countersigned by the prescriber within 62 days.

D. An order received by facsimile machine must have been signed by the prescriber and must be immediately recorded or a durable copy placed in the client's record by a person authorized by the class F home care provider licensee.

Subp. 8. **Implementation of order.** When an order is received, the class F home care provider licensee or an employee of the licensee must take action to implement the order within 24 hours of receipt of the order.

Subp. 9. **Renewal of orders.** A medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$350;
- B. subpart 3, \$350;
- C. subpart 4, \$350;
- D. subpart 5, \$350;
- E. subpart 6, \$350;
- F. subpart 7, item A, \$250;
- G. subpart 7, item B, \$300;
- H. subpart 7, item C, \$300;
- I. subpart 7, item D, \$300;
- J. subpart 8, \$500 per day; and
- K. subpart 9, \$100.

4668.0865 CENTRAL STORAGE OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Nursing assessment and service plan.** For a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of a client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Control of medications.**

A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

- B. The system must contain at least the following provisions:

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- (1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;
- (2) a description of how the distribution and storage of medications will be handled, including a description of suitable storage facilities;
- (3) the procedures for recording medications that clients are taking;
- (4) the procedures for storage of legend and over-the-counter drugs;
- (5) a method of refrigeration of biological medications; and
- (6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.

Subp. 4. **Over-the-counter drugs.** An over-the-counter drug may be retained in general stock supply and must be kept in the original labeled container.

Subp. 5. **Legend drugs.** A legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of a time-dated drug, directions for use, client's name, prescriber's name, date of issue, and the name and address of the licensed pharmacy that issued the medications.

Subp. 6. **Medication samples.** A sample of medication provided to a client by an authorized prescriber may be used by that client, and must be kept in its original container bearing the original label with legible directions for use. If assistance with self-administration of medication or medication administration is provided by the class F home care provider licensee, a client's plan of care must address the use of a medication sample.

Subp. 7. **Prohibitions.** No legend drug supply for one client may be used or saved for the use of another client.

Subp. 8. **Storage of drugs.** A class F home care provider licensee providing central storage of medications must store all drugs in locked compartments under proper temperature controls and permit only authorized nursing personnel to have access to keys.

Subp. 9. **Storage of Schedule II drugs.** A class F home care provider licensee providing central storage of medications must provide separately locked compartments, permanently affixed to the physical plant or medication cart, for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$350;
- B. subpart 3, \$300;
- C. subpart 4, \$300;
- D. subpart 5, \$300;
- E. subpart 6, \$300;
- F. subpart 7, \$300;
- G. subpart 8, \$300; and
- H. subpart 9, \$300.

4668.0870 DISPOSITION OF MEDICATIONS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Drugs given to discharged clients.** Current medications belonging to a client must be given to the client, or the client's responsible person, when the client is discharged or moves from the housing with services establishment. A class F home care provider licensee must document in the client's record to whom the medications were given.

Subp. 3. **Disposition of medications.**

A. Unused portions of a controlled substance remaining in a housing with services establishment after death or discharge of the client for whom the controlled substance was prescribed, or any controlled substance discontinued permanently, must be disposed of by contacting the Minnesota Board of Pharmacy, which shall furnish the necessary instructions and forms, a copy of which shall be kept on file by the class F home care provider licensee for two years.

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B. Unused portions of a legend drug remaining in a housing with services establishment after the death or discharge of the client for whom the legend drug was prescribed, or any legend drug permanently discontinued, must be destroyed by the class F home care provider licensee or a designee of the licensee, in the presence of a pharmacist or nurse who shall witness the destruction. A notation of the destruction listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded in the client's record.

Subp. 4. **Loss or spillage.** When a loss or spillage of a Schedule II drug occurs, an explanatory notation must be made in the client's record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill.

Subp. 5. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$300;
- B. subpart 3, \$300; and
- C. subpart 4, \$300.

4669.0001 AUTHORITY.

This chapter establishes fees for the licensing of home care providers, as required by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (c), and part 4668.0012, subpart 18.

4669.0010 DEFINITIONS.

Subpart 1. **Applicant.** "Applicant" means a provider of home care services that applies for a new license or renewal license under chapter 4668.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Health.

Subp. 3. **Provider.** "Provider" means a home care provider required to be licensed under Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Revenues.** "Revenues" means all money or the value of property or services received by a registrant and derived from the provision of home care services, including fees for services, grants, bequests, gifts, donations, appropriations of public money, and earned interest or dividends.

4669.0020 LICENSE FEE.

An applicant for a new license or renewal license under chapter 4668 shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the formula in part 4669.0050.

4669.0030 PROCEDURE FOR PAYING LICENSE FEE.

Subpart 1. **Payment of fee.** An applicant shall submit the fee required by part 4669.0050 to the commissioner together with the application for the license.

Subp. 2. **Verification of revenues.** Under a circumstance listed in item A or B, the commissioner shall require each applicant to verify its revenues by providing a copy of an income tax return; informational tax return, such as an Internal Revenue Service form 1065 partnership return or form 990 tax-exempt organization return; Medicare cost report; certified financial statement; or other documentation that verifies the accuracy of the revenues derived from the provision of home care services for the reporting period on which the fee is based if either:

- A. the commissioner has received information that a revenue report may be inaccurate; or
- B. the provider has been randomly selected for compliance verification.

4669.0040 FEE LIMITATION.

A provider is subject to one license fee, regardless of the number of distinct programs through which home care services are provided unless the provider operates under multiple units as set forth in part 4668.0012, subpart 2. The fee shall be based on the total revenue of all home care services.

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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.